

Application for Credentialing Review
Advanced Practice Registered Nurses

Submitted by:
The Nebraska Board of Nursing

June 11, 2020

Purpose: This proposal seeks to modernize licensure and regulation of advanced practice registered nurses (APRNs) in Nebraska with the creation of a single APRN Practice Act that aligns scope of practice for all APRN groups with the national Consensus Model for APRN Regulation (Appendix A: Consensus Model). Consensus alignment is required for Nebraska to enter into the APRN licensure compact, which will afford licensure portability across state lines.

Description of the Applicant Group

1. Provide the following information for the applicant group:

a. Name, address, telephone number, e-mail address, and website of the applicant group in Nebraska, and any national parent organization;

Nebraska Board of Nursing

Ann Oertwich PhD, RN, Executive Director
301 Centennial Mall South
Lincoln, NE 68509
402-471-0317
ann.oertwich@nebraska.gov

National Council of State Boards of
Nursing (NCSBN)

David Benton, PhD, RN, CEO
111 East Wacker Drive, Suite 2900
Chicago, IL 60601-4277
312-525-3600
info@ncsbn.org

b. Composition of the group and approximate number of members in Nebraska;

The Nebraska Board of Nursing is composed of 12 members:

Eight registered nurses (RNs):

- (a) One practical nurse educator;
- (b) one associate degree or diploma nurse educator;
- (c) one baccalaureate nurse educator;
- (d) two nursing service administrators;
- (e) two staff nurses; and
- (f) one advanced practice registered nurse (APRN)
- (g) two licensed practical nurses (LPNs); and
- (h) two public members

Members are appointed by the Board of Health with consideration that the Board of Nursing is representative of acute care, long-term care, and community-based care, as well as a statewide geographic representation based on Congressional districts.

c. Relationship of the group to the occupation dealt with in the application.

Board of Nursing. This application is submitted on behalf of APRNs in Nebraska by the Nebraska Board of Nursing. Advanced practice registered nurses hold at least two licenses, one license as registered nurse (RN) and one APRN license in at least one of four APRN roles:

Certified Nurse Midwife (CNM)
Certified Registered Nurse Anesthetist (CRNA)
Clinical Nurse Specialist (CNS)
Nurse Practitioner (NP)

The Nebraska Department of Health and Human Services (NDHHS), Public Health Division, Licensure Unit regulates all licensed nurses in Nebraska including APRNs, RNs and licensed practice nurses (LPNs) and manages their respective Boards. The Board of Nursing makes licensure recommendations on the RN base licensure of the APRN license.

APRN Board. APRNs in Nebraska are also regulated by the NDHHS Licensure Unit, with licensure recommendations on the APRN license by an APRN Board. Nebraska is the only state with an APRN Board.

2. Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of the following;

a. Members of the same occupation or profession as that of the applicant group

Nebraska Nurses Association (NNA)

Douglas Haas, President
info@nebraskanurses.org
www.nebraskanurses.org

American College of Nurse Midwives (ACNM)

Nebraska Affiliate,
Heather Swanson, President
Neacnm@gmail.com for affiliate email
T: 308-830-1435

Nebraska Association of Nurse Anesthetists (NANA)

State affiliate, American Association of Nurse Anesthetists (AANA)
Kris Rohde, President
3901 Normal Blvd, Suite 100

Lincoln, NE 68506
T: 402-476-3852
www.neana.org

National Association of Clinical Nurse Specialists (NACNS) (no state affiliate)
100 N. 20th St., 4th Floor
Philadelphia, PA 19103
T: 215-320-3881
www.nacns.org
Alice Kindschuh is local representative for CNS' on APRN Board

Nebraska Nurse Practitioners (NNP)
State affiliate, American Association of Nurse Practitioners (AANP)
Tara Whitmire, President
President@nebraskanp.com

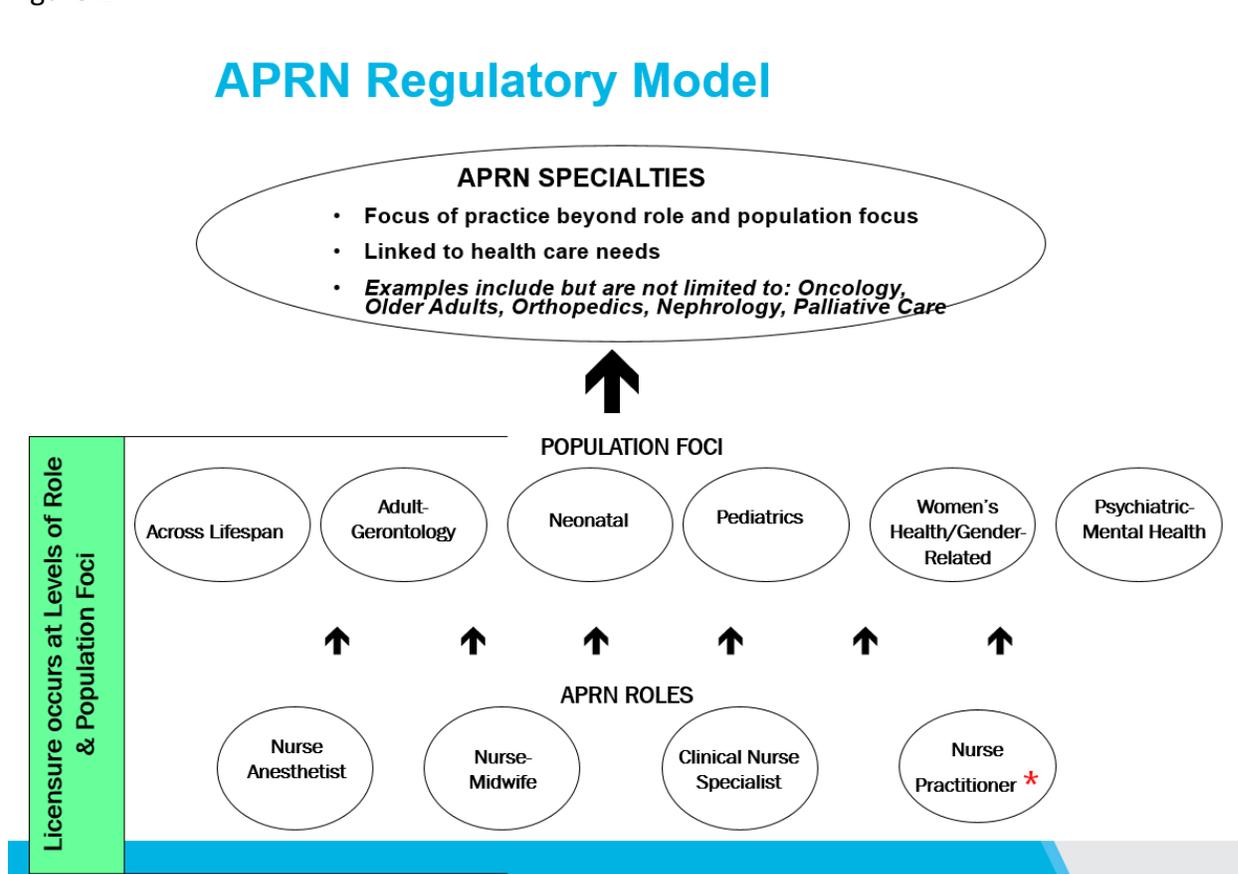
b. Members of the occupation dealt with in the application

Advanced practice registered nurses are RNs with advanced nursing education and certification (NCSBN, 2008). In the NCSBN APRN Consensus Model of Regulation (2008), there are four roles:

Certified Nurse Midwife (CNM),
Certified Registered Nurse Anesthetist (CRNA)
Clinical Nurse Specialist (CNS),
Certified Nurse Practitioner (CNP)

These four roles are collectively titled advanced practice registered nurse (APRN). Advanced practice registered nurses are licensed in at least one of the four roles and at least one of six population foci: 1) family/individual across the lifespan, 2) adult-gerontology, 3) pediatrics, 4) neonatal, 5) women's health/gender-related or 6) psych/mental health (See Figure 1).

Figure 1



Source: https://www.ncsbn.org/Consensus_Model_for_AP RN_Regulation_July_2008.pdf

3. Employers of the occupation dealt with in the application

APRNs are employed in a wide variety of health care settings, including acute care, private or public clinics, home and community-based practice settings. Practice owners are private, public and not-for-profit. Advanced practice registered nurses may also be self-employed as practice owners.

4. Practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application;

Practitioners that work closely with members of the occupation include physicians, physician assistants, RNs and LPNs, ancillary health care professionals, unlicensed support staff and health care administrators/practice owners.

5. Educators or trainers of prospective members of the occupation dealt with in the application;

All APRNs Have a Common Core Education Before Specialization

APRN education programs, including degree granting and post-graduate education programs are nationally accredited. All APRN education consists of a broad-based education, including a common core: three separate graduate-level courses in advanced physiology/pathophysiology, advanced health assessment and advanced pharmacology as well as appropriate clinical experiences. All newly developed APRN education programs or tracks go through a preapproval, pre-accreditation, or accreditation process prior to admitting students. Advanced Practice Registered Nurse education programs must be housed within graduate programs that are nationally accredited and graduates must meet eligibility requirements for national certification (NCSBN, 2008). Initial and ongoing national certification is a requirement for APRN licensure in Nebraska.

The list that follows includes Nebraska based, brick and mortar institutions that provide accredited APRN education in Nebraska. There are also accredited online programs that provide APRN education that are not based in Nebraska. Advanced Practice Registered Nursing education programs are not approved by the Board of Nursing in Nebraska: only pre-licensure programs are approved. Since all APRN education programs are accredited, which is required for the APRN to sit for certification, the Board of Nursing only focuses on approval of pre-licensure programs that prepare students to take the NCLEX-PN or NCLEX- RN, which are the entrance to practice exams for Practical Nursing and Registered Nursing.

Certified Nurse Midwife education programs in Nebraska:

None

Certified Registered Nurse Anesthetist education programs in Nebraska:

Bryan College of Health Sciences

1535 S. 52nd St.

Lincoln, NE 68506

402-481-3801

www.bryanhealthcollege.edu

Clarkson College

101 S. 42nd St.

Omaha, NE 68131

(402) 552-3100

www.clarksoncollege.edu

Clinical Nurse Specialist education programs in Nebraska:

Nebraska Methodist College

720 N 87th St.
Omaha, NE 68114
(402) 354-7000
www.methodistcollege.edu

Nurse Practitioner education programs in Nebraska:

Nebraska Methodist College

720 N 87th St.
Omaha, NE 68114
(402) 354-7000
www.methodistcollege.edu

Clarkson College

101 S. 42nd St.
Omaha, NE 68131
(402) 552-3100
www.clarksoncollege.edu

University of Nebraska Medical Center (UNMC)

College of Nursing
4111 Dewey Avenue
Omaha, NE 68198
(402)-559-4000
<http://www.unmc.edu/nursing>
Campuses in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff

Creighton University

College of Nursing, Omaha Campus
2500 California Plaza
Omaha, NE 68178
(402) 280-2700
www.creighton.edu
Campuses in Omaha and Hastings

6. **Citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.); and**

Please refer to **Appendix B** for a full list of agencies and organizations that utilize APRN services.

7. Any other group that would have an interest in the application.

Professional associations of physicians e.g. Nebraska Medical Association; and others such as the Nebraska Hospital Association, Nebraska Healthcare Association, Nebraska Homecare Association, Public Health Association of Nebraska, and others. Though not intended to be inclusive, this category is addressed in **Appendix C**.

8. If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal. Note: see Appendix D for full statutory references.

Certified Nurse Midwife (CNM)

The Certified Nurse Midwife Practice Act identifies the following scope of practice for CNMs:

38-611. Certified nurse midwife; authorized activities.

A certified nurse midwife may, under the provisions of a practice agreement,

- (1) attend cases of normal childbirth,
- (2) provide prenatal, intrapartum, and postpartum care,
- (3) provide normal obstetrical and gynecological services for women, and
- (4) provide care for the newborn immediately following birth. The conditions under which a certified nurse midwife is required to refer cases to a collaborating licensed practitioner shall be specified in the practice agreement.

Certified Registered Nurse Anesthetist (CRNA)

The Certified Registered Nurse Anesthetist Practice Act identifies the following scope of practice for CRNAs:

38-706. Practice of anesthesia, defined; activities not subject to act.

- (1) Practice of anesthesia means
 - (a) the performance of or the assistance in any act involving the determination, preparation, administration, or monitoring of any drug used to render an individual insensible to pain for procedures requiring the presence of persons educated in the administration of anesthetics or
 - (b) the performance of any act commonly the responsibility of educated anesthesia personnel. Practice of anesthesia includes the use of those techniques which are deemed necessary for adequacy in performance of anesthesia administration.

38-711. Certified registered nurse anesthetist; performance of duties.

- (1) The determination and administration of total anesthesia care shall be performed by the certified registered nurse anesthetist or a nurse anesthetist temporarily licensed pursuant to section 38-708 in consultation and collaboration with and with the consent of the licensed practitioner.
- (2) The following duties and functions shall be considered as specific expanded role functions of the certified registered nurse anesthetist:
 - (a) Preanesthesia evaluation including physiological studies to determine proper anesthetic management and obtaining informed consent;
 - (b) Selection and application of appropriate monitoring devices;
 - (c) Selection and administration of anesthetic techniques;
 - (d) Evaluation and direction of proper postanesthesia management and dismissal from postanesthesia care;
 - (e) Evaluation and recording of postanesthesia course of patients; and
 - (f) Use of fluoroscopy in conjunction with a licensed medical radiographer in connection with the performance of authorized duties and functions upon
 - (i) the successful completion of appropriate education and training as approved jointly by the department and the board and promulgated by the department in rules and regulations pursuant to section 71-3508 and
 - (ii) a determination regarding the scope and supervision of such use consistent with subsection (3) of this section.
- (3) The determination of other duties that are normally considered medically delegated duties to the certified registered nurse anesthetist or to a nurse anesthetist temporarily licensed pursuant to section 38-708 shall be the joint responsibility of the governing board of the hospital, medical staff, and nurse anesthetist personnel of any duly licensed hospital or, if in an office or clinic, the joint responsibility of the duly licensed practitioner and nurse anesthetist. All such duties, except in cases of emergency, shall be in writing in the form prescribed by hospital or office policy.

Clinical Nurse Specialist (CNS)

The Clinical Nurse Specialist Practice Act identifies the following scope of practice for CNSs:

38-906. Clinical nurse specialist practice, defined. The practice of a clinical nurse specialist includes health promotion, health supervision, illness prevention, and disease management, including assessing patients, synthesizing and analyzing data, and applying advanced nursing practice. A clinical nurse specialist conducts and applies research, advocates, serves as an agent of change, engages in systems management, and assesses and intervenes in complex health care problems within the selected clinical specialty.

Nurse Practitioner (NP). The Nurse Practitioner Practice Act identifies the following as the scope of practice for NPs:

38-2315. Nurse Practitioner; functions; scope.

- (1) A nurse practitioner may provide health care services within specialty areas. A nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider.
- (2) Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions, including:
 - (a) Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;
 - (b) Dispensing, incident to practice only, sample medications which are provided by the manufacturer and are provided at no charge to the patient; and
 - (c) Prescribing therapeutic measures and medications relating to health conditions within the scope of practice. Any limitation on the prescribing authority of the nurse practitioner for controlled substances listed in Schedule II of section 28-405 shall be recorded in the integrated practice agreement established pursuant to section 38-2310.
- (3) A nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty may manage the care of patients committed under the Nebraska Mental Health Commitment Act. Patients who require care beyond the scope of practice of a nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty shall be referred to an appropriate health care provider.
- (4) A nurse practitioner may pronounce death and may complete and sign death certificates and any other forms if such acts are within the scope of practice of the nurse practitioner and are not otherwise prohibited by law.

Scope of Practice Changes Sought in this Application:

This proposal seeks to make scope of practice and licensure requirements the same for all four APRN groups. The table that follows indicates the inconsistency in statutory language and practice authority. Full statutory references are located in **Appendix D**.

Current Scope based on Nebraska Statutes (see Appendix D)

	CNM	CRNA	CNS	NP
National certification	Yes	Yes	Yes	Yes
Accredited APRN education program	Yes	Yes	Yes	Yes
Full practice authority	No Practice agreement with a physician whose practice includes obstetrics (in statute)	Yes	Yes	Yes Transition to Practice (TTP) supervisory agreement initial 2000 hours of practice (in statute)
Prescriptive authority	No Limited by practice agreement	Yes	No	Yes

Summary of changes:

1. Full practice authority for CNMs
2. Prescriptive authority for CNMs and CNSs
3. No TTP requirement for NPs

It should be noted that full practice authority is recommended for all four APRN groups by the Institute of Medicine (IOM), Robert Wood Johnson Foundation (RWJF), National Governors Association (NGA), and the Federal Trade Commission (FTC) based on conclusions from academic research comparing health care quality among the different providers (Markowitz, Adams, Lewitt, and Dunlop, 2016). There is no evidence that Collaborative Practice Agreements or Transition to Practice (TTP) agreements change practice outcomes.

9. If the profession is not currently credentialed in Nebraska, describe the proposed credential and the proposed scope of practice, and/or the proposed functions and procedures of the group to be reviewed. This description of the desired scope of practice and the proposed credential constitute the core of the proposal. Also, please describe how the proposal would be administered. The application comprises the documentation the documentation and other materials that are provided in support of the proposal.

Not applicable

10. Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions. If possible, explain why the Legislature created these restrictions.

Certified Nurse Midwife (CNM).

Role Functions: The American College of Nurse-Midwives (ACNM) provides the following description of the role functions of the Certified Nurse-Midwife. The CNM role encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include the independent provision of primary care, gynecological and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. CNMs provide initial and ongoing comprehensive assessment, diagnosis and treatment. CNMs conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. CNMs also provide health promotion, disease prevention, and individualized wellness education and counseling. Services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers. CNMs practice in accord with the Standards of Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM, 2020).

History: CNM's first legislated their role in 1984 and have been required to have a practice agreement specifically with a physician whose practice includes obstetrics (OB-GYN). The CNMs have completed two Credentialing Reviews to date, but have been unsuccessful in removing requirements for a practice agreement with a physician. The CNM's education and certification are in alignment with national standards and the other three APRN groups. CNMs were initially regulated under the Board of Medicine, but changed to the APRN Board in 1996 under LB 414. ***This proposal seeks to remove the practice agreement requirement between a CNM and physician.***

Certified Registered Nurse Anesthetist (CRNA).

Role Functions: CRNAs administer anesthesia and anesthesia-related care in four general categories: (1) preanesthetic preparation and evaluation; (2) anesthesia induction, maintenance and emergence; (3) postanesthesia care; and (4) perianesthetic and clinical support functions. The CRNA scope of practice includes, but is not limited to, the following:

1. Performing and documenting a preanesthetic assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering, or administering preanesthetic medications and fluids; and obtaining informed consent for anesthesia.
2. Developing and implementing an anesthetic plan.
3. Selecting and initiating the planned anesthetic technique that may include general, regional, and local anesthesia and intravenous sedation.
4. Selecting, obtaining, or administering the anesthetics, adjuvant drugs, accessory drugs, and fluids necessary to manage the anesthetic, to maintain the patient's physiologic homeostasis, and to correct abnormal responses to the anesthesia or surgery.
5. Selecting, applying, or inserting appropriate noninvasive and invasive monitoring modalities for collecting and interpreting patient physiological data.
6. Managing a patient's airway and pulmonary status using endotracheal intubation, mechanical ventilation, pharmacological support, respiratory therapy, or extubation.
7. Managing emergence and recovery from anesthesia by selecting, obtaining, ordering, or administering medications, fluids, or ventilatory support in order to maintain homeostasis, to provide relief from pain and anesthesia side effects, or to prevent or manage complications.
8. Releasing or discharging patients from a post-anesthesia care area, and providing post-anesthesia follow-up evaluation and care related to anesthesia side effects or complications.
9. Ordering, initiating or modifying pain relief therapy, through the utilization of drugs, regional anesthetic techniques, or other accepted pain relief modalities, including labor epidural analgesia.
10. Responding to emergency situations by providing airway management, administration of emergency fluids or drugs, or using basic or advanced cardiac life support techniques.
11. Additional nurse anesthesia responsibilities which are within the expertise of the individual CRNA.

The functions listed above are a summary of CRNA practice and are not intended to be all-inclusive. A more specific list of CRNA functions and practice parameters is detailed in the *AANA Scope of Nurse Anesthesia Practice and Standards for Nurse Anesthesia Practice* (AANA, 2020).

History: Certified Registered Nurse Anesthetists were the first APRN group to obtain statutory authority to practice in 1981. CRNA practice act and scope of practice has changed relatively little with the exception of fluoroscopy privileges added in 2009. CRNAs were initially regulated under the Board of Medicine, but moved to the APRN Board in 1996 under LB 414. The APRN-CRNA requirements for education and certification have aligned with the other three groups to date. ***There are no changes in current statutory authority for CRNA practice in this proposal.***

Clinical Nurse Specialist.

Role Functions: A CNS is an expert clinician who provides an advanced level of care in hospitals and other clinical locations. The CNS works to improve healthcare through evidence-based practice at the individual patient and systems levels. The CNS provides clinical expertise, leadership in nursing practice, as well as systems innovation in hospital, community, outpatient, and long-term care settings. Role functions may include:

- Diagnosis and treatment
- Health promotion and wellness
- Maintain patient records
- Conduct research and share findings
- Research, develop, maintain, and train others in departmental policies, procedures, and patient care standards
- Order tests and evaluate them
- Advise other nurses
- Being a subject matter expert
- Disease management
- Prevention
- Risk reduction
- Prescribe medications

A CNS generally focuses or specializes role by one or more of the following:

- Population (e.g. pediatrics, geriatrics, or women's health)
- Setting (e.g. critical care, emergency room, etc.)
- Disease or medical subspecialty (e.g. psychiatric or rehabilitation)
- Type of problem (e.g. pain, wound care, stress)

There are core competencies that define CNS practice per the National Association of Clinical Nurse Specialists (NACNS), but more specific scope and standards of practice come with role specialization as noted above (NACNS, 2020).

History: The CNS role was established nationally over 60 years ago, gaining statutory recognition (licensure) in Nebraska in 2005. There are no supervisory requirements for the role and the statute is silent regarding prescriptive authority. Clinical nurse specialists are educated to prescribe and manage population health. Regulation of the

CNS was placed under the APRN Board in 2005. ***This proposal seeks to authorize prescriptive authority for the CNS.***

Nurse Practitioner (NP).

Role Functions: The American Academy of Nurse Practitioners (AANP) provides the following description of the functions of the NP in their Standards of Practice, identified as *The Process of Care*. The NP merges the nursing scientific process—assessment, diagnosis, plan, implement and evaluate—with national standards of care for advanced nursing practice as the framework for managing patient care.

A. Assessment of health status

- Obtains a relevant health and medical history
- Performs a physical examination based on age and history
- Performs or orders preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

- Utilizes critical thinking in the diagnostic process
- Synthesizes and analyzes collected data
- Formulates a differential diagnosis based on the history, physical examination, and diagnostic test results
- Establishes priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential.

- Orders and interprets additional diagnostic tests
- Prescribes/orders pharmacologic and non-pharmacologic interventions
- Develops a patient education plan
- Provides appropriate consultation/referral

D. Implementation of the plan

Interventions are based upon established priorities.

Actions by the nurse practitioner are:

- Individualized
- Consistent with an appropriate plan of care
- Based on scientific principles, theoretical knowledge, and clinical expertise
- Consistent with teaching and learning opportunities

Actions include:

- Accurately conducting supervising, and interpreting diagnostic tests

- Prescribing/ordering pharmacologic agents and non-pharmacologic therapies
- Providing relevant patient education
- Making appropriate referrals to other health professionals and community agencies

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up.

- Determines the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassesses and modifies the plan with the patient and family as necessary to achieve health and medical goals (AANP, 2010)

History: The Nurse Practitioner group legislated their role in Nebraska in 1984. LB 414 in 1996, created a lifetime Integrated Practice Agreement (IPA) requirement with physicians. Following several legislative initiatives, NPs successfully achieved the removal of the IPA in 2015 with LB 107. The IPA was replaced with a transition to practice (TTP) requirement with a qualifying supervisory physician or nurse practitioner for the initial 2000 hours of practice in 2015. Nurse Practitioners were initially regulated under the Board of Medicine, but changed to the APRN Board in 1996 under LB 414. ***This proposal seeks removal of the TTP requirement.***

History of APRN legislation: In 2018, Senator Carol Blood introduced the APRN licensure Compact. This bill was tabled following disagreement regarding statutory provisions of the APRN Compact, which allowed for alignment of the four APRN groups under Consensus Model. Compact law precedes state law, and adversaries of APRN scope of practice change stopped the bill.

In 2019, LB 730, a consensus model bill for all four APRN groups failed to advance from the HHS Committee. Senator Howard asked for another Credentialing Review for CNMs. The CNMs have previously completed successful Credentialing Reviews in 1994 and 2007. A third Credentialing Review application by CNMs has been withdrawn and replaced by this more comprehensive application for APRN consensus by Board of Nursing.

11. Identify other occupations that perform some of the same functions or similar functions.

Since the core of the APRN education and licensure is the nursing science (RN licensure) with additional advanced focused education, no one other occupation performs the same functions as an APRN. However, there is overlap of tasks with licensed physicians and physician assistants (PAs).

12. What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

Foundational education in nursing science and RN licensure is merged in an advanced practice nursing role and distinguishes APRN role functions in practice from physician's assistants or physicians.

Advanced practice registered nurses, by the nature of their advanced focused education, experience and emphasis on caring for the individual, emphasize a holistic approach to health care. Education in traditional medical components like pathophysiology, diagnosis and treatment are rooted in nursing philosophy that emphasizes the psychosocial aspects of patient, family and community. The nursing model of care also emphasizes prevention, disease state management and continuity of care, while PAs follow a disease-centered model.

13. Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

Supervision in Healthcare. Supervisory relationships with physicians may be required for compliance with Centers for Medicare and Medicaid Services (CMS) and/or state regulations that mandate how hospitals, clinics, private practices, and other agencies must conduct credentialing and privileging in order to receive funding from these sources (McMullen & Howie, 2020). **These are outside the jurisdiction of this proposal.**

Supervision by APRNs of Other Occupations. Advanced practice registered nurses may have supervisory responsibilities for other licensed and unlicensed staff. This would be dependent upon the needs of the practice setting, e.g., practice owners providing direct care services or facilities relying on nursing staff.

Certified Nurse Midwife (CNM). The Certified Nurse Midwifery Practice Act requires a CNM to have a practice agreement (38-609) with a licensed practitioner, "...any physician licensed to practice pursuant to the Medicine and Surgery Practice Act, whose practice includes obstetrics" (38-608). *Supervision* is "...the ready availability of a collaborating licensed practitioner for consultation and direction of the activities of the certified nurse midwife related to delegated medical functions as outlined in the practice agreement" (38-610). ***This application proposes to remove the practice agreement requirement from the CNM statute.***

Certified Registered Nurse Anesthetist (CRNA).

Any current supervisory relationships for CRNAs are employer-based and would not change with this application.

Clinical Nurse Specialist (CNS). The CNS statute is silent on supervision, however, a CNS may enter into supervisory relationships with physicians in hospital-based practice settings in compliance with credentialing and medical staff requirements and/or CMS requirements. ***This application retains no supervisory requirements for the CNS.***

Nurse Practitioner (NP). The transition-to-practice (TTP) agreement is defined in the Nurse Practitioner Practice Act as a "...collaborative agreement for two thousand initial hours of practice between a nurse practitioner and a supervising provider..." (38-2314.01). A *supervising* provider is defined as "...a physician, osteopathic physician, or nurse practitioner licensed and practicing in Nebraska and practicing in the same practice specialty, related specialty, or field of practice as the nurse practitioner being supervised;" (38-2322). The TTP requirement was a legislative concession in 2015 with the removal of the Integrated Practice Agreement (IPA) requirement. ***This proposal includes removal of the TTP.***

14. What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice autonomous?

Members of each APRN group practice without supervision, i.e., full practice authority or practice under the authority of their own licensure in a number of states (**Appendix E**). National standards for education and certification provide APRNs with the knowledge, skills and core competencies needed to practice autonomously in each of the four APRN roles. Autonomy implies direct lines of responsibility and accountability. Advanced practice registered nurses are responsible for their practice decisions and are accountable to clients, peers, and professional organizations.

Autonomous practice is not independent practice. APRNs are educated to practice collaboratively, consult and refer to other health care professionals to provide the best outcomes of care possible. *Collaboration* is defined in both the Certified Nurse Midwifery Practice Act (38-607) and the Nurse Practitioner Practice Act (38-2308). *Consultation* (38-2309) and *referral* (38-2314) are also defined in the Nurse Practitioner Practice Act. *Consultation* (38-610) and *referral* (38-611) also appear within statutory provisions in the Certified Nurse Midwifery Practice Act. Consultation, collaboration and referral were retained as statutory provisions in the draft proposal for LB730 in 2019.

15. Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

The current numbers of licensed APRNs in Nebraska is as follows:

- | | |
|--|-----|
| 1. Certified Nurse Midwife (CNM) | 55 |
| 2. Certified Registered Nurse Anesthetist (CRNA) | 594 |

3. Clinical Nurse Specialist (CNS)	89
4. Nurse Practitioner (NP)	<u>2035</u>
Total	2,773

The APRN must maintain an active RN license and APRN license to practice in Nebraska. The RN license may be multistate with a licensure compact privilege in 32 states. The APRN license is currently single state. However, Nebraska seeks to enter the APRN Compact through implementation of the consensus Model for Regulation of APRNs.

16. Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

For entry into APRN practice and for regulatory purposes, APRN education must:

- Be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- Be awarded pre-approval, pre-accreditation, or accreditation status prior to admitting students;
- Be comprehensive and at the graduate level; prepare the graduate to practice in one of the four identified APRN roles;
- Prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- Include a minimum, three separate comprehensive *graduate-level* courses (the APRN Core) in:
 1. Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
 2. Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
 3. Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN Core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and

- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

17. Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g. private physician, dentist, optometrist, etc.)

Advanced practice registered nurses are employed in a wide variety of health care settings, including acute care, private or public clinics, home and community-based practice settings. Advanced practice registered nurses may also be self-employed as practice owners.

18. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)?

Advanced practice nurses work with individuals and patients across the lifespan. Limitations are imposed by scope of practice for particular roles and patient populations, and specialties. Examples of this include 1) a NP would not attend childbirth or administer anesthesia in surgery; or 2) a CNM does not perform a school physical on a male; or 3) a psychiatric mental health NP would not treat a patient with chronic respiratory problems.

Conversely, licensed employers, most notably hospitals may credential NPs for specialty practice roles that require overlapping APRN education or skills, e.g., the administration of procedural sedation and analgesia in the Emergency Department in a Critical Access Hospital or role functions of another licensee that are recognized in statute, e.g., Surgical First Assist.

19. Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify.

Certified Nurse Midwife (CNM). The CNM provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of the female client for sexually transmitted disease and reproductive health. This is the core education of the CNM. Care is provided in diverse settings, which may include a hospital, birth center, and a variety of ambulatory care settings including private offices, community and public health clinics. Removal of the longstanding home birth restriction is not being

sought for CNM practice in Nebraska, though it is part of the services a CNM provides in other states.

Certified Registered Nurse Anesthetist (CRNA). The CRNA is educationally prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.

Clinical Nurse Specialist (CNS). The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: 1) the patient, (2) the nurse, and 3) the system. The three spheres are overlapping and each sphere has a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities. The majority of CNSs practice in hospitals. They have also demonstrated an increasing presence in primary care practices with the rising prevalence of advanced age and chronic disease (Gordon, Lorilla, and Lehman, 2012).

Nurse Practitioner (NP). The NP provides care along the wellness-illness continuum. This is a dynamic process in which direct primary and acute care is provided across settings. Nurse Practitioners are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. NPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnosis. Both primary and acute care NPs provide initial, ongoing, and comprehensive care, including taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Nurse practitioner care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Nurse practitioners are prepared to practice in primary and acute care settings.

**20. Identify typical referral patterns to and from members of the occupational group.
What are the most common reasons for referral?**

Advanced practice registered nurses consult, collaborate and refer to other members of the health care team. APRNs are educated to recognize when a patient requires care that exceeds their scope of practice and referrals may be made to physicians; physician assistants; other APRNs; physical, occupational or speech therapists; specialty practice RNs; or other practitioners who have a skill set needed to effect optimal patient outcomes.

21. Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

No, a prescription or order is not necessary in order for services to be provided based on Nebraska statutes or regulations. However, as noted above in question 13, a prescription from a physician may be required for compliance with Centers for Medicare and Medicaid Services (CMS) and/or state regulations that mandate how hospitals, clinics, private practices, and other agencies must conduct credentialing and privileging in order to receive funding from these sources (McMullen & Howie, 2020). **These are outside the jurisdiction of this proposal.**

22. How is continuing competence of credentialed practitioners evaluated?

Credentialing requirements for APRNs in Nebraska adhere to the common language of the APRN Consensus Model, which requires licensure, accreditation (of educational programs), certification (noted below), and core educational coursework of advanced health assessment, advanced pharmacology, and advanced pathophysiology

Graduates of an accredited program qualify to be seated for a national board certification examination. Successful completion of the examination is required for state licensure. Each credentialed APRN must maintain professional certification in his/her area of expertise, which generally includes practice hours and continuing education. The following list reflects the current certification and credentialing bodies for APRNs:

Certified Nurse Midwife (CNM).

American Midwifery Certification Board (AMCB)

<https://www.amcbmidwife.org/amcb-certification>

Certified Registered Nurse Anesthetist (CRNA)

National Board of Certification and Recertification for Nurse Anesthetists

<https://www.nbcrna.com/>

Clinical Nurse Specialist (CNS)

American Nurses Credentialing Center (ANCC)

<https://www.nursingworld.org/our-certifications/>

- Adult Gerontology

American Association of Critical Care Nurses (AACN)

<https://www.aacn.org/certification/advanced-practice>

- Adult Gerontology
- Pediatric
- Neonatal

Nurse Practitioner (NP)

American Association of Nurse Practitioners (AANP)

<https://www.aanp.org/student-resources/np-certification>

- Adult Gerontology
- Family

American Nurses Credentialing Center Certification (ANCC)

<https://www.nursingworld.org/our-certifications/>

- Adult Gerontology Acute Care
- Adult Gerontology Primary Care
- Family
- Pediatric Primary Care
- Psychiatric-Mental Health

American Association of Critical Care Nurses (AACN)

<https://www.aacn.org/certification/advanced-practice>

- Acute Care
- Adult Gerontology

National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)

<https://www.nccwebsite.org/certification-exams>

- Women's Health
- Neonatal

Pediatric Nursing Certification Board (PCNB)

<https://www.pncb.org/>

- Pediatric Acute Care
- Pediatric Primary Care

23. What requirements must the practitioner meet before his or her credentials may be renewed?

The APRN in Nebraska has two licenses or credentials to renew. For the RN credential, one must complete 20 hours of continuing education and 500 practice hours within a five-year time period. For the APRN credential, one must maintain active professional certification in their practice role. National board certification is generally 4-5 year intervals, based on the certification body. Practice hours and continuing education requirements exceed those for RN state licensure renewal and are required for re-certification for the practice role.

24. Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typical for this occupation in these jurisdictions.

Appendix E provides maps of practice authority by APRN practice role in the U.S.

The healthcare workforce is shaped by a variety of factors, with a central theme of occupational licensing. Occupational licenses exist to ensure that practitioners are knowledgeable and competent, protecting the public from harm. However, certain provisions of licenses can also generate significant barriers to workforce entry, restrict competition, raise prices and protect guilds (Markowitz et al., 2016).

Scope of practice laws are set by individual states and define the range of tasks legally allowed for a given provider within state boundaries. Physicians generally have no restrictions on scope of practice, while other practitioners, such as APRNs, often face restrictions on scope of practice. These restrictions may generate unnecessary barriers to practice, block patients' access to care and restrict the achievement of efficiencies in the overall health care system. The central theme in this argument is determination of costs and benefits (Markowitz et al., 2016).

For example, Markowitz et al., 2016, examined the effect of laws on the markets for CNMs and their services as well as related maternal and infant outcomes. States were categorized into low, moderate and high scope of practice barriers. The results of the study demonstrated that allowing CNMs to practice with no barriers created lower probabilities of labor inductions, C-sections, apparent elective inductions and apparent elective C-sections as compared to states with high scope of practice barriers. All of these procedures are most directly and immediately affected by the different practitioner approaches to labor and delivery. Removing barriers to CNM practice will not harm mothers and infants, and restrictive practice laws primarily serve as artificial barriers to care.

Additional questions an Applicant Group Must Answer about their Proposal

1. **What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review?**

Regulatory Inefficiency. The current regulatory environment in Nebraska with five APRN statutes and five sets of accompanying regulations creates regulatory inefficiency. In 2017, Governor Ricketts called for a review of all regulations in Executive Order No. 17-04, for which APRN regulations were subject to review. A draft of 172 NAC 98, a combination of all five sets of regulations into one non-duplicative set, has been approved by the Board of Health and is moving towards adoption and implementation.

The statutory issues for APRNs are much larger, with out of date language and provisions. Even though all APRNs have fundamentally similar education and certification requirements, there are separate and sometimes conflicting requirements for licensure in statute. The statutes also provide for regulatory duplication with the authorization for an APRN Board, when there is an existing Board of Nursing. Nebraska is the only state in the country to have a separate Board to regulate the APRN group. Furthermore, with two Boards in existence, a licensee facing Board review must have their case go before two Boards for review, taking a significant amount of time and adding to the cost of state government.

Consumer Access. The fragmentation of APRN practice, related to the four individual groups having separate requirements in statute, has created confusion in the eyes of the public in reference to what an APRN can do in practice. The varying requirements to practice, as well as partial vs. full-scope of practice differences, has created confusion for employers, patients, and providers, such as pharmacists filling prescriptions.

The biggest loser in the current division of practice acts are consumers of health care. There are currently 594 APRN-CRNAs and 2,035 APRN-NPs in Nebraska. This means that 2,659 APRNs have full practice authority in Nebraska. That leaves 55 APRN-CNMs and 89 APRN-CNSs or about 5% of APRNs in Nebraska with practice restrictions. APRNs must be viewed as one group with different practice roles and population foci. The inequity for practice authority impacts Nebraskans access to essential services and the gap is progressively widening in our rural communities. Examples follow:

Certified Nurse Midwife (CNM). A practice agreement is required with a physician whose practice includes obstetrics to practice in Nebraska, which limits CNMs to the most populous areas of the state where these physicians are located (**Appendix F**). Nebraska's infant mortality rate has started an upward trend and negatively impacts Nebraska's Health Rankings particularly in rural

counties (**Appendix G, Figure 2**). Twenty-five of Nebraska's sixty-four critical access hospitals (CAHs) no longer offer obstetric services. Removal of a practice agreement could allow for prenatal, postpartum, and gynecological care to be provided by a specialty provider and aid in restoring birthing services to rural areas of Nebraska. A study on autonomous APRN practice in rural areas, found that states allowing autonomous CNM practice have a greater proportion of rural hospitals with CNMs attending births (Kozhimannil, Hennig-Smith, and Hung, 2016). A different study comparing states with and without autonomous CNM practice found that states without practice restrictions had a larger CNM workforce and improved birth outcomes (Yang, Attanasio, and Kozhimannil, 2016).

Clinical Nurse Specialist (CNS). The CNS statute is currently silent on prescribing authority in Nebraska. The lack of prescriptive authority can greatly limit the practice of the CNS, not allowing practice to the full extent of their education and training. Prescribing involves more than just medications. Prescribing can include orders for laboratory or diagnostic tests, durable medical equipment and supplies, and discharge instructions.

Health Outcomes. **Appendix G** presents Nebraska data from America's Health Rankings (2019). Figure 1 presents how core measures are impacted in the state. Green rows are a positive impact and yellow rows reflect a negative impact. It can be noted that obesity is the one core measure that needs focus. Nurse Practitioners and Clinical Nurse Specialists are uniquely positioned to focus interventions to alleviate this problem. Also, in **Appendix G** is Figure 3, which indicates outcomes for Nebraska. It is clear that chronic disease, stress, and birth issues lead the state in negative outcomes. NPs, CNSs, and CNMs are all prepared and ready to focus on improving health outcomes.

Not a New Problem. The disparities in access to licensed practitioners, i.e., those with statutory authority to prescribe medications and other treatments has been chronicled and debated for nearly 40 years in this state. In 1991, the Board of Health convened a task force of members to evaluate the efficacy of mid-level practitioners as alternative providers to a declining physician population as one solution to the rural health crisis. (**Appendix H**). This early study lumped APRNs and PAs under the title of midlevel provider. The study excluded CRNAs, only focusing on the CNM, NP and CNS. The descriptor 'mid-level', while persistent in some circles, is misleading and confusing to providers and the public regarding the education and competencies of the APRNs and PAs.

Since the 1991 study, there has been a growth of APRN education programs in Nebraska, except the CNM still has no state-based program. The University of Nebraska Medical College of Nursing has risen to the challenge of providing statewide education with five campuses located across the state. However, UNMC only prepares Nurse

Practitioners. The number of NPs has increased 5,000% since the 1991 report, based on DHHS Licensure data (2020). Nebraska has done a good job increasing that particular APRN role. The CRNA role has increased to a reported presence of 99% in state operating rooms and being sole anesthesia providers in 95% of the Critical Access Hospitals (CAHs). The CNS role numbers have increased slowly, but still out-number the CNMs with no Nebraska educational program.

Growth and dispersion of CNMs remains relatively unchanged since the 1991 report. CNMs are required to hold a collaborative practice agreement with an OB/GYN physician. Reviewing the map in **Appendix F**, one will note that the CNMs are largely congregated in urban areas of Nebraska, which is where OB/GYN or specialty services are located. Evidence from other states indicates that removal of a practice agreement yields increased numbers and migration of providers to rural underserved communities.

Evidence exists that allowing APRNs, specifically CRNAs and NPs, to practice under the authority of their own license has enabled their migration into rural Nebraska communities. Nebraska Center for Nursing, shortly after launching a regional workforce data analysis model, released a first of its kind study which not only confirmed migration of the CRNA and NP workforce into rural communities, but demonstrated proximity of CRNA and NP residence and practice to Rural Health Clinics and Critical Access Hospitals (Hoebelheinrich and Ramirez, 2019). Inarguably, RHCs and CAHs provide the hub of health care services in our rural communities and demonstrate the most promise for allowing consumers to access services in their communities. The need for licensure portability became immediately apparent in the current pandemic and most predictions indicate that continuation of services is not likely to go away with resolution current emergency state. The current increased use of technology, such as virtual clinic encounters, support the existing patient base and tele-support services for specialty practice and emergency support.

- 2. If the proposal is for the regulation of a health professional group not previously regulated, all feasible methods of regulation, including those methods listed below, and the impact of such methods on the public, must be considered. For each of the following evaluate the feasibility of applying it to the profession and the extent to which the regulatory method would protect the public.**

RNs and APRNs are currently regulated by the Nebraska Department of Health and Human Services (NDHHS). The regulatory model utilized by NDHHS is a complaint-based model. Professional Boards, the Board of Nursing for RNs and Advanced Practice Registered Nurse Board for APRNs, provide input from licensed professionals into the discipline process for complaints about individual practice. The professional boards exist to protect the public.

3. **What is the benefit to the public of regulating the health professional group under review or changing the scope of practice of the regulated health profession under review?**

The overall supply of primary care providers is secondary to the problems created by the inequities in distribution of providers (Goodell, Dower and O'Neill, 2011). Skilled primary care providers are the hallmark of high-performing healthcare systems (Pohl, Hanson, Newland and Cronenwett, 2010). Demographic changes related to age, longevity and chronic disease impose additional strains on the health care system as it is currently organized (AARP, 2009). Primary care should be supported and figure prominently in the health care system.

Expanded APRN practice is regarded as a key strategy to alleviate provider shortages, especially in primary care, in medically underserve areas, and for medically underserved populations (IOM, 2010). Xue et al. (2018) sought to examine trends in primary care provider supply and if Federally Qualified Health Centers (FQHCs) have been successful in reducing the gap in provider supply in primary care health professional shortage areas (HPSAs). The study demonstrated that FQHCs expand access to primary care and reduce disparities. However, the increase in primary care providers in these shortage areas were nurse practitioners and physician assistants. Given the current shortage of primary care health professionals in the U.S., full practice authority for all APRNs could help build the workforce necessary to meet the country's primary care needs and contribute their unique skills to the delivery of patient-centered, community-based health care (IOM, 2016).

Certified Nurse Midwife (CNM). Anil, Hagen, Harkness and Sousou (2019) proposed a midwife laborist model to alleviate the shortage of obstetricians in a collaborative community practice. The model added additional CNMs, with 1 CNM to staff a 24-hour in-hospital shift. During this time frame, the CNM provided care for obstetric patients only and admit labor inductions, active labor patients, and antepartum patients. The CNM also triaged patients to determine whether they required admission or further medical care or discharge. A generalist obstetrician was on call from home for operative deliveries, high-risk obstetric patient care, and gynecologic consultations. This collaborative care model resulted in several positive outcomes: 1) primary cesarean birth rate decreased by 11%; 2) vaginal operative deliveries declined by 4.6%; and 3) the rate of vaginal birth after cesarean section increased by 12.6%. Press Ganey satisfaction scores ranked in the high 90th percentile for patient and staff satisfaction.

Clinical Nurse Specialist (CNS). Based on a 2014 CNS Census Document (NACNS, 2014), 66% of CNSs work in hospital settings, with 44% of those having responsibility across the entire hospital. The most common population focus is adult care or gerontology. About 25% of CNSs spend most of their time providing direct patient care. Clinical nurse specialists excel at chronic disease management including cancer, diabetes, obesity and

chronic obstructive pulmonary disease (Gordon et al.s, 2012). In 2020, CNS practice is increasingly moving from hospital inpatient care to outpatient primary care settings to treat patients and impact outcomes that are focused on disease prevention, health promotion, and wellness care.

4. What is the extent to which the proposed regulation or the proposed change in scope of practice might harm the public?

Figure 2 below presents data from the last 20 years that indicates no change in complaint-based discipline to any of the four groups, even as the CRNA has always had full practice authority (Figure 3), and the NP gained that authority in 2015 (Figure 4). Of note is that the NP discipline decreased *after* the removal of the integrated practice agreement in 2015. This provides evidence that when any licensed individual practices within their given scope of practice, there is generally no harm to the public. For a case in point, the Bureau of Economic Research concluded that removing practice barriers on CNMs “...will not harm mothers and infants...” (Markowitz et al., 2016).

The complaint-based system examines scope of practice for individually licensed health care providers, as well as harm to the public. The role of professional Boards is to protect the public. Boards determine if any individual licensee has violated statutory scope or professional conduct, based on their professional expertise.

Figure 2

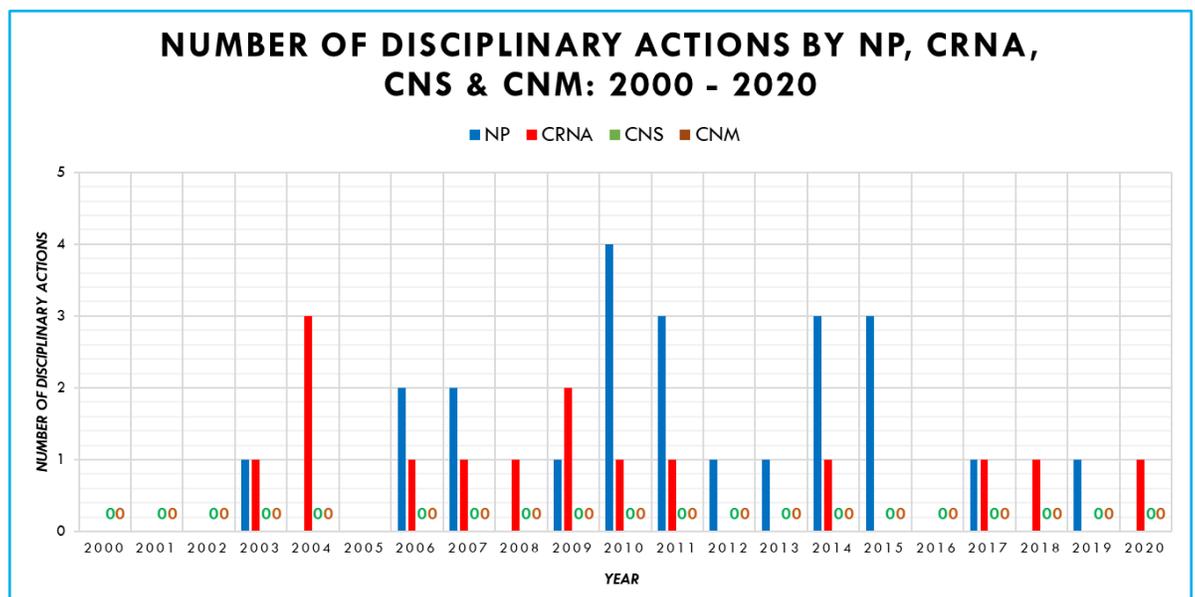
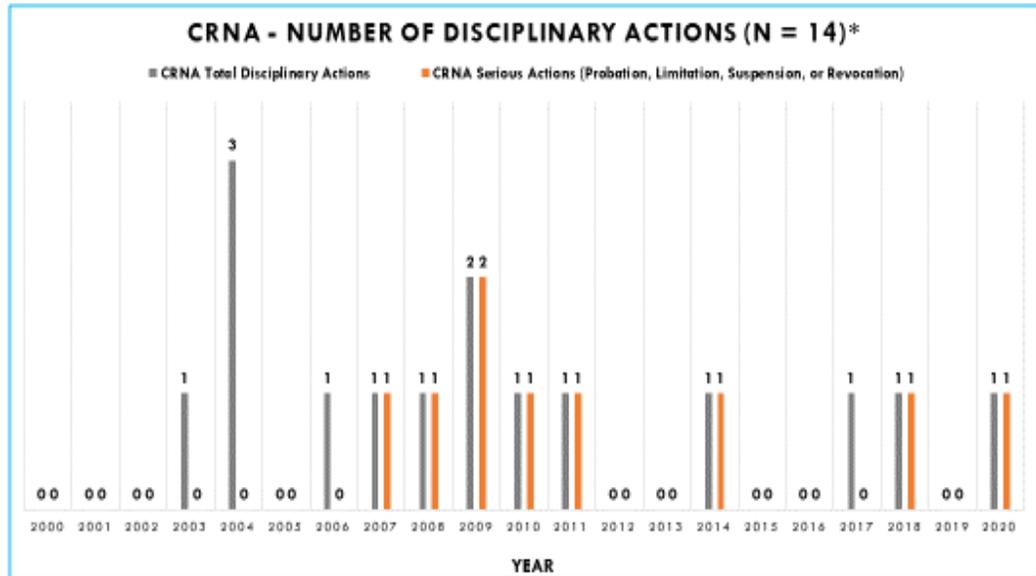
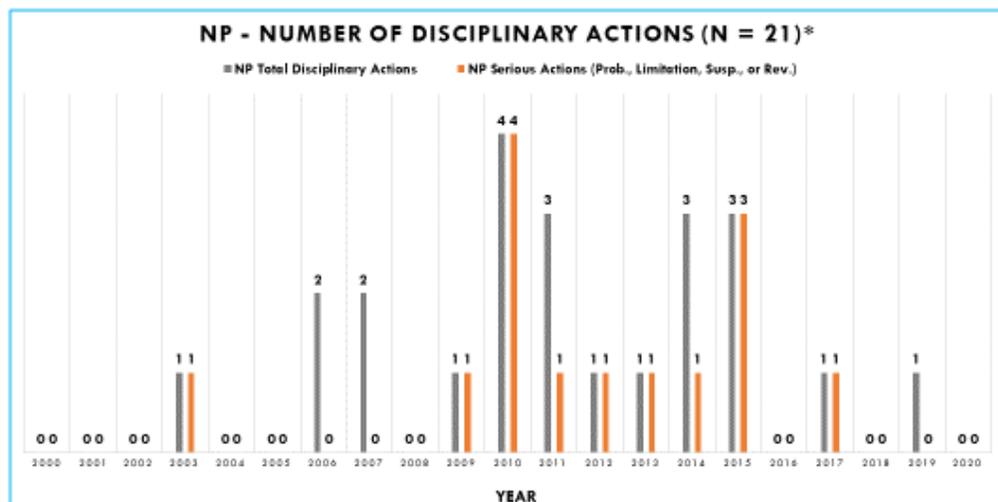


Figure 3 CRNA numbers singled out



* Unduplicated

Figure 4 NP numbers singled out



* Unduplicated

5. What standards exist or are proposed to ensure that a practitioner of the health professional group under review would maintain competency?

The national APRN regulatory model is the Consensus Model for APRN Regulation (NCSBN, 2008) [Appendix A]. This document specifies the required licensure, accreditation, certification and education for each of the four practice roles, which serves to maintain competency for the practice role.

Site-based evaluation of competence and skill sets of APRNs is based primarily on requirements within the practice environment. For example, APRNs with hospital privileges undergo medical staff requirements for credentialing and apply for core and advanced practice privileges or skill sets related to their specialty. The credentialing process ensures that the provision of healthcare services is quality, driven by safe and competent providers. The credentialing process also provides an additional level of scrutiny by a peer review credentialing committee. Providers are generally required to undergo a review process for hospital reappointments at two-year intervals.

The Joint Commission (TJC), an accrediting body for health care organizations in the U.S., has two standards for evaluation and maintenance of clinical competency for any clinician who is credentialed by a medical staff board to provide services and perform procedures (The Joint Commission, 2019).

The first of the TJC standards is a Focused Professional Practice Evaluation which is a process that evaluates clinical competency on, and immediately following, appointment to the medical staff. Evaluation may also occur when a question of clinical competency arises in the care of patients. This type of evaluation may include:

- Chart review
- Monitoring clinical practice patterns
- Simulation
- Proctoring/direct observation
- External peer review
- Discussion with other individuals involved in the care of each patient
- Direct observation

The Joint Commission has a second standard called the Ongoing Professional Practice Standard (The Joint Commission, 2019). This process continually monitors a provider's clinical competence on an ongoing and regular basis with appropriate, timely interventions as needed. This ongoing evaluation is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. This type of evaluation may use the following methodologies for collecting information:

- Periodic chart review

- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

In other types of health care settings, employers vary in their competency requirements and certifications for APRNs. Employers generally require that a specified number of procedures are done annually to maintain competence and expertise. There may be requirements for patient record reviews to ensure safety, adherence to standards of care, referral, and adequate follow up.

6. **What is the current and proposed role and availability of third-party reimbursement for the services provided by the health professional group under review?**

CNM. A CNM cannot directly bill Medicare. Federal legislation in 1980 (Public Law 96-499) required that states reimburse for CNM services under Medicaid, regardless of whether these services are provided under direct physician supervision. Legislation in 1985 (Public Law 99-272) further directed that CNM-operated birthing centers do not have to be administered by physicians in order to qualify for Medicaid reimbursement. State legislation (Nebraska) mandating third-party reimbursement does not exist, however, most all insurance carriers cover CNM services.

CRNA. Nebraska is an Opt Out state, which refers to a decision made by the Centers for Medicare & Medicaid (CMS) in 2001 to allow states to 'opt out' of the federal supervision requirement for CRNAs. A state's Governor had to sign the state's intent to opt out of the existing supervisory rule. CRNA's working in an Opt Out state, have no issues with reimbursement. They are reimbursed by CMS for 100 % of services as it relates to the Nebraska Relative Value Scale. There are no issues with billing private insurance companies either. Typically contracts are negotiated with each private payers, and an agreed dollar amount value per unit of anesthesia time is established. Tri-Care follows CMS for service reimbursement in Nebraska.

CNS. Currently due to the non-specific scope of practice in Nebraska law, there is no third party reimbursement for the CNS. However in states where a CNS has a broader scope of practice, one would attain an individual provider number. Using that number, the CNS would be able to directly bill Medicare, Medicaid, and private insurances similar to other providers using CPT and ICD-10 codes related to the visit.

NP. Nurse practitioners currently are able to bill independently or they can split/share billing with a physician. Nurse practitioners that bill independent visits are paid by

Medicare at a rate of 85% of the physician fee. All procedures and visits are reimbursable for a nurse practitioner with both Medicare and private insurance.

7. What is the experience of other jurisdictions in regulating the practitioners affected by the proposal? Identify appropriate statistics on complaints, describing actions taken, etc., by jurisdictions where the profession is regulated. (Appendix E has full practice authority maps)

CNMs play a more predominant role in some U.S. states than in others. The percentage of total births attended by CNMs varies substantially from state to state (from 0.6% in Arkansas to 26.8% in Alaska in 2013). States that restrict CNM practice have fewer CNM deliveries (Nursing@Georgetown, 2019). The variability in regulations of CNM practice across states make tracking CNM outcomes across the U.S. a difficult one. In 2016, a study was undertaken to estimate the association between state scope of practice laws related to the autonomy of CNM practice. States with autonomous practice laws had an average of 4.85 CNMs per 1,000 births, compared with 2.17 in states where CNM practice was subject to a collaborative agreement. This is important because in states with autonomous CNM practice, women had lower rates of cesarean delivery, preterm birth, and low birthweight compared to states without such practice (Yang et al., 2016).

Accessible public data on complaints and discipline against CNM practice is available at <https://www.amcbmidwife.org/about-amcb/discipline> . The American Midwifery Certification Board (AMCB) is the national certifying body which administers the National Examination in Nurse-Midwifery and awards certification for the CNM. Of the over 11,000 CNMs nationwide, ten revocations is a very small percentage.

Year	Closed Cases	Revoked Certifications	Active Cases
1989		2	
1992		1	
2003	1		
2007	2	1	
2008	3		
2010		1	
2012	1	1	
2013	3	3	
2014	1		
2015	1		1
2016	3	1	
2017	2		
2018	1		
2019	1		2
2020			1
	19	10	4

There has been no discipline against a CNM in Nebraska (Figure 2).

CNS data is a little harder to locate. This is due to the Department of Labor's Standard Occupational Classification system rejecting the request to add a new detailed occupation for 'Clinical Nurse Specialists' (U.S. Bureau of Labor, 2009). There are approximately 72,000 clinical nurse specialists in the U.S. The majority of CNS' practice in acute care settings and may or may not prescribe, based on state law. Based on the role and setting, few complaints are logged against CNS practice. Nebraska has had no discipline against any APRN-CNS license.

8. What are the expected costs of regulating the health professional group under review, including the impact of registration, certification, or licensure on the costs of services to the public? What are the expected costs to the state and to the general public of implementing the proposed legislation?

The streamlining of statutory requirements for APRN practice will actually save the state of Nebraska money and create regulatory efficiency. It will also prepare Nebraska to join the APRN compact, which will save healthcare systems and individual licensees time, redundancies and costs, as current APRN licensure requires a separate license in every state as well as a separate APRN license if a person holds more than one credential. The RN license can be multi-state, therefore it would make regulatory sense that the APRN license also be multi-state.

Another cost savings could potentially be recognized if the APRN Board were dissolved and APRNs were governed by the Board of Nursing. This is the model in most states and would eliminate duplication, save staff time, and ultimately be more efficient for the licensee as well as the public with having complaints go through only one Board.

9. Is there any additional information that would be useful to the technical committee members in their review of the proposal?

In Nebraska, the Credentialing Review process has entertained scope of practice issues since its inception in the late 1900s. A variety of professions have applied for endorsement of an expansion or change in scope of practice as a basis for legislation. The history for the evolution of credentialing review and individual APRN roles is as follows:

- APRN-NPs (2013, 1994)
- APRN-CRNAs (2007, 1990)
- APRN-CNMs (2006, 1994)
- APRN-CNS have not completed 407

Noting that the CNS group had never been through a credentialing review, and that the CNM group had been through two prior, the Board of Nursing agreed that the only

prudent option is to proceed with a credentialing review for APRN licensure as a group, with all four different roles being part of that group. This credentialing review will demonstrate that APRNs are alike in education, training, certification, and scope, creating evidence necessary to support a successful APRN Consensus Model bill in the future.

The APRN Consensus Model for APRN Regulation has been in existence since 2008. It establishes common core standards for all four APRN roles to obtain and maintain competency for the practice role. Provider shortages continue to grow, especially in medically underserved areas. As health care evolves, APRNs need a regulatory model that 1) is flexible; 2) provides for competency for the practice role, and 3) affords the freedom to practice to the full extent of their education and training, regardless of the practice role.

Establishment of the common regulatory core for all four APRN practice roles is also needed for APRNs to join the APRN licensure Compact. Just like the Nurse Licensure Compact (which is for the RN license that an APRN holds), the APRN Compact would provide for mobility of the APRN license as well (Hoebelheinrich and Ramirez, 2019). Currently, many APRNs provide locum tenens work in various states. Others provide patient health care services across state lines via telehealth. APRNs may hold a multi-state privilege in a Compact state such as Nebraska, but have to license as an APRN in every state they practice in. Licensure portability through compacts set a consistent and often higher standard of licensure which states have agreed upon in formation of a licensure compact.

The argument for changes related to scope of practice in a profession should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supporting evidence; and (4) appropriate regulatory environment. If a profession can provide support evidence in these areas, the proposed changes in scope of practice are likely to be in the public's best interest (NCSBN, 2009).

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Appendix A: Consensus Model for APRN Regulation
National Council of State Boards of Nursing (NCSBN) 2008

Consensus Model for APRN Regulation: Licensure, Accreditation,
Certification & Education

July 7, 2008

**Completed through the work of the APRN Consensus Work Group & the
National Council of State Boards of Nursing APRN Advisory Committee**

The APRN Consensus Work Group and the APRN Joint Dialogue Group members would like to recognize the significant contribution to the development of this report made by Jean Johnson, PhD, RN-C, FAAN, Senior Associate Dean, Health Sciences, George Washington School of Medicine and Health Sciences. Consensus could not have been reached without her experienced and dedicated facilitation of these two national, multi-organizational groups.

LIST OF ENDORSING ORGANIZATIONS

This Final Report of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee has been disseminated to participating organizations. The names of endorsing organizations will be added periodically.

The following organizations have endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education:

(Posted December
2010) N=48

Academy of Medical-Surgical Nurses (AMSN)
Accreditation Commission for Midwifery Education (ACME) American
Academy of Nurse Practitioners (AANP)
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing (AACN) American
Association of Critical-Care Nurses (AACN)
American Association of Critical-Care Nurses Certification Corporation
American Association of Legal Nurse Consultants (AALNC)
American Association of Nurse Anesthetists (AANA)
American Board of Nursing Specialties (ABNS) American
College of Nurse-Midwives (ACNM) American College of
Nurse Practitioners (ACNP) American Holistic Nurses
Association (AHNA) American Midwifery Certification
Board (AMCB) American Nurses Association (ANA)
American Nurses Credentialing Center (ANCC) American
Psychiatric Nurses Association (APNA) Arkansas State
Board of Nursing
Association of Faculties of Pediatric Nurse Practitioners (AFPNP) Association
of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
Commission on Collegiate Nursing Education (CCNE)
Council on Accreditation of Nurse Anesthesia Educational Programs (COA)
Dermatology Nurses Association (DNA)
Dermatology Nursing Certification Board (DNCB)
Emergency Nurses Association (ENA)
Gerontological Advanced Practice Nurses Association (GAPNA)
Hospice and Palliative Nurses Association (HPNA)
The International Society of Psychiatric Nurses (ISPN)
National Association of Clinical Nurse Specialists (NACNS)
National Association of Neonatal Nurses (NANN)
National Association of Orthopedic Nurses (NAON)
National Association of Pediatric Nurse Practitioners (NAPNAP)
National Board for Certification of Hospice and Palliative Nurses (NBCHPN) National
Board on Certification & Recertification of Nurse Anesthetists (NBCRNA) National
Certification Corporation (NCC)

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National Council of State Boards of Nursing (NCSBN)
National Gerontological Nursing Association (NGNA) National League for Nursing (NLN)
National League for Nursing Accrediting Commission, Inc. (NLNAC)
National Organization of Nurse Practitioner Faculties (NONPF) Nurse
Practitioners in Women's Health (NPWH)
Nurses Organization of Veterans Affairs (NOVA)
Oncology Nursing Certification Corporation (ONCC)
Oncology Nursing Society (ONS)
Orthopedic Nurses Certification Board (ONCB)
Pediatric Nursing Certification Board (PNCB)
Wound, Ostomy and Continence Nurses Society (WOCN)
Wound, Ostomy and Continence Nursing Certification Board (WOCNCB)

INTRODUCTION

Advanced Practice Registered Nurses (APRNs) have expanded in numbers and capabilities over the past several decades with APRNs being highly valued and an integral part of the health care system. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs need to be effectively aligned in order to continue to ensure patient safety while expanding patient access to APRNs.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but shares the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards-governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

Many nurses with advanced graduate nursing preparation practice in roles and specialties e.g., informatics, public health, education, or administration) that are essential to advance the health of the public but do not focus on direct care to individuals and, therefore, their practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the four current APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education. Although extremely important to the nursing profession and to the delivery of safe, high quality patient care, these other advanced, graduate nursing roles, which do not focus on direct patient care, are not roles for Advanced Practice Registered Nurses (APRN) and are not the subject or focus of the Regulatory Model presented in this paper.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations included in this document. In a few instances, when agreement was not unanimous a 66% majority was used to determine the final recommendation. However, extensive dialogue and transparency in the decision-making process is reflected in each recommendation. The background of each group can be found on pages 13-16 and individual and organizational participants in each group in Appendices C-H.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population

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foci, and presents strategies for implementation.

Overview of APRN Model of Regulation

The APRN Model of Regulation described will be the model of the future. It is recognized that current regulation of APRNs does not reflect all of the components described in this paper and will evolve incrementally over time. A proposed timeline for implementation is presented at the end of the paper.

In this APRN model of regulation there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: 1) family/individual across the lifespan, 2) adult-gerontology, 3) pediatrics, 4) neonatal, 5) women's health/gender-related or 6) psych/mental health. APRN education programs, including degree-granting and post-graduate education programs¹, are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a pre-approval, pre-accreditation, or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited² and their graduates must be eligible for national certification used for state licensure.

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes. APRN certification programs will be accredited by a national certification accrediting body³. APRN certification programs will require a continued competency mechanism.

Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they cannot be licensed solely within a specialty area. *In addition, specialties can provide depth in one's practice within the established population foci.* Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e., nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations.

¹ Degree granting programs include master's and doctoral programs. Post-graduate programs include both post-master's and post-doctoral certificate education programs.

² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

³ The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

In addition, a mechanism that enhances the communication and transparency among APRN licensure, accreditation, certification and education bodies (LACE) will be developed and supported.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for **all** APRNs is that a significant component of the education and practice focuses on direct care of individuals;
4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**

7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

The Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and

system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

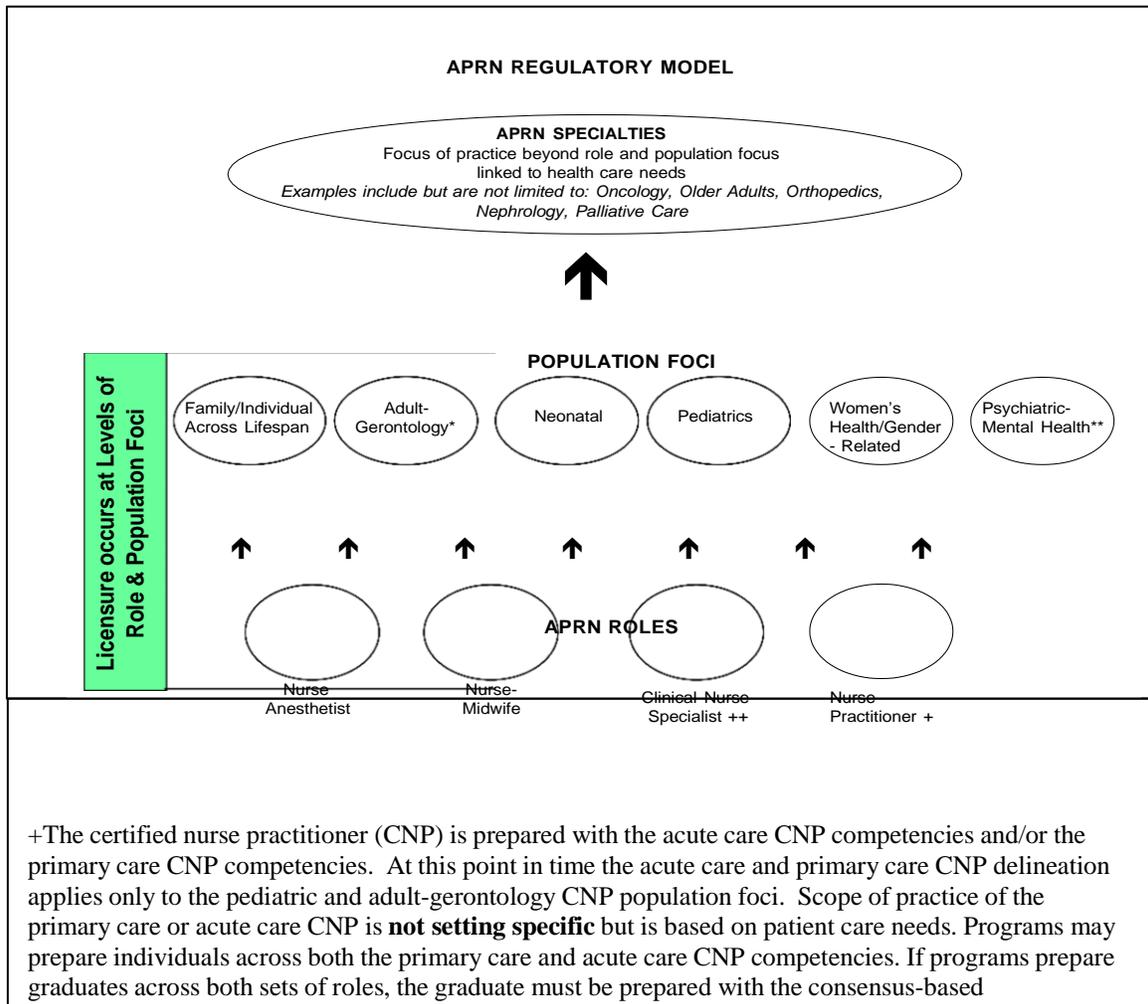
Titling

The title Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.⁴ This title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles. An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

⁴ Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term *advanced public health nursing* however, may be used to identify nurses practicing in this advanced specialty area of nursing.



+The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is **not setting specific** but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Diagram 1: APRN Regulatory Model

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one’s practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

++ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation, or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- include at a minimum, three separate comprehensive **graduate-level** courses (the APRN Core) in:
 - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
 - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
 - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre-approval, pre-accreditation, or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to ensure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse, or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.

An APRN specialty

- preparation cannot replace educational preparation in the role or one of the six population foci;
- preparation can not expand one's scope of practice beyond the role or population focus
- addresses a subset of the population-focus;
- title may not be used in lieu of the licensing title, which includes the role or role/population; and
- is developed, recognized, and monitored by the profession.

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the role practice as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations, etc.).

Education programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN education programs, including preparation in the APRN core, role, and population core competencies. In addition, for licensure purposes, one exam must assess the APRN core, role, and population-focused competencies. For example, a nurse anesthetist would write one certification examination, which tests the APRN core, CRNA role, and population-focused competencies, administered by the Council on Certification for Nurse Anesthetist; or a primary care family nurse practitioner would write one certification examination, which tests the APRN core, CNP role, and family population-focused competencies, administered by ANCC or AANP. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty, *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the four nationally recognized APRN roles and in one of the six population foci. Individuals must be

recognized and credentialed in one of the four APRN roles within at least one population foci. APRNs are licensed at the role/population focus level and **not** at the specialty level. However, if not intended for entry-level preparation in one of the four roles/population foci and not for regulatory purposes, education programs, using a variety of formats and methodologies, may provide licensed APRNs with the additional knowledge, skills, and abilities, to become professionally certified in the specialty area of APRN practice.

Emergence of New APRN Roles and Population-Foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. In addition, the scope of practice within the role or population focus is not entirely subsumed within one of the other roles. Careful consideration of new APRN roles or population-foci is in the best interest of the profession.

For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus. A new role or population focus should be discussed and vetted through the national licensure, accreditation, certification, education communication structure: LACE. An essential part of being recognized as a role or population-focus is that educational standards and practice competencies must exist, be consistent, and must be nationally recognized by the profession. Characteristics of the process to be used to develop nationally recognized core competencies, and education and practice standards for a newly emerging role or population-focus are:

1. national in scope
2. inclusive
3. transparent
4. accountable
5. initiated by nursing
6. consistent with national standards for licensure, accreditation, certification and education
7. evidence-based
8. consistent with regulatory principles.

To be recognized, an APRN role must meet the following criteria:

- nationally recognized education standards and core competencies for programs preparing individuals in the role;
- education programs, including graduate degree granting (master's, doctoral) and post-graduate certificate programs, are accredited by a nursing or nursing-related accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA); and
- professional nursing certification program that is psychometrically sound, legally defensible, and which meets nationally recognized accreditation standards for certification programs.⁵

⁵ The professional certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

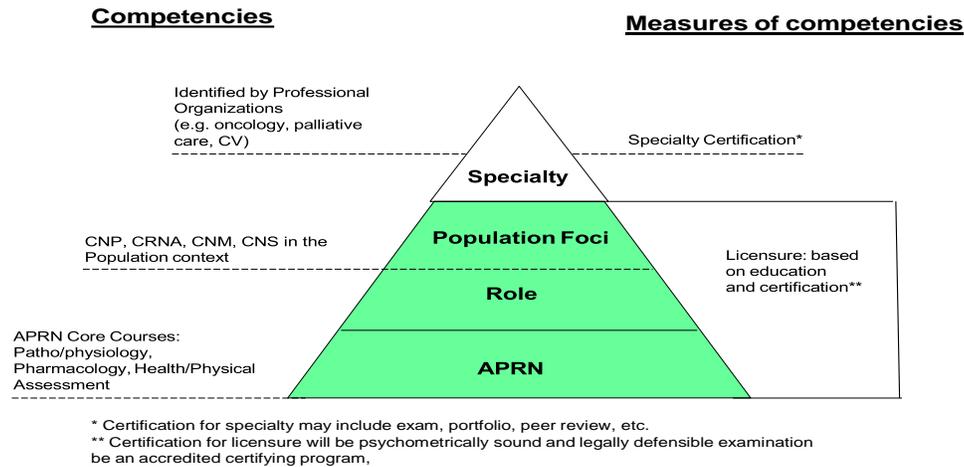


Diagram 2: Relationship Among Educational Competencies, Licensure, & Certification in the Role/Population Foci and Education and Credentialing in a Specialty

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification, and education (LACE) must work together. Expectations for licensure, accreditation, certification, and education are listed below:

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses⁶;
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;
8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact;

9. have at least one APRN representative position on the board and utilize an APRN advisory committee that includes representatives of all four APRN roles; and,
10. institute a grandfathering⁷ clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

Foundational Requirements for Accreditation of Education Programs

Accreditors will:

1. be responsible for evaluating APRN education programs including graduate degree-granting and post-graduate certificate programs.⁸
2. through their established accreditation standards and process, assess APRN education programs in light of the APRN core, role core, and population core competencies;
3. assess developing APRN education programs and tracks by reviewing them using established accreditation standards and granting pre-approval, pre-accreditation, or accreditation prior to student enrollment;
4. include an APRN on the visiting team when an APRN program/track is being reviewed; and
5. monitor APRN educational programs throughout the accreditation period by reviewing them using established accreditation standards and processes.

Foundational Requirements for Certification

Certification programs providing APRN certification used for licensure will:

1. follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure (see appendix A for the NCSBN Criteria for APRN Certification Programs);
2. assess the APRN core and role competencies across at least one population focus of practice;
3. assess specialty competencies, if appropriate, separately from the APRN core, role and population-focused competencies;
4. be accredited by a national certification accreditation body;⁹

⁷ Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure.

However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- current, active practice in the advanced role and population focus area,
- current active, national certification or recertification, as applicable, in the advanced role and population focus area,
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and
- compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure).

Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) all new graduates applying for APRN licensure must meet the requirements outlined in this regulatory model

⁸ Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs.

⁹ The certification program should be nationally accredited by the American Board of Nursing Specialties

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(ABNS) or the National Commission for Certifying Agencies (NCCA).

5. enforce congruence (role and population focus) between the education program and the type of certification examination;
6. provide a mechanism to ensure ongoing competence and maintenance of certification;
7. participate in ongoing relationships which make their processes transparent to boards of nursing;
8. participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Foundational Requirements for Education

APRN education programs/tracks leading to APRN licensure, including graduate degree-granting and post-graduate certificate programs will:

1. follow established educational standards and ensure attainment of the APRN core, role core and population core competencies^{10,11}
2. be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA).¹²
3. be pre-approved, pre-accredited, or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. ensure that graduates of the program are eligible for national certification and state licensure; and
5. ensure that official documentation (e.g., transcript) specifies the role and population focus of the graduate.

Communication Strategies

A formal communication mechanism, LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities would be created. The purpose of LACE would be to provide a formal, ongoing communication mechanism that provides for transparent and aligned communication among the identified entities. The collaborative efforts between the APRN Consensus Group and the NCSBN APRN Advisory Panel, through the APRN Joint Dialogue Group have illustrated the ongoing level of communication necessary among these groups to ensure that all APRN stakeholders are involved. Several strategies including equal representation on an integrated board with

¹⁰ The APRN core competencies for all APRN nursing education programs located in schools of nursing are delineated in the American Association of Colleges of Nursing (1996) *The Essentials of Master's Education for Advanced Practice Nursing Education* or the AACN (2006) *The Essentials of Doctoral Education for Advanced Nursing Practice*. The APRN core competencies for nurse anesthesia and nurse-midwifery education programs located outside of a school of nursing are delineated by the accrediting organizations for their respective roles i.e., Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME).

¹¹ APRN programs outside of schools of nursing must prepare graduates with the APRN core which includes three separate graduate-level courses in pathophysiology/physiology, health assessment, and pharmacology.

¹² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

face-to-face meetings, audio and teleconferencing, pass-protected access to agency web sites, and regular reporting mechanisms have been recommended. These strategies will build trust and enhance information sharing. Examples of issues to be addressed by the group would be: guaranteeing appropriate representation of APRN roles among accreditation site visitors, documentation of program completion by education institutions, notification of examination outcomes to educators and regulators, notification of disciplinary action toward licensees by boards of nursing.

Creating the LACE Structure and Processes

Several principles should guide the formulation of a structure including: 1) all four entities of LACE should have representation; 2) the total should allow effective discussion of and response to issues and ; 3) the structure should not be duplicative of existing structures such as the Alliance for APRN Credentialing. Consideration should be given to evolving the existing Alliance structure to meet the needs of LACE. Guidance from an organizational consultant will be useful in forming a permanent structure that will endure and support the work that needs to continue. The new structure will support fair decision-making among all relevant stakeholders. In addition, the new structure will be in place as soon as possible.

The LACE organizational structure should include representation of:

- State licensing boards, including at least one compact and one non-compact state;
- Accrediting bodies that accredit education programs of the four APRN roles;
- Certifying bodies that offer APRN certification used for regulatory purposes; and,
- Education organizations that set standards for APRN education.

Timeline for Implementation of Regulatory Model

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification, and education, certain recommendations will be implemented sequentially. However, recognizing that this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform decisions made by each of these entities as the APRN community moves to fully implement the APRN Regulatory Model. A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

HISTORICAL BACKGROUND

NCSBN APRN Committee (previously APRN Advisory Panel)

NCSBN became involved with advanced practice nursing when boards of nursing began using the results of APRN certification examinations as one of the requirements for APRN licensure. During the 1993 NCSBN annual meeting, delegates adopted a position paper on the licensure of advanced nursing practice which included model legislation language and model administrative rules for advanced nursing practice. NCSBN core competencies for certified nurse practitioners were adopted the following year.

In 1995, NCSBN was directed by the Delegate Assembly to work with APRN certifiers to make certification examinations suitable for regulatory purposes. Since then, much effort has been made toward that purpose. During the mid and late 90's, the APRN certifiers agreed to undergo accreditation and provide additional information to boards of nursing to ensure that their examinations were psychometrically sound and legally defensible (NCSBN, 1998).

During the early 2000s, the APRN Advisory Panel developed criteria for APRN certification programs and for accreditations agencies. In January 2002, the board of directors approved the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to improve the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues such as with the establishment of the annual NCSBN APRN Roundtable in the mid 1990's. In 2002, the Advisory Panel also developed a position paper describing APRN regulatory issues of concern.

In 2003, the APRN Advisory Panel began a draft APRN vision paper in an attempt to resolve APRN regulatory concerns such as the proliferation of APRN subspecialty areas. The purpose of the APRN Vision Paper was to provide direction to boards of nursing regarding APRN regulation for the next 8-10 years by identifying an ideal future APRN regulatory model. Eight recommendations were made. The draft vision paper was completed in 2006. After reviewing the draft APRN vision paper at their February 2006 board meeting, the board of directors directed that the paper be disseminated to boards of nursing and APRN stakeholders for feedback. The Vision paper also was discussed during the 2006 APRN Roundtable. The large response from boards of nursing and APRN stakeholders was varied. The APRN Advisory Panel spent the remaining part of 2006, reviewing and discussing the feedback with APRN stakeholders. (See Appendix C for the list of APRN Advisory Panel members who worked on the draft APRN Vision Paper and Appendix D for the list of organizations represented at the 2006 APRN Roundtable where the draft vision paper was presented.)

APRN Consensus Group

In March 2004, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) submitted a proposal to the Alliance for Nursing Accreditation, now named Alliance for APRN Credentialing¹³ (hereafter referred to as *the APRN Alliance*) to establish a process to develop a consensus¹⁴ statement on the credentialing of advanced practice nurses (APNs).¹⁵ The APRN Alliance¹⁶, created in 1997,

¹³ At its March 2006 meeting, the Alliance for Nursing Accreditation voted to change its name to the Alliance for APRN Credentialing which more accurately reflects its membership.

¹⁴ The goal of the APRN Work Group was unanimous agreement on all issues and recommendations. However, this was recognized as an unrealistic expectation and may delay the process; therefore, consensus was defined as a two thirds majority agreement by those members of the Work Group present at the table as organizational representatives with each participating organization having one vote.

¹⁵ The term advanced practice nurse (APN) was initially used by the Work Group and is used in this section of the report to accurately reflect the background discussion. However, the Work group reached consensus that the term advanced practice registered nurse (APRN) should be adopted for use in subsequent discussions and documents.

was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. A number of differing views on how APN practice is defined, what constitutes specialization versus subspecialization, and the appropriate credentialing requirements that would authorize practice had emerged over the past several years.

An invitation to participate in a national APN consensus process was sent to 50 organizations that were identified as having an interest in advanced practice nursing (see Appendix F). Thirty-two organizations participated in the APN Consensus Conference in Washington, D.C. June 2004. The focus of the one-day meeting was to initiate an in-depth examination of issues related to APN definition, specialization, sub-specialization, and regulation, which includes accreditation, education, certification, and licensure¹⁷. Based on recommendations generated in the June 2004 APN Consensus Conference, the Alliance formed a smaller work group made up of designees from 23 organizations with broad representation of APN certification, licensure, education, accreditation, and practice. The charge to the work group was to develop a statement that addresses the issues, delineated during the APN Consensus Conference with the goal of envisioning a future model for APNs. The Alliance APN Consensus Work Group (hereafter referred to as *the Work Group*) convened for 16 days of intensive discussion between October 2004 and July 2007 (see Appendix H for a list of organizations represented on the APN Work Group).

In December 2004, the American Nurses Association (ANA) and AACN co-hosted an APN stakeholder meeting to address those issues identified at the June 2004 APN Consensus meeting. Attendees agreed to ask the APN Work Group to continue to craft a consensus statement that would include recommendations regarding APN regulation, specialization, and subspecialization. It also was agreed that organizations in attendance who had not participated in the June 2004 APN Consensus meeting would be included in the APN Consensus Group and that this larger group would reconvene at a future date to discuss the recommendations of the APN Work Group.

Following the December 2004 APN Consensus meeting, the Work Group continued to work diligently to reach consensus on the issues surrounding APRN education, practice, accreditation, certification, and licensure, and to create a future consensus-based model for APRN regulation. Subsequent APRN Consensus Group meetings were held in September 2005 and June 2006. All organizations who participated in the APRN Consensus Group are listed in Appendix G.

¹⁶ Organizational members of the Alliance for APRN Credentialing : American Academy of Nurse Practitioners Certification Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, National Organization of Nurse Practitioner Faculties

¹⁷ The term regulation refers to the four prongs of regulation: licensure, accreditation, certification and education.

APRN Joint Dialogue Group

In April, 2006, the APRN Advisory Panel met with the APRN Consensus Work Group to discuss APRN issues described in the NCSBN draft vision paper. The APRN Consensus Work Group requested and was provided with feedback from the APRN Advisory Panel regarding the APRN Consensus Group Report. Both groups agreed to continue to dialogue.

As the APRN Advisory Panel and APRN Consensus Work Group continued their work in parallel fashion, concerns regarding the need for each group's work not to conflict with the other were expressed. A subgroup of seven people from the APRN Consensus Work Group and seven individuals from the APRN Advisory Panel were convened in January, 2007. The group called itself the APRN Joint Dialogue Group (see Appendix E) and the agenda consisted of discussing areas of agreement and disagreement between the two groups. The goal of the subgroup meetings was anticipated to be two papers that did not conflict, but rather complemented each other. However, as the APRN Joint Dialogue Group continued to meet, much progress was made regarding areas of agreement; it was determined that rather than two papers being disseminated, one joint paper would be developed, which reflected the work of both groups. This document is the product of the work of the APRN Joint Dialogue Group and through the consensus-based work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification, and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

CONCLUSION

The recommendations offered in this paper present an APRN regulatory model as a collaborative effort among APRN educators, accreditors, certifiers, and licensure bodies. The essential elements of APRN regulation are identified as licensure, accreditation, certification, and education. The recommendations reflect a need and desire to collaborate among regulatory bodies to achieve a sound model and continued communication with the goal of increasing the clarity and uniformity of APRN regulation.

The goals of the consensus processes were to:

- strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- develop a vision for APRN regulation, including education, accreditation, certification, and licensure;

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- establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and
- produce a written statement that reflects consensus on APRN regulatory issues.

In summary, this report includes: a definition of the APRN Regulatory Model, including a definition of the Advanced Practice Registered Nurse; a definition of broad-based APRN education; a model for regulation that ensures APRN education and certification as a valid and reliable process, that is based on nationally recognized and accepted standards; uniform recommendations for licensing bodies across states; a process and characteristics for recognizing a new APRN role; and a definition of an APRN specialty that allows for the profession to meet future patient and nursing needs.

The work of the Joint Dialogue Group in conjunction with all organizations representing APRN licensure, accreditation, certification, and education to advance a regulatory model is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge, the APRN Regulatory Model will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

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APPENDIX 1 – APRN Joint Dialogue

NCSBN CRITERIA FOR EVALUATING CERTIFICATION PROGRAMS

Criteria	Elaboration
<p>I. The program is national in the scope of its credentialing.</p>	<p>A. The advanced nursing practice category and standards of practice have been identified by national organizations.</p> <p>B. Credentialing services are available to nurses throughout the United States and its territories.</p> <p>C. There is a provision for public representation on the certification board.</p> <p>D. A nursing specialty organization that establishes standards for the nursing specialty exists.</p> <p>E. A tested body of knowledge related to the advanced practice nursing specialty exists.</p> <p>F. The certification board is an entity with organizational autonomy.</p>
<p>II. Conditions for taking the examination are consistent with acceptable standards of the testing community.</p>	<p>A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program.</p> <p>B. Eligibility criteria rationally related to competence to practice safely.</p> <p>C. Published criteria are enforced.</p> <p>D. In compliance with the American Disabilities Act.</p> <p>E. Sample application(s) are available.</p> <ol style="list-style-type: none"> 1) Certification requirements included 2) Application procedures include: <ul style="list-style-type: none"> • procedures for ensuring match between education and clinical experience, and APRN specialty being certified, • procedures for validating information provided by candidate, • procedures for handling omissions and discrepancies 3) Professional staff responsible for credential review and admission decisions. 4) Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items. <p>F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.</p>
<p>III. Educational requirements are consistent with the requirements of the advanced practice specialty.</p>	<p>A. Current U.S. registered nurse licensure is required.</p> <p>B. Graduation from a graduate advanced practice education program meets the following requirements:</p> <ol style="list-style-type: none"> 1) Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking 2) If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1. 3) Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing

	<p>accreditation guidelines</p> <p>4) The curriculum includes, but is not limited to:</p> <ul style="list-style-type: none"> • biological, behavioral, medical, and nursing sciences relevant to practice as an APRN in the specified category; • legal, ethical, and professional responsibilities of the APRN; and • supervised clinical practice relevant to the specialty of APRN <p>5) The curriculum meets the following criteria:</p> <ul style="list-style-type: none"> • Curriculum is consistent with competencies of the specific areas of practice • Instructional track/major has a minimum of 500 supervised clinical hours overall • The supervised clinical experience is directly related to the knowledge and role of the specialty and category <p>C. All individuals, without exception, seeking a national certification must complete a formal didactic and clinical advanced practice program meeting the above criteria.</p>
<p>IV. The standard methodologies used are acceptable to the testing community such as incumbent job analysis study, logical job analysis studies.</p>	<p>A. Exam content based on a job/task analysis.</p> <p>B. Job analysis studies are conducted at least every five years.</p> <p>C. The results of the job analysis study are published and available to the public.</p> <p>D. There is evidence of the content validity of the job analysis study.</p>
<p>V. The examination represents entry-level practice in the advanced nursing practice category.</p>	<p>A. Entry-level practice in the advanced practice specialty is described including the following:</p> <ol style="list-style-type: none"> 1) Process 2) Frequency 3) Qualifications of the group making the determination 4) Geographic representation 5) Professional or regulatory organizations involved in the reviews
<p>VI. The examination represents the knowledge, skills, and abilities essential for the delivery of safe and effective advanced nursing care to the clients.</p>	<p>A. The job analysis includes activities representing knowledge, skills, and abilities necessary for competent performance.</p> <p>B. The examination reflects the results of the job analysis study.</p> <p>C. Knowledge, skills, and abilities, which are critical to public safety, are identified.</p> <p>D. The examination content is oriented to educational curriculum practice requirements and accepted standards of care.</p>
<p>VII. Examination items are reviewed for content validity, cultural bias, and correct scoring using an established mechanism, both before use and periodically.</p>	<p>A. Each item is associated with a single cell of the test plan.</p> <p>B. Items are reviewed for currency before each use at least every three years.</p> <p>C. Items are reviewed by members of under-represented gender and ethnicities who are active in the field being certified. Reviewers have been trained to distinguish irrelevant cultural dependencies from knowledge necessary to safe and effective practice. Process for identifying and processing flagged items is identified.</p>

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	<p>D. A statistical bias analysis is performed on all items.</p> <p>E. All items are subjected to an “unscored” use for data collection purposes before their first use as a “scored” item.</p> <p>F. A process to detect and eliminate bias from the test is in place.</p> <p>G. Reuse guidelines for items on an exam form are identified.</p> <p>H. Item writing and review is done by qualified individuals who represent specialties, population subgroups, etc.</p>
VIII. Examinations are evaluated for psychometric performance.	A. Reference groups used for comparative analysis are defined.
IX. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically.	A. Passing standard is criterion-referenced.
X. Examination security is maintained through established procedures.	<p>A. Protocols are established to maintain security related to:</p> <ol style="list-style-type: none"> 1) Item development (e.g., item writers and confidentiality, how often items are re-used) 2) Maintenance of question pool 3) Printing and production process 4) Storage and transportation of examination is secure 5) Administration of examination (e.g., who administers, who checks administrators) 6) Ancillary materials (e.g., test keys, scrap materials) 7) Scoring of examination 8) Occurrence of a crisis (e.g., exam is compromised, etc)
XI. Certification is issued based upon passing the examination and meeting all other certification requirements.	<p>A. Certification process is described, including the following:</p> <ol style="list-style-type: none"> 1) Criteria for certification decisions are identified 2) The verification that passing exam results and all other requirements are met 3) Procedures are in place for appealing decisions <p>B. There is due process for situations such as nurses denied access to the examination or nurses who have had their certification revoked.</p> <p>C. A mechanism is in place for communicating with candidate.</p> <p>D. Confidentiality of nonpublic candidate data is maintained.</p>
XII. A retake policy is in place.	<p>A. Failing candidates permitted to be reexamined at a future date.</p> <p>B. Failing candidates informed of procedures for retakes.</p> <p>C. Test for repeating examinees should be equivalent to the test for first time candidates.</p> <p>D. Repeating examinees should be expected to meet the same test performance standards as first time examinees.</p> <p>E. Failing candidates are given information on content areas of deficiency.</p> <p>F. Repeating examinees are not exposed to the same items when taking the exam previously.</p>
XIII. Certification maintenance	A. Certification maintenance requirements are specified (e.g., continuing

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<p>program, which includes review of qualifications and continued competence, is in place.</p>	<p>education, practice, examination, etc.).</p> <p>B. Certification maintenance procedures include:</p> <ol style="list-style-type: none"> 1) Procedures for ensuring match between continued competency measures and APRN specialty 2) Procedures for validating information provided by candidates 3) Procedures for issuing re-certification <p>C. Professional staff oversee credential review.</p> <p>D. Certification maintenance is required a minimum of every 5 years.</p>
<p>XIV. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.</p>	<p>A. Communication mechanisms address:</p> <ol style="list-style-type: none"> 1) Permission obtained from candidates to share information regarding the certification process 2) Procedures to provide verification of certification to Boards of Nursing 3) Procedures for notifying Boards of Nursing regarding changes of certification status 4) Procedures for notification of changes in certification programs (qualifications, test plan or scope of practice) to Boards of Nursing
<p>XV. An evaluation process is in place to provide quality assurance in its certification program.</p>	<p>A. Internal review panels are used to establish quality assurance procedures.</p> <ol style="list-style-type: none"> 1) Composition of these groups (by title or area of expertise) is described 2) Procedures are reviewed 3) Frequency of review <p>B. Procedures are in place to ensure adherence to established QA policy and procedures.</p>

APPENDIX 2 – APRN Joint Dialogue
American Nurses Association
Congress on Nursing Practice and Economics 2004
Recognition as a Nursing Specialty

The process of recognizing an area of practice as a nursing specialty allows the profession to formally identify subset areas of focused practice. A clear description of that nursing practice assists the larger community of nurses, healthcare consumers, and others to gain familiarity and understanding of the nursing specialty. Therefore, the document requesting ANA recognition must clearly and fully address each of the fourteen specialty recognition criteria. The inclusion of additional materials to support the discussion and promote understanding of the criteria is acceptable. A scope of practice statement must accompany the submission requesting recognition as a nursing specialty.

Criteria for Recognition as a Nursing Specialty

The following criteria are used by the Congress on Nursing Practice and Economics in the review and decision-making processes to recognize an area of practice as a nursing specialty:

A nursing specialty:

1. Defines itself as nursing.
2. Adheres to the overall licensure requirements of the profession.
3. Subscribes to the overall purposes and functions of nursing.
4. Is clearly defined.
5. Is practiced nationally or internationally.
6. Includes a substantial number of nurses who devote most of their practice to the specialty.
7. Can identify a need and demand for itself.
8. Has a well derived knowledge base particular to the practice of the nursing specialty.
9. Is concerned with phenomena of the discipline of nursing.
10. Defines competencies for the area of nursing specialty practice.
11. Has existing mechanisms for supporting, reviewing and disseminating research to support its knowledge base.
12. Has defined educational criteria for specialty preparation or graduate degree.
13. Has continuing education programs or continuing competence mechanisms for nurses in the specialty.
14. Is organized and represented by a national specialty association or branch of a parent organization.

APPENDIX 3 – APRN Joint Dialogue

NCBN APRN Committee Members 2003 -2008

2003

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Georgia Manning, Arkansas State Board of Nursing
- Deborah Bohannon-Johnson, Board President, North Dakota Board of Nursing
- Jane Garvin, Board President, Maryland Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Nancy Chornick, NCSBN

2004

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing
- Georgia Manning, Arkansas State Board of Nursing
- Jane Garvin RN, Board President, Maryland Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Nancy Chornick, NCSBN

2005

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing
- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- Kim Powell, Board President, Montana Board of Nursing
- Nancy Chornick, NCSBN

2006

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing

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- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Sheila N. Kaiser, Board Vice-Chair, Massachusetts Board of Registration in Nursing
- Nancy Chornick, NCSBN

2007

- Faith Fields, Board Liaison, Arkansas State Board of Nursing
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member, Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Nancy Chornick, NCSBN

2008

- Doreen K. Begley, Board Member, Nevada State Board of Nursing
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member, Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Tracy Klein, Member Staff, Oregon State Board of Nursing
- Darlene Byrd, Board Member, Arkansas State Board of Nursing
- Nancy Chornick, NCSBN

APPENDIX 4 – APRN Joint Dialogue

2006 NCSBN APRN Roundtable

Organization Attendance List

Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Psychiatric Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Holistic Nurses' Certification Corporation
American Midwifery Certification Board
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurses Executives
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Emergency Nurses Association
George Washington School of Medicine
Idaho Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing
Massachusetts Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Board for Certification of Hospice & Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National League for Nursing Accrediting Commission

North Carolina Board of Nursing
Oncology Nursing Certification Corporation
Pediatric Nursing Certification Board
Rhode Island Board of Nursing
Texas Board of Nurse Examiners
Utah Board of Nursing
Vermont Board of Nursing
Wound, Ostomy and Continence Nursing Certification Board

2007 APRN Roundtable Attendance List

American Association of Colleges of Nursing
ABNS Accreditation Council
Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American College of Nurse Practitioners
American Midwifery Certification Board
American Nurses Credentialing Center - Certification Services
American Organization of Nurse Executives
Arkansas State Board of Nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Colorado Board of Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Council on Certification of Nurse Anesthetists and Council on Recertification of Nurse Anesthetists
Emergency Nurses Association
Idaho Board of Nursing
Illinois State Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing

Loyola University Chicago Niehoff School of Nursing
Minnesota Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Pediatric Nurse Practitioners
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
Oncology Nursing Certification Corporation
Pennsylvania Board of Nursing
Pediatric Nursing Certification Board
Rhode Island Board of Nursing
Rush University College of Nursing
South Dakota Board of Nursing
Tennessee Board of Nursing
Texas Board of Nurse Examiners
Vermont Board of Nursing

APPENDIX 5 – APRN Joint Dialogue

APRN Joint Dialogue Group

Organizations represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
Compact Administrators
National Association of Clinical Nurse Specialists
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Council of State Boards of Nursing
NCSBN APRN Advisory Committee Representatives (5)

Appendix 6 APRN Joint Dialogue

ORGANIZATIONS INVITED TO APN CONSENSUS CONFERENCE JUNE, 2004

Accreditation Commission for Midwifery Education
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Academy of Nursing
American Association of Critical Care Nurses
American Association of Critical Care Nurses Certification Program
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
Association of Faculties of Pediatric Nurse Practitioners
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Certification Board Perioperative Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
Hospice and Palliative Nurses Association
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
NANDA International
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Board for Certification of Hospice and Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing
Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National Gerontological Nursing Association
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties

Nurse Licensure Compact Administrators/State of Utah Department of Commerce/Division
of Occupational & Professional Licensing
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Sigma Theta Tau, International
Society of Pediatric Nurses
Wound Ostomy & Continence Nurses Society
Wound Ostomy Continence Nursing Certification Board

APPENDIX 7 – APRN Joint Dialogue

ORGANIZATIONS PARTICIPATING IN APRN CONSENSUS PROCESS

Academy of Medical-Surgical Nurses
Accreditation Commission for Midwifery Education
American College of Nurse-midwives Division of Accreditation
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical Care Nurses Certification
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board for Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse-Midwives
American College of Nurse Practitioners
American Holistic Nurses Association
American Nephrology Nurses Association
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Faculties of Pediatric Nurse Practitioners
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools
District of Columbia Board of Nursing
Department of Health
Dermatology Nurses Association
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
George Washington University
Health Resources and Services Administration
Infusion Nurses Society
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
Kentucky Board of Nursing

National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School of Nurses
National Association of Orthopedic Nurses
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing
Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
Nephrology Nursing Certification Commission
North American Nursing Diagnosis Association International
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Pennsylvania State Board of Nursing
Public Health Nursing Section of the American Public Health Association.
Rehabilitation Nursing Certification Board
Society for Vascular Nursing
Texas Nurses Association
Texas State Board of Nursing
Utah State Board of Nursing
Women's Health, Obstetric & Neonatal Nurses
Wound, Ostomy, & Continence Nurses Society
Wound, Ostomy, & Continence Nursing Certification

APPENDIX 8 – APRN Joint Dialogue

APRN CONSENSUS PROCESS WORK GROUP

ORGANIZATIONS THAT WERE REPRESENTED AT THE WORK GROUP MEETINGS

Jan Towers, American Academy of Nurse Practitioners Certification Program
Joan Stanley, American Association of Colleges of Nursing
Carol Hartigan, American Association of Critical Care Nurses Certification Corporation
Leo LeBel, American Association of Nurse Anesthetists
Bonnie Niebuhr, American Board of Nursing Specialties
Peter Johnson & Elaine Germano, American College of Nurse-Midwives
Mary Jean Schumann, American Nurses Association
Mary Smolenski, American Nurses Credentialing Center
M.T. Meadows, American Organization of Nurse Executives
Edna Hamera & Sandra Talley, American Psychiatric Nurses Association
Elizabeth Hawkins-Walsh, Association of Faculties of Pediatric Nurse Practitioners
Jennifer Butlin, Commission on Collegiate Nursing Education
Laura Poe, APRN Compact Administrators
Betty Horton, Council on Accreditation of Nurse Anesthesia Educational Programs
Kelly Goudreau, National Association of Clinical Nurse Specialists
Fran Way, National Association of Nurse Practitioners in Women’s Health, Council on Accreditation
Mimi Bennett, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
Kathy Apple, National Council of State Boards of Nursing
Grace Newsome & Sharon Tanner, National League for Nursing Accrediting Commission
Kitty Werner & Ann O’Sullivan, National Organization of Nurse Practitioner Faculties
Cyndi Miller-Murphy, Oncology Nursing Certification Corporation
Janet Wyatt, Pediatric Nursing Certification Board
Carol Calianno, Wound, Ostomy and Continence Nursing Certification Board
Irene Sandvold, DHHS, HRSA, Division of Nursing (*observer*)

ADDENDUM – APRN Joint Dialogue

Example of a National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies

The national consensus-based process described here was originally designed, with funding by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, to develop and validate national consensus-based primary care nurse practitioner competencies in five specialty areas. The process was developed with consultation from a nationally recognized expert in higher education assessment. The process subsequently has been used and validated for the development of similar sets of competencies for other areas of nursing practice, including competencies for mass casualty education for all nurses and competencies for acute care nurse practitioners and psych/mental health nurse practitioners.

This process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies is an iterative, step-wise process.

The steps are:

Step 1: At the request of the organization(s) representing the role or specialty, a neutral group or groups convenes and facilitates a national panel of all stakeholder organizations as defined in step 2.

Step 2: To ensure broad representation, invitations to participate should be extended to one representative of each of the recognized nursing accrediting organizations, certifiers within the role and specialty, groups whose primary mission is graduate education and who have established educational criteria for the identified role and specialty, and groups with competencies and standards for education programs that prepare individuals in the role and specialty.

Step 3: Organizational representatives serving on the national consensus panel bring and share role delineation studies, competencies for practice and education, scopes and standards of practice, and standards for education programs.

Step 4: Agreement is reached among the panel members

Step 5: Panel members take the draft to their individual boards for feedback.

Step 6: That feedback is returned to the panel. This is an iterative process until agreement is reached.

Step 7: Validation is sought from a larger group of stakeholders including organizations and individuals. This is known as the Validation Panel.

Step 8: Feedback from the Validation Panel is returned to National Panel to prepare the final document.

Step 9: Final document is sent to boards represented on the National Panel and the Validation Panel for endorsement.

The final document demonstrates national consensus through consideration of broad input from key stakeholders. The document is then widely

Appendix B

Nebraska Advocacy Groups, Patients' Rights Groups, and Volunteer Agencies that Represent Citizens Familiar with or Utilizing the Services of APRNs

Alzheimer's Association, Nebraska Chapter

Lincoln, Omaha, Kearney Offices

www.alz.org/nebraska

402-502-4300

American Cancer Society

www.cancer.org/about-us/local/nebraska.html

Lincoln: 402-423-4888

Omaha: 402-393-5800

American Diabetes Association

Kansas, Iowa, Nebraska, South Dakota Office

ADAIA_NB_SD@diabetes.org

(913) 383-8210

American Heart Association, Nebraska Chapter

www.heart.org/en/affiliates/nebraska/nebraska

402-875-7382

American Lung Association in Nebraska

(402) 502-4950

www.facebook.com/alanebraska

www.lung.org

Juvenile Diabetes Research Foundation, Heartland Chapter

nebraska@jdrf.org

402-484-8300

March of Dimes

www.marchofdimes.org

402-817-7606

National Kidney Foundation

Iowa & Nebraska

Mark.Davis@kidney.org

515-440-0402

Nebraska Arthritis Foundation

www.arthritis.org/local-offices/ne

(402) 262-0144

Nebraska Hospital Association

www.nebraskahospitals.org

402-742-8140

Nebraska Kidney Association

develop@kidneyne.org

402-932-7200

Parkinson's Foundation Heartland

Kansas, Nebraska, Iowa and Missouri

heartland@parkinson.org

913-416-4116

Parkinson's Nebraska

parkinsonsnebraska.org

402-715-4707

Appendix C

Other groups, Associations, or Organizations in Nebraska with an Interest in the Application

AARP Nebraska

neaarp@aarp.org

1-866-389-5651 (toll-free)

American Association of Colleges of Nursing (AACN)

www.aacnnursing.org

202-463-6930

Americans for Prosperity

Americans for Prosperity.org

7003-224-3200

Center for Rural Affairs

www.cfra.org

402-687-2100

CIMRO of Nebraska

www.cimro.com

800-458-4262

Federal Trade Commission

www.ftc.gov

202-326-2222

Joint Commission on Accreditation of Healthcare Organizations

www.jointcommission.org

630-792-5800

National Organization of Nurse Practitioners Faculty

www.nonpf.com

nonpf@nonpf.org

202-289-8044

Nebraska Action Coalition

www.neactioncoalition.org

402-830-7769

Nebraska Appleseed

www.neappleseed.org

402-438-8853

Nebraska Association of Behavioral Health Organizations

www.nabho.org

402-475-0727

Nebraska Association for Home Healthcare and Hospice

www.nebraskahomecare.org

402-423-0718

Nebraska Cardiovascular and Pulmonary Rehab Network

<http://www.ncvprn.org>

www.ncvprn.org

Nebraska Chamber of Commerce & Industry

nechamber@nechamber.com

www.nechamber.com

402-474-4422

Nebraska Healthcare Association

www.nehca.org

402-435-3551

Nebraska Hospice and Palliative Care Association

<https://www.nehospice.org>

402-477-0204

Nebraska Hospital Association

www.nebraskahospitals.org

402-742-8140

Nebraska Medical Association

www.nebmed.org

402-474-4472

Nebraska Organization of Nurse Leaders

NebraskaONL@NebraskaONL.org

www.nebreaskaonl.org

Nebraska Rural Health Association

nebraskaruralhealth.org

402-421-2356

Public Health Association of Nebraska

publichealthne.org

402-904-8640

Appendix D
Full Statutory References

ADVANCED PRACTICE REGISTERED NURSE PRACTICE ACT

INDEX

38-201.	Act, how cited.
38-202.	Legislative findings and declarations.
38-203.	Definition, where found.
38-204.	Board, defined.
38-205.	Board; members; qualifications; terms.
38-206.	Board; duties.
38-207.	License; issuance; department; powers and duties.
38-208.	License; qualifications; military spouse; temporary license.
38-209.	License; renewal; requirements.
38-210.	Expiration of license; conditions.
38-211.	Fees.
38-212.	Use of title.
71-17,131.	Transferred to section 38-201.
71-17,132.	Transferred to section 38-202.
71-17,133.	Transferred to section 38-203.
71-17,134.	Transferred to section 38-205.
71-17,135.	Transferred to section 38-206.
71-17,136.	Transferred to section 38-207.
71-17,137.	Transferred to section 38-208.
71-17,138.	Transferred to section 38-209.
71-17,139.	Repealed. Laws 2007, LB 463, § 1319.
71-17,140.	Transferred to section 38-210.
71-17,141.	Repealed. Laws 2007, LB 463, § 1319.

STATUTES PERTAINING TO ADVANCED PRACTICE REGISTERED NURSE PRACTICE ACT

38-201. Act, how cited.

Sections 38-201 to 38-212 shall be known and may be cited as the Advanced Practice Registered Nurse Practice Act.

Source: Laws 2005, LB 256, § 36; R.S.Supp.,2006, § 71-17,131; Laws 2007, LB463, § 140.

38-202. Legislative findings and declarations.

The Legislature finds and declares that:

(1) Because of the geographic maldistribution of health care services in Nebraska, it is necessary to utilize the skills and proficiency of existing health professionals more efficiently;

(2) It is necessary to encourage the more effective utilization of the skills of registered nurses by enabling them to perform advanced roles in nursing; and

(3) The purpose of the Advanced Practice Registered Nurse Practice Act is to encourage registered nurses to perform advanced roles in nursing.

Source: Laws 2005, LB 256, § 37; R.S.Supp.,2006, § 71-17,132; Laws 2007, LB463, § 141.

38-203. Definition, where found.

For purposes of the Advanced Practice Registered Nurse Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definition found in section 38-204 applies.

Source: Laws 2005, LB 256, § 38; R.S.Supp.,2006, § 71-17,133; Laws 2007, LB463, § 142.

38-204. Board, defined.

Board means the Board of Advanced Practice Registered Nurses.

Source: Laws 2007, LB463, § 143.

38-205. Board; members; qualifications; terms.

(1) Until July 1, 2007, the board shall consist of (a) five advanced practice registered nurses representing different advanced practice registered nurse specialties for which a license has been issued, (b) five physicians licensed under the Uniform Licensing Law to practice medicine in Nebraska, at least three of whom shall have a current collaborating relationship with an advanced practice registered nurse, (c) three consumer members, and (d) one licensed pharmacist.

(2) On and after July 1, 2007, the board shall consist of:

(a) One nurse practitioner holding a license under the Nurse Practitioner Practice Act, one certified nurse midwife holding a license under the Certified Nurse Midwifery Practice Act, one certified registered nurse anesthetist holding a license under the Certified Registered Nurse Anesthetist Practice Act, and one clinical nurse specialist holding a license under the Clinical Nurse Specialist Practice Act, except that the initial clinical nurse specialist appointee may be a clinical nurse specialist practicing pursuant to the Nurse Practice Act as such act existed prior to July 1, 2007. Of the initial appointments under this subdivision, one shall be for a two-year term, one shall be for a three-year term, one shall be for a four-year term, and one shall be for a five-year term. All subsequent appointments under this subdivision shall be for five-year terms;

(b) Three physicians, one of whom shall have a professional relationship with a nurse practitioner, one of whom shall have a professional relationship with a certified nurse midwife, and one of whom shall have a professional relationship with a certified registered nurse anesthetist. Of the initial appointments under this subdivision, one shall be for a three-year term, one shall be for a four-year term, and one shall be for a five-year term. All subsequent appointments under this subdivision shall be for five-year terms; and

(c) Two public members. Of the initial appointments under this subdivision, one shall be for a three-year term, and one shall be for a four-year term. All subsequent appointments under this subdivision shall be for five-year terms.

(3) Members of the board serving immediately before July 1, 2007, shall serve until members are appointed and qualified under subsection (2) of this section.

Source: Laws 1996, LB 414, § 27; Laws 2000, LB 1115, § 42; R.S.1943, (2003), § 71-1718.01; Laws 2005, LB 256, § 39; R.S.Supp.,2006, § 71-17,134; Laws 2007, LB185, § 36; Laws 2007, LB463, § 144.

Cross References

- **Certified Nurse Midwifery Practice Act**, see section 38-601.
- **Certified Registered Nurse Anesthetist Practice Act**, see section 38-701.
- **Clinical Nurse Specialist Practice Act**, see section 38-901.
- **Nurse Practice Act**, see section 38-2201.
- **Nurse Practitioner Practice Act**, see section 38-2301.

38-206. Board; duties.

The board shall:

(1) Establish standards for integrated practice agreements between collaborating physicians and certified nurse midwives;

(2) Monitor the scope of practice by certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners;

(3) Recommend disciplinary action relating to licenses of advanced practice registered nurses, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners;

(4) Engage in other activities not inconsistent with the Advanced Practice Registered Nurse Practice Act, the Certified Nurse Midwifery Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice Act, and the Nurse Practitioner Practice Act; and

(5) Adopt rules and regulations to implement the Advanced Practice Registered Nurse Practice Act, the Certified Nurse Midwifery Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice Act, and the Nurse Practitioner Practice Act, for promulgation by the department as provided in section 38-126. Such rules and regulations shall also include: (a) Approved certification organizations and approved certification programs; and (b) professional liability insurance.

Source: Laws 1996, LB 414, § 28; Laws 2000, LB 1115, § 43; Laws 2002, LB 1021, § 56; R.S.1943, (2003), § 71-1718.02; Laws 2005, LB 256, § 40; R.S.Supp.,2006, § 71-17,135; Laws 2007, LB185, § 37; Laws 2007, LB463, § 145; Laws 2015, LB107, § 1.

Cross References

- **Certified Nurse Midwifery Practice Act**, see section 38-601.
- **Certified Registered Nurse Anesthetist Practice Act**, see section 38-701.
- **Clinical Nurse Specialist Practice Act**, see section 38-901.
- **Nurse Practitioner Practice Act**, see section 38-2301.

38-207. License; issuance; department; powers and duties.

The department shall issue a license as an advanced practice registered nurse to a registered nurse who meets the requirements of subsection (1) or (3) of section 38-208. The department may issue a license as an advanced practice registered nurse to a registered nurse pursuant to subsection (2) of section 38-208.

Source: Laws 2005, LB 256, § 41; R.S.Supp.,2006, § 71-17,136; Laws 2007, LB463, § 146.

38-208. License; qualifications; military spouse; temporary license.

(1) An applicant for initial licensure as an advanced practice registered nurse shall:

(a) Be licensed as a registered nurse under the Nurse Practice Act or have authority based on the Nurse Licensure Compact to practice as a registered nurse in Nebraska;

(b) Be a graduate of or have completed a graduate-level advanced practice registered nurse program in a clinical specialty area of certified registered nurse anesthetist, clinical nurse specialist, certified nurse midwife, or nurse practitioner, which program is accredited by a national accrediting body;

(c) Be certified as a certified registered nurse anesthetist, a clinical nurse specialist, a certified nurse midwife, or a nurse practitioner, by an approved certifying body or an alternative method of competency assessment approved by the board, pursuant to the Certified Nurse Midwifery Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice Act, or the Nurse Practitioner Practice Act, as appropriate to the applicant's educational preparation;

(d) Provide evidence as required by rules and regulations; and

(e) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for discipline under the Nurse Practice Act, the board has found after investigation that sufficient restitution has been made.

(2) The department may issue a license under this section to an applicant who holds a license from another jurisdiction if the licensure requirements of such other jurisdiction meet or exceed the requirements for licensure as an advanced practice registered nurse under the Advanced Practice Registered Nurse Practice Act. An applicant under this subsection shall submit documentation as required by rules and regulations.

(3) A person licensed as an advanced practice registered nurse or certified as a certified registered nurse anesthetist or a certified nurse midwife in this state on July 1, 2007, shall be issued a license by the department as an advanced practice registered nurse on such date.

(4) An applicant who is a military spouse may apply for a temporary license as provided in section 38-129.01.

Source: Laws 2005, LB 256, § 42; R.S.Supp.,2006, § 71-17,137; Laws 2007, LB185, § 38; Laws 2007, LB463, § 147; Laws 2017, LB88, § 35.

Cross References

- **Certified Nurse Midwifery Practice Act**, see section 38-601.
- **Certified Registered Nurse Anesthetist Practice Act**, see section 38-701.
- **Clinical Nurse Specialist Practice Act**, see section 38-901.
- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.
- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.
- **Nurse Practice Act**, see section 38-2201.
- **Nurse Practitioner Practice Act**, see section 38-2301.

38-209. License; renewal; requirements.

The license of each person licensed under the Advanced Practice Registered Nurse Practice Act shall be renewed at the same time and in the same manner as renewal of a license for a registered nurse and shall require that the applicant have (1) a license as a registered nurse issued by the state or have the authority based on the Nurse Licensure Compact to practice as a registered nurse in Nebraska, (2) documentation of continuing competency, either by reference, peer review, examination, or one or more of the continuing competency activities listed in section 38-145 and established by the board in rules and regulations, and (3) met any specific requirements for renewal under the Certified Nurse Midwifery Practice Act, the Certified Registered Nurse Anesthetist Practice Act, the Clinical Nurse Specialist Practice Act, or the Nurse Practitioner Practice Act, as applicable.

Source: Laws 2005, LB 256, § 43; R.S.Supp.,2006, § 71-17,138; Laws 2007, LB185, § 39; Laws 2007, LB463, § 148.

Cross References

- **Certified Nurse Midwifery Practice Act**, see section 38-601.
- **Certified Registered Nurse Anesthetist Practice Act**, see section 38-701.
- **Clinical Nurse Specialist Practice Act**, see section 38-901.

- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.
- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.
- **Nurse Practitioner Practice Act**, see section 38-2301.

38-210. Expiration of license; conditions.

An advanced practice registered nurse's license expires if he or she does not renew his or her license to practice as a registered nurse or is not authorized to practice as a registered nurse in this state under the Nurse Licensure Compact.

Source: Laws 2005, LB 256, § 45; R.S.Supp.,2006, § 71-17,140; Laws 2007, LB185, § 41; Laws 2007, LB463, § 149.

Cross References

- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.

38-211. Fees.

The department shall establish and collect fees for initial licensure and renewal under the Advanced Practice Registered Nurse Practice Act as provided in sections 38-151 to 38-157.

Source: Laws 2007, LB463, § 150.

38-212. Use of title.

A person licensed as an advanced practice registered nurse in this state may use the title advanced practice registered nurse and the abbreviation APRN.

Source: Laws 2007, LB463, § 151.

- 71-17,131. Transferred to section 38-201.
- 71-17,132. Transferred to section 38-202.
- 71-17,133. Transferred to section 38-203.
- 71-17,134. Transferred to section 38-205.
- 71-17,135. Transferred to section 38-206.
- 71-17,136. Transferred to section 38-207.
- 71-17,137. Transferred to section 38-208.
- 71-17,138. Transferred to section 38-209.
- 71-17,139. Repealed. Laws 2007, LB 463, § 1319.
- 71-17,140. Transferred to section 38-210.
- 71-17,141. Repealed. Laws 2007, LB 463, § 1319.

CERTIFIED NURSE MIDWIFERY PRACTICE ACT

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- 71-1738. Transferred to section 38-601.
- 71-1739. Transferred to section 38-602.
- 71-1740. Transferred to section 38-603.
- 71-1741 and 71-1742. Repealed. Laws 1999, LB 828, § 178
- 71-1743. Transferred to section 38-605.
- 71-1744. Repealed. Laws 2002, LB 93, s. 27.
- 71-1745. Repealed. Laws 2007, LB 463, § 1319.
- 71-1746. Transferred to section 38-608.
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- 71-1754. Transferred to section 38-614.
- 71-1755. Transferred to section 38-615.
- 71-1756. Transferred to section 38-617.
- 71-1757. Transferred to section 38-616.
- 71-1758. Repealed. Laws 2007, LB 185, § 54.
- 71-1759. Repealed. Laws 2002, LB 93, §27.
- 71-1760. Repealed. Laws 2003, LB 242, s. 154.
- 71-1761 and 71-1762. Repealed. Laws 2007, LB 185, § 54.
- 71-1763. Transferred to section 38-618.
- 71-1764. Repealed. Laws 2007, LB 463, § 1319.
- 71-1765. Transferred to section 38-612.

STATUTES PERTAINING TO THE CERTIFIED NURSE MIDWIFERY PRACTICE ACT

38-601. Act, how cited.

Sections 38-601 to 38-618 shall be known and may be cited as the Certified Nurse Midwifery Practice Act.

Source: Laws 1984, LB 761, § 1; Laws 2005, LB 256, § 82; R.S.Supp.,2006, § 71-1738; Laws 2007, LB463, § 213.

38-602. Legislative findings.

The Legislature hereby finds and declares that the Certified Nurse Midwifery Practice Act is necessary to safeguard public life, health, safety, and welfare, to assure the highest degree of professional conduct by practitioners of certified nurse midwifery, and to insure the availability of high quality midwifery services to persons desiring such services.

Source: Laws 1984, LB 761, § 2; R.S.1943, (2003), § 71-1739; Laws 2007, LB463, § 214.

38-603. Definitions, where found.

For purposes of the Certified Nurse Midwifery Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-604 to 38-610 apply.

Source: Laws 1984, LB 761, § 3; Laws 1999, LB 828, § 160; R.S.1943, (2003), § 71-1740; Laws 2007, LB463, § 215.

38-604. Approved certified nurse midwifery education program, defined.

Approved certified nurse midwifery education program means a certified nurse midwifery education program approved by the board. The board may require such program to be accredited by the American College of Nurse-Midwives.

Source: Laws 1984, LB 761, § 12; Laws 2005, LB 256, § 85; R.S.Supp.,2006, § 71-1749; Laws 2007, LB185, § 21; Laws 2007, LB463, § 216.

38-605. Board, defined.

Board means the Board of Advanced Practice Registered Nurses.

Source: Laws 1984, LB 761, § 6; Laws 1993, LB 536, § 74; Laws 1999, LB 828, § 161; Laws 2005, LB 256, § 83; R.S.Supp.,2006, § 71-1743; Laws 2007, LB463, § 217.

38-606. Certified nurse midwife, defined.

Certified nurse midwife means a person certified by a board-approved certifying body and licensed under the Advanced Practice Registered Nurse Practice Act to practice certified nurse midwifery in the State of Nebraska. Nothing in the Certified Nurse Midwifery Practice Act is intended to restrict the practice of registered nurses.

Source: Laws 1984, LB 761, § 11; R.S.1943, (2003), § 71-1748; Laws 2007, LB185, § 20; Laws 2007, LB463, § 218.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.

38-607. Collaboration, defined.

Collaboration means a process and relationship in which a certified nurse midwife works together with other health professionals to deliver health care within the scope of practice of certified nurse midwifery as provided in the Certified Nurse Midwifery Practice Act. The collaborative relationship between the physician and the nurse midwife shall be subject to the control and regulation of the board.

Source: Laws 1984, LB 761, § 10; Laws 2005, LB 256, § 84; R.S.Supp.,2006, § 71-1747; Laws 2007, LB463, § 219.

38-608. Licensed practitioner, defined.

Licensed practitioner means any physician licensed to practice pursuant to the Medicine and Surgery Practice Act, whose practice includes obstetrics.

Source: Laws 1984, LB 761, § 9; R.S.1943, (2003), § 71-1746; Laws 2007, LB463, § 220.

Cross References

- **Medicine and Surgery Practice Act**, see section 38-2001.

38-609. Practice agreement, defined.

Practice agreement means the written agreement authored and signed by the certified nurse midwife and the licensed practitioner with whom he or she is associated which:

- (1) Identifies the settings within which the certified nurse midwife is authorized to practice;
- (2) Names the collaborating licensed practitioner or, if more than one licensed practitioner is a party to such practice agreement, names all of the collaborating licensed practitioners;
- (3) Defines or describes the medical functions to be performed by the certified nurse midwife, which are not inconsistent with the Certified Nurse Midwifery Practice Act, as agreed to by the nurse midwife and the collaborating licensed practitioner; and
- (4) Contains such other information as required by the board.

Source: Laws 1984, LB 761, § 13; Laws 2005, LB 256, § 86; R.S.Supp.,2006, § 71-1750; Laws 2007, LB463, § 221.

38-610. Supervision, defined.

Supervision means the ready availability of a collaborating licensed practitioner for consultation and direction of the activities of the certified nurse midwife related to delegated medical functions as outlined in the practice agreement.

Source: Laws 1984, LB 761, § 14; R.S.1943, (2003), § 71-1751; Laws 2007, LB463, § 222.

38-611. Certified nurse midwife; authorized activities.

A certified nurse midwife may, under the provisions of a practice agreement, (1) attend cases of normal childbirth, (2) provide prenatal, intrapartum, and postpartum care, (3) provide normal obstetrical and gynecological services for women, and (4) provide care for the newborn immediately following birth. The conditions under which a certified nurse midwife is required to refer cases to a collaborating licensed practitioner shall be specified in the practice agreement.

Source: Laws 1984, LB 761, § 15; R.S.1943, (2003), § 71-1752; Laws 2007, LB185, § 22; Laws 2007, LB463, § 223.

38-612. Unlicensed person; acts not prohibited.

The Certified Nurse Midwifery Practice Act shall not prohibit the performance of the functions of a certified nurse midwife by an unlicensed person if performed:

- (1) In an emergency situation;
- (2) By a legally qualified person from another state employed by the United States Government and performing official duties in this state; or
- (3) By a person enrolled in an approved program for the preparation of certified nurse midwives as part of such approved program.

Source: Laws 1984, LB 761, § 28; R.S.1943, (2003), § 71-1765; Laws 2007, LB185, § 27; Laws 2007, LB463, § 224.

38-613. Permitted practice described in practice agreement; supervision; settings; subject to review by board; rules and regulations.

- (1) The specific medical functions to be performed by a certified nurse midwife within the scope of permitted practice prescribed by section 38-611 shall be described in the practice agreement which shall be reviewed and approved by the board. A copy of the agreement shall be maintained on file with the board as a condition of lawful practice under the Certified Nurse Midwifery Practice Act.
- (2) A certified nurse midwife shall perform the functions detailed in the practice agreement only under the supervision of the licensed practitioner responsible for the medical care of the patients described in the practice agreement. If the collaborating licensed practitioner named in the practice agreement becomes temporarily unavailable, the certified nurse midwife may perform the authorized medical functions only under the supervision of another licensed practitioner designated as a temporary substitute for that purpose by the collaborating licensed practitioner.
- (3) A certified nurse midwife may perform authorized medical functions only in the following settings:
 - (a) In a licensed or certified health care facility as an employee or as a person granted privileges by the facility;
 - (b) In the primary office of a licensed practitioner or in any setting authorized by the collaborating licensed practitioner, except that a certified nurse midwife shall not attend a home delivery; or

(c) Within an organized public health agency.

(4) The department shall, after consultations with the board, adopt and promulgate rules and regulations to carry out the Certified Nurse Midwifery Practice Act.

Source: Laws 1984, LB 761, § 16; Laws 1993, LB 536, § 75; Laws 2005, LB 256, § 87; R.S.Supp.,2006, § 71-1753; Laws 2007, LB463, § 225.

38-614. Change in practice; new or amended agreement.

If a certified nurse midwife intends to alter his or her practice status by reason of a change in the setting, supervision by a different licensed practitioner, modification of the authorized medical functions, or for any other reason, he or she shall submit a new or amended practice agreement to the board for approval before any change may be permitted.

Source: Laws 1984, LB 761, § 17; Laws 2005, LB 256, § 88; R.S.Supp.,2006, § 71-1754; Laws 2007, LB463, § 226.

38-615. Licensure as nurse midwife; application; requirements; temporary licensure.

(1) An applicant for licensure under the Advanced Practice Registered Nurse Practice Act to practice as a certified nurse midwife shall submit such evidence as the board requires showing that the applicant is currently licensed as a registered nurse by the state or has the authority based on the Nurse Licensure Compact to practice as a registered nurse in Nebraska, has successfully completed an approved certified nurse midwifery education program, and is certified as a nurse midwife by a board-approved certifying body.

(2) The department may, with the approval of the board, grant temporary licensure as a certified nurse midwife for up to one hundred twenty days upon application (a) to graduates of an approved nurse midwifery program pending results of the first certifying examination following graduation and (b) to nurse midwives currently licensed in another state pending completion of the application for a Nebraska license. A temporary license issued pursuant to this subsection may be extended for up to one year with the approval of the board.

(3) An applicant who is a military spouse may apply for a temporary license as provided in section 38-129.01.

(4) If more than five years have elapsed since the completion of the nurse midwifery program or since the applicant has practiced as a nurse midwife, the applicant shall meet the requirements in subsection (1) of this section and provide evidence of continuing competency, as may be determined by the board, either by means of a reentry program, references, supervised practice, examination, or one or more of the continuing competency activities listed in section 38-145.

Source: Laws 1984, LB 761, § 18; Laws 1993, LB 536, § 76; Laws 1997, LB 752, § 175; Laws 2002, LB 1021, § 63; Laws 2003, LB 242, § 107; Laws 2005, LB 256, § 89; R.S.Supp.,2006, § 71-1755; Laws 2007, LB185, § 23; Laws 2007, LB463, § 227; Laws 2017, LB88, § 40.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.
- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.

- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.

38-616. License; renewal.

To renew a license as a certified nurse midwife, the applicant shall have a current certification by a board-approved certifying body to practice nurse midwifery.

Source: Laws 1984, LB 761, § 20; Laws 1986, LB 926, § 57; Laws 1993, LB 536, § 77; Laws 1994, LB 1223, § 42; Laws 2002, LB 1021, § 64; Laws 2002, LB 1062, § 48; Laws 2003, LB 242, § 108; Laws 2005, LB 256, § 90; R.S.Supp.,2006, § 71-1757; Laws 2007, LB185, § 25; Laws 2007, LB463, § 228.

38-617. Certified nurse midwife; right to use title or abbreviation.

Any person who holds a license to practice nurse midwifery in this state shall have the right to use the title certified nurse midwife and the abbreviation CNM. No other person shall use such title or abbreviation to indicate that he or she is licensed under the Advanced Practice Registered Nurse Practice Act to practice certified nurse midwifery.

Source: Laws 1984, LB 761, § 19; R.S.1943, (2003), § 71-1756; Laws 2007, LB185, § 24; Laws 2007, LB463, § 229.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.

38-618. Act, how interpreted.

Nothing in the Certified Nurse Midwifery Practice Act shall be interpreted to permit independent practice.

Source: Laws 1984, LB 761, § 26; R.S.1943, (2003), § 71-1763; Laws 2007, LB463, § 230.

71-1738. Transferred to section 38-601.

71-1739. Transferred to section 38-602.

71-1740. Transferred to section 38-603.

71-1741 and 71-1742. Repealed. Laws 1999, LB 828, § 178.

71-1743. Transferred to section 38-605.

71-1744. Repealed. Laws 2002, LB 93, s. 27.

71-1745. Repealed. Laws 2007, LB 463, § 1319.

71-1746. Transferred to section 38-608.

71-1747. Transferred to section 38-607.

71-1748. Transferred to section 38-606.

71-1749. Transferred to section 38-604.

71-1750. Transferred to section 38-609.

71-1751. Transferred to section 38-610.

71-1752. Transferred to section 38-611.

71-1753. Transferred to section 38-613.

71-1754. Transferred to section 38-614.

71-1755. Transferred to section 38-615.

71-1756. Transferred to section 38-617.

71-1757. Transferred to section 38-616.

71-1758. Repealed. Laws 2007, LB 185, § 54.

71-1759. Repealed. Laws 2002, LB 93, §27.

71-1760. Repealed. Laws 2003, LB 242, s. 154.

71-1761 and 71-1762. Repealed. Laws 2007, LB 185, § 54.

71-1763. Transferred to section 38-618.

71-1764. Repealed. Laws 2007, LB 463, § 1319.

71-1765. Transferred to section 38-612.

CERTIFIED REGISTERED NURSE ANESTHETIST PRACTICE ACT

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- 38-701. Act, how cited.
- 38-702. Definitions, where found.
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- 71-1728. Transferred to section 38-701.
- 71-1729. Transferred to section 38-706.
- 71-1730. Transferred to section 38-707.
- 71-1731. Transferred to section 38-708.
- 71-1732 and 71-1733. Repealed. Laws 1992, LB 1019, §129.
- 71-1734. Transferred to section 38-711.
- 71-1735. Transferred to section 38-709.
- 71-1736. Repealed. Laws 2005, LB 256, §103.
- 71-1736.01 to 71-1736.03. Repealed. Laws 2007, LB 185, § 54.
- 71-1737. Repealed. Laws 2007, LB 463, § 1319.

STATUTES PERTAINING TO THE CERTIFIED REGISTERED NURSE ANESTHETIST PRACTICE ACT

38-701. Act, how cited.

Sections 38-701 to 38-711 shall be known and may be cited as the Certified Registered Nurse Anesthetist Practice Act.

Source: Laws 2005, LB 256, § 73; R.S.Supp.,2006, § 71-1728; Laws 2007, LB463, § 231.

38-702. Definitions, where found.

For purposes of the Certified Registered Nurse Anesthetist Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-703 to 38-706 apply.

Source: Laws 2007, LB463, § 232.

38-703. Board, defined.

Board means the Board of Advanced Practice Registered Nurses.

Source: Laws 2007, LB463, § 233.

38-704. Certified registered nurse anesthetist, defined.

Certified registered nurse anesthetist means a licensed registered nurse certified by a board-approved certifying body and licensed under the Advanced Practice Registered Nurse Practice Act to practice as a certified registered nurse anesthetist in the State of Nebraska.

Source: Laws 2007, LB463, § 234.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.

38-705. Licensed practitioner, defined.

Licensed practitioner means any physician or osteopathic physician licensed to prescribe, diagnose, and treat as prescribed in the Medicine and Surgery Practice Act.

Source: Laws 2007, LB463, § 235.

Cross References

- **Medicine and Surgery Practice Act**, see section 38-2001.

38-706. Practice of anesthesia, defined; activities not subject to act.

(1) Practice of anesthesia means (a) the performance of or the assistance in any act involving the determination, preparation, administration, or monitoring of any drug used to render an individual insensible to pain for procedures requiring the presence of persons educated in the administration of anesthetics or (b) the performance of any act commonly the responsibility of educated anesthesia personnel. Practice of anesthesia includes the use of those techniques which are deemed necessary for adequacy in performance of anesthesia administration.

(2) Nothing in the Certified Registered Nurse Anesthetist Practice Act prohibits (a) routine administration of a drug by a duly licensed registered nurse, licensed practical nurse, or other duly authorized person for the alleviation of pain or (b) the practice of anesthesia by students enrolled in an accredited school of nurse anesthesia when the services performed are a part of the course of study and are under the supervision of a licensed practitioner or certified registered nurse anesthetist.

Source: Laws 1981, LB 379, § 26; Laws 1992, LB 1019, § 73; Laws 2002, LB 1062, § 47; Laws 2005, LB 256, § 74; R.S.Supp.,2006, § 71-1729; Laws 2007, LB185, § 14; Laws 2007, LB296, § 485; Laws 2007, LB463, § 236.

38-707. Certified registered nurse anesthetist; license; requirements.

(1) An applicant for a license under the Advanced Practice Registered Nurse Practice Act to practice as a certified registered nurse anesthetist shall:

(a) Hold a license as a registered nurse in the State of Nebraska or have the authority based on the Nurse Licensure Compact to practice as a registered nurse in Nebraska;

(b) Submit evidence of successful completion of a course of study in anesthesia in a school of nurse anesthesia accredited or approved by or under the auspices of the department or the Council on Accreditation of Nurse Anesthesia and Educational Programs; and

(c) Submit evidence of current certification by the Council on Certification of Nurse Anesthetists.

(2) If more than five years have elapsed since the applicant completed the nurse anesthetist program or since the applicant has practiced as a nurse anesthetist, he or she shall meet the requirements of subsection (1) of this section and shall provide evidence of continuing competency as determined by the board, including, but not limited to, a reentry program, supervised practice, examination, or one or more of the continuing competency activities listed in section 38-145.

Source: Laws 1981, LB 379, § 27; Laws 1984, LB 724, § 29; Laws 1992, LB 1019, § 74; Laws 1996, LB 414, § 44; Laws 1997, LB 752, § 174; Laws 1999, LB 828, § 155; Laws 2002, LB 1021, § 61; Laws 2003, LB 242, § 105; Laws 2005, LB 256, § 78; R.S.Supp.,2006, § 71-1730; Laws 2007, LB185, § 15; Laws 2007, LB463, § 237.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.
- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.
- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.

38-708. Certified registered nurse anesthetist; temporary license; permit.

(1) The department may, with the approval of the board, grant a temporary license in the practice of anesthesia for up to one hundred twenty days upon application (a) to graduates of an accredited school of nurse anesthesia pending results of the first certifying examination following graduation and (b) to registered nurse anesthetists currently licensed in another state pending completion of the application for a Nebraska license. A temporary license issued pursuant to this subsection may be extended at the discretion of the board with the approval of the department.

(2) An applicant for a license to practice as a certified registered nurse anesthetist who is a military spouse may apply for a temporary license as provided in section 38-129.01.

Source: Laws 1981, LB 379, § 28; Laws 1984, LB 724, § 30; Laws 1992, LB 1019, § 75; Laws 1996, LB 414, § 45; Laws 1999, LB 828, § 156; Laws 2005, LB 256, § 79; R.S.Supp.,2006, § 71-1731; Laws 2007, LB185, § 16; Laws 2007, LB463, § 238; Laws 2017, LB88, § 41.

38-709. Certified registered nurse anesthetist; license; renewal.

To renew a license to practice as a certified registered nurse anesthetist, the applicant shall have current certification by the Council on Certification of Nurse Anesthetists.

Source: Laws 1981, LB 379, § 32; Laws 1993, LB 536, § 73; Laws 1995, LB 563, § 42; Laws 1996, LB 414, § 46; Laws 1999, LB 828, § 157; Laws 2000, LB 1115, § 61; Laws 2002, LB 1021, § 62; Laws 2003, LB 242, § 106; Laws 2005, LB 256, § 80; R.S.Supp.,2006, § 71-1735; Laws 2007, LB185, § 18; Laws 2007, LB463, § 239.

Cross References

- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.

38-710. Use of title and abbreviation.

A person licensed as a certified registered nurse anesthetist has the right to use the title certified registered nurse anesthetist and the abbreviation C.R.N.A.

Source: Laws 2007, LB463, § 240.

38-711. Certified registered nurse anesthetist; performance of duties.

(1) The determination and administration of total anesthesia care shall be performed by the certified registered nurse anesthetist or a nurse anesthetist temporarily licensed pursuant to section 38-708 in consultation and collaboration with and with the consent of the licensed practitioner.

(2) The following duties and functions shall be considered as specific expanded role functions of the certified registered nurse anesthetist:

(a) Preanesthesia evaluation including physiological studies to determine proper anesthetic management and obtaining informed consent;

(b) Selection and application of appropriate monitoring devices;

(c) Selection and administration of anesthetic techniques;

(d) Evaluation and direction of proper postanesthesia management and dismissal from postanesthesia care;

(e) Evaluation and recording of postanesthesia course of patients; and

(f) Use of fluoroscopy in conjunction with a licensed medical radiographer in connection with the performance of authorized duties and functions upon (i) the successful completion of appropriate education and training as approved jointly by the department and the board and promulgated by the department in rules and regulations pursuant to section 71-3508 and (ii) a determination regarding the scope and supervision of such use consistent with subsection (3) of this section.

(3) The determination of other duties that are normally considered medically delegated duties to the certified registered nurse anesthetist or to a nurse anesthetist temporarily licensed pursuant to section 38-708 shall be the joint responsibility of the governing board of the hospital, medical staff, and nurse anesthetist personnel of any duly licensed hospital or, if in an office or clinic, the joint responsibility of the duly licensed practitioner and nurse anesthetist. All such duties, except in cases of emergency, shall be in writing in the form prescribed by hospital or office policy.

Source: Laws 1981, LB 379, § 31; Laws 1992, LB 1019, § 76; R.S.1943, (2003), § 71-1734; Laws 2007, LB185, § 17; Laws 2007, LB463, § 241; Laws 2008, LB928, § 4.

71-1728. Transferred to section 38-701.

71-1729. Transferred to section 38-706.

71-1730. Transferred to section 38-707.

71-1731. Transferred to section 38-708.

71-1732 and 71-1733. Repealed. Laws 1992, LB 1019, §129.

71-1734. Transferred to section 38-711.

71-1735. Transferred to section 38-709.

71-1736. Repealed. Laws 2005, LB 256, §103.

71-1736.01 to 71-1736.03. Repealed. Laws 2007, LB 185, § 54.

71-1737. Repealed. Laws 2007, LB 463, § 1319.

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 - 71-17,122. Repealed. Laws 2007, LB 463, § 1319.
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 - 71-17,125 to 71-17,127. Repealed. Laws 2007, LB 185, § 54.
 - 71-17,128. Transferred to section 38-907.
 - 71-17,129. Repealed. Laws 2007, LB 463, § 1319.
 - 71-17,130. Repealed. Laws 2007, LB 463, § 1319.

STATUTES PERTAINING TO THE CLINICAL NURSE SPECIALIST PRACTICE ACT

38-901. Act, how cited.

Sections 38-901 to 38-910 shall be known and may be cited as the Clinical Nurse Specialist Practice Act.

Source: Laws 2005, LB 256, § 1; R.S.Supp.,2006, § 71-17,117; Laws 2007, LB463, § 253.

38-902. Definitions, where found.

For purposes of the Clinical Nurse Specialist Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-903 to 38-905 apply.

Source: Laws 2007, LB463, § 254.

38-903. Approved certifying body, defined.

Approved certifying body means a national certification organization which (1) is approved by the board, (2) certifies qualified licensed registered nurses for advanced practice, (3) has eligibility requirements related to education and practice, and (4) offers an examination in an area of practice which meets psychometric guidelines and tests approved by the board.

Source: Laws 2005, LB 256, § 2; R.S.Supp.,2006, § 71-17,118; Laws 2007, LB185, § 28; Laws 2007, LB296, § 493; Laws 2007, LB463, § 255.

38-904. Board, defined.

Board means the Board of Advanced Practice Registered Nurses.

Source: Laws 2007, LB463, § 256.

38-905. Clinical nurse specialist, defined.

Clinical nurse specialist means a registered nurse certified as described in section 38-908 and licensed under the Advanced Practice Registered Nurse Practice Act to practice as a clinical nurse specialist in the State of Nebraska.

Source: Laws 2007, LB463, § 257.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.

38-906. Clinical nurse specialist practice, defined.

The practice of a clinical nurse specialist includes health promotion, health supervision, illness prevention, and disease management, including assessing patients, synthesizing and analyzing data, and applying advanced nursing practice. A clinical nurse specialist conducts and applies research, advocates, serves as an agent of change, engages in systems management, and assesses and intervenes in complex health care problems within the selected clinical specialty.

Source: Laws 2005, LB 256, § 4; R.S.Supp.,2006, § 71-17,120; Laws 2007, LB463, § 258.

38-907. Exemptions from act.

The Clinical Nurse Specialist Practice Act does not prohibit the performance of the professional activities of a clinical nurse specialist by a person not holding a license issued under the act if performed:

- (1) In an emergency situation;
- (2) By a legally qualified person from another state employed by the United States and performing official duties in this state; or
- (3) By a person enrolled in an approved clinical nurse specialist program for the education of clinical nurse specialists as part of that approved program.

Source: Laws 2005, LB 256, § 12; R.S.Supp.,2006, § 71-17,128; Laws 2007, LB185, § 34; Laws 2007, LB463, § 259.

38-908. Licensure; eligibility; application.

An applicant for licensure under the Advanced Practice Registered Nurse Practice Act to practice as a clinical nurse specialist shall be licensed as a registered nurse under the Nurse Practice Act or have the authority based on the Nurse Licensure Compact to practice as a registered nurse in Nebraska and shall submit to the department the following:

- (1) Evidence that the applicant holds a graduate degree in a nursing clinical specialty area or has a graduate degree in nursing and has successfully completed a graduate-level clinical nurse specialist education program; and
- (2) Evidence of certification issued by an approved certifying body or, when such certification is not available, an alternative method of competency assessment by any means approved by the board.

Source: Laws 2005, LB 256, § 3; R.S.Supp.,2006, § 71-17,119; Laws 2007, LB185, § 29; Laws 2007, LB463, § 260.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.
- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.
- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.
- **Nurse Practice Act**, see section 38-2201.

38-909. License; renewal; qualifications.

To renew a license as a clinical nurse specialist, the applicant shall have current certification by an approved certifying body as a clinical nurse specialist or, when such certification is not available, an alternative method of competency assessment by any means approved by the board.

Source: Laws 2007, LB463, § 261.

38-910. Use of title and abbreviation.

A person licensed as a clinical nurse specialist has the right to use the title Clinical Nurse Specialist and the abbreviation CNS.

Source: Laws 2005, LB 256, § 5; R.S.Supp.,2006, § 71-17,121; Laws 2007, LB185, § 30; Laws 2007, LB463, § 262.

- 71-17,117. Transferred to section 38-901.
- 71-17,118. Transferred to section 38-903.
- 71-17,119. Transferred to section 38-908.
- 71-17,120. Transferred to section 38-906.
- 71-17,121. Transferred to section 38-910.
- 71-17,122. Repealed. Laws 2007, LB 463, § 1319.
- 71-17,123. Repealed. Laws 2007, LB 463, § 1319.
- 71-17,124. Repealed. Laws 2007, LB 463, § 1319.
- 71-17,125 to 71-17,127. Repealed. Laws 2007, LB 185, § 54.
- 71-17,128. Transferred to section 38-907.
- 71-17,129. Repealed. Laws 2007, LB 463, § 1319.
- 71-17,130. Repealed. Laws 2007, LB 463, § 1319.

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- 38-2323. Nurse practitioner; actions not prohibited.
- 38-2324. Nurse practitioner; signing of death certificates; grounds for disciplinary action.

- 71-1704. Transferred to section 38-2301.
- 71-1705. Repealed. Laws 2005, LB 256, §103.
- 71-1706. Transferred to section 38-2302.
- 71-1707. Transferred to section 38-2312.
- 71-1708. Transferred to section 38-2306.

- 71-1709. Repealed. Laws 1996, LB 414, §52.

- 71-1709.01. Transferred to section 38-2307.
- 71-1709.02. Transferred to section 38-2309.

- 71-1710. Repealed. Laws 2007, LB 463, § 1319.
- 71-1711. Repealed. Laws 1996, LB 414, §52.

- 71-1712. Transferred to section 38-2311.

- 71-1713. Repealed. Laws 1993, LB 536, §128.

- 71-1714. Transferred to section 38-2313.

- 71-1715. Repealed. Laws 1996, LB 414, §52.

- 71-1716. Transferred to section 38-2308.

71-1716.01.	Transferred to section 38-2304.
71-1716.02.	Transferred to section 38-2303.
71-1716.03.	Transferred to section 38-2310.
71-1716.04.	Repealed. Laws 1996, LB 414, §52.
71-1716.05.	Transferred to section 38-2314.
71-1717.	Transferred to section 38-2305.
71-1718.	Repealed. Laws 1993, LB 536, §128.
71-1718.01	Transferred to section 71-17,134.
71-1718.02	Transferred to section 71-17,135
71-1719 to 71-1720.	Repealed. Laws 1993, LB 536, §128.
71-1721.	Transferred to section 38-2315.
71-1721.01 to 71-1721.06.	Repealed. Laws 1996, LB 414, §52.
71-1721.07.	Repealed. Laws 2007, LB 463, § 1319.
71-1722	Transferred to section 38-2317.
71-1723.	Repealed. Laws 2007, LB 463, § 1319.
71-1723.01.	Transferred to section 38-2321.
71-1723.02.	Transferred to section 38-2322.
71-1723.03.	Transferred to section 38-2323.
71-1723.04.	Transferred to section 38-2320.
71-1724.	Transferred to section 38-2319.
71-1724.01.	Transferred to section 38-2318.
71-1724.02 to 71-1726.	Repealed. Laws 2007, LB 185, § 54.
71-1726.01.	Transferred to section 38-2316.
71-1726.02.	Repealed. Laws 2007, LB 463, § 1319.

STATUTES PERTAINING TO NURSE PRACTITIONER PRACTICE ACT

38-2301. Act, how cited.

Sections 38-2301 to 38-2324 shall be known and may be cited as the Nurse Practitioner Practice Act.

Source: Laws 1981, LB 379, § 1; Laws 1984, LB 724, § 2; Laws 1996, LB 414, § 11; Laws 2000, LB 1115, § 26; Laws 2005, LB 256, § 47; R.S.Supp.,2006, § 71-1704; Laws 2007, LB463, § 793; Laws 2012, LB1042, § 1; Laws 2015, LB107, § 2.

38-2302. Definitions, where found.

For purposes of the Nurse Practitioner Practice Act and elsewhere in the Uniform Credentialing Act, unless the context otherwise requires, the definitions found in sections 38-2303 to 38-2314.01 apply.

Source: Laws 1981, LB 379, § 3; Laws 1984, LB 724, § 3; Laws 1992, LB 1019, § 70; Laws 1996, LB 414, § 13; Laws 2000, LB 1115, § 28; Laws 2005, LB 256, § 48; R.S.Supp.,2006, § 71-1706; Laws 2007, LB463, § 794; Laws 2015, LB107, § 3.

38-2303. Approved certification program, defined.

Approved certification program means a certification process for nurse practitioners utilized by an approved certifying body that (1) requires evidence of completion of a formal program of study in the nurse practitioner clinical specialty, (2) requires successful completion of a nationally recognized certification examination developed by the approved certifying body, (3) provides an ongoing recertification program, and (4) is approved by the board.

Source: Laws 1984, LB 724, § 7; Laws 1996, LB 414, § 20; Laws 2000, LB 1115, § 38; Laws 2005, LB 256, § 53; R.S.Supp.,2006, § 71-1716.02; Laws 2007, LB463, § 795.

38-2304. Approved certifying body, defined.

Approved certifying body means a national certification organization which certifies qualified licensed nurses for advanced practice in a clinical specialty area and which (1) requires eligibility criteria related to education and practice, (2) offers an examination in an advanced nursing area which meets current psychometric guidelines and tests, and (3) is approved by the board.

Source: Laws 1984, LB 724, § 6; Laws 1996, LB 414, § 19; Laws 2000, LB 1115, § 37; R.S.1943, (2003), § 71-1716.01; Laws 2007, LB463, § 796.

38-2305. Approved nurse practitioner program, defined.

Approved nurse practitioner program means a program which:

(1) Is a graduate-level program accredited by a national accrediting body recognized by the United States Department of Education;

(2) Includes, but is not limited to, instruction in biological, behavioral, and health sciences relevant to practice as a nurse practitioner in a specific clinical area; and

(3) For the specialties of women's health and neonatal, grants a post-master certificate, master's degree, or doctoral degree for all applicants who graduated on or after July 1, 2007, and for all other specialties, grants a post-master certificate, master's degree, or doctoral degree for all applicants who graduated on or after July 19, 1996.

Source: Laws 1981, LB 379, § 14; Laws 1984, LB 724, § 12; Laws 1993, LB 536, § 67; Laws 1996, LB 414, § 22; Laws 2000, LB 1115, § 41; Laws 2005, LB 256, § 56; R.S.Supp.,2006, § 71-1717; Laws 2007, LB463, § 797; Laws 2017, LB88, § 75.

38-2306. Board, defined.

Board means the Board of Advanced Practice Registered Nurses.

Source: Laws 1981, LB 379, § 5; Laws 1996, LB 414, § 15; Laws 2000, LB 1115, § 30; R.S.1943, (2003), § 71-1708; Laws 2007, LB463, § 798.

38-2307. Boards, defined.

Boards means the Board of Advanced Practice Registered Nurses and the Board of Nursing of the State of Nebraska.

Source: Laws 1984, LB 724, § 4; Laws 1996, LB 414, § 16; Laws 2000, LB 1115, § 31; R.S.1943, (2003), § 71-1709.01; Laws 2007, LB463, § 799.

38-2308. Collaboration, defined.

Collaboration means a process and relationship in which a nurse practitioner, together with other health professionals, delivers health care within the scope of authority of the various clinical specialty practices.

Source: Laws 1981, LB 379, § 13; Laws 1984, LB 724, § 11; Laws 1996, LB 414, § 18; Laws 2000, LB 1115, § 36; Laws 2005, LB 256, § 52; R.S.Supp.,2006, § 71-1716; Laws 2007, LB463, § 800.

38-2309. Consultation, defined.

Consultation means a process whereby a nurse practitioner seeks the advice or opinion of a physician or another health care practitioner.

Source: Laws 1996, LB 414, § 23; Laws 2000, LB 1115, § 32; Laws 2005, LB 256, § 50; R.S.Supp.,2006, § 71-1709.02; Laws 2007, LB463, § 801.

38-2310. Transferred to section 38-2314.01.

38-2311. Licensed practitioner, defined.

Licensed practitioner means any podiatrist, dentist, physician, or osteopathic physician licensed to prescribe, diagnose, and treat as provided in the Uniform Credentialing Act.

Source: Laws 1981, LB 379, § 9; Laws 2000, LB 1115, § 34; R.S.1943, (2003), § 71-1712; Laws 2007, LB463, § 803.

38-2312. Nurse practitioner, defined.

Nurse practitioner means a registered nurse certified as described in section 38-2317 and licensed under the Advanced Practice Registered Nurse Practice Act to practice as a nurse practitioner.

Source: Laws 1981, LB 379, § 4; Laws 1984, LB 724, § 5; Laws 1996, LB 414, § 14; Laws 2000, LB 1115, § 29; Laws 2005, LB 256, § 49; R.S.Supp.,2006, § 71-1707; Laws 2007, LB185, § 5; Laws 2007, LB463, § 804.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.

38-2313. Preceptorship, defined.

Preceptorship means the clinical practice component of an educational program for the preparation of nurse practitioners.

Source: Laws 1981, LB 379, § 11; Laws 1996, LB 414, § 17; Laws 2000, LB 1115, § 35; Laws 2005, LB 256, § 51; R.S.Supp.,2006, § 71-1714; Laws 2007, LB463, § 805.

38-2314. Referral, defined.

Referral means a process whereby a nurse practitioner directs the patient to a physician or other health care practitioner for management of a particular problem or aspect of the patient's care.

Source: Laws 1996, LB 414, § 24; Laws 2000, LB 1115, § 40; Laws 2005, LB 256, § 55; R.S.Supp.,2006, § 71-1716.05; Laws 2007, LB463, § 806.

38-2314.01. Transition-to-practice agreement, defined.

Transition-to-practice agreement means a collaborative agreement for two thousand hours of initial practice between a nurse practitioner and a supervising provider which provides for the delivery of health care through a collaborative practice and which meets the requirements of section 38-2322.

Source: Laws 1984, LB 724, § 9; Laws 1996, LB 414, § 21; Laws 2000, LB 1115, § 39; Laws 2005, LB 256, § 54; R.S.Supp.,2006, § 71-1716.03; Laws 2007, LB463, § 802; R.S.1943, (2008), § 38-2310; Laws 2015, LB107, § 4; Laws 2017, LB88, § 76.

38-2315. Nurse practitioner; functions; scope.

(1) A nurse practitioner may provide health care services within specialty areas. A nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider.

(2) Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and acute and chronic conditions, including:

(a) Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;

(b) Dispensing, incident to practice only, sample medications which are provided by the manufacturer and are provided at no charge to the patient; and

(c) Prescribing therapeutic measures and medications relating to health conditions within the scope of practice.

(3) A nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty may manage the care of patients committed under the Nebraska Mental Health Commitment Act. Patients who require care beyond the scope of practice of a nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty shall be referred to an appropriate health care provider.

(4) A nurse practitioner may pronounce death and may complete and sign death certificates and any other forms if such acts are within the scope of practice of the nurse practitioner and are not otherwise prohibited by law.

Source: Laws 1981, LB 379, § 18; Laws 1984, LB 724, § 14; Laws 1996, LB 414, § 25; Laws 2000, LB 1115, § 44; Laws 2005, LB 256, § 57; Laws 2006, LB 994, § 96; R.S.Supp.,2006, § 71-1721; Laws 2007, LB463, § 807; Laws 2012, LB1042, § 2; Laws 2013, LB243, § 1; Laws 2015, LB107, § 5.

Cross References

- **Nebraska Mental Health Commitment Act**, see section 71-901.

38-2316. Unlicensed person; acts permitted.

The Nurse Practitioner Practice Act does not prohibit the performance of activities of a nurse practitioner by a person who does not have a license or temporary license under the act if performed:

- (1) In an emergency situation;
- (2) By a legally qualified person from another state employed by the United States Government and performing official duties in this state; or
- (3) By a person enrolled in an approved nurse practitioner program for the preparation of nurse practitioners as part of that approved program.

Source: Laws 1984, LB 724, § 25; Laws 1996, LB 414, § 40; Laws 2000, LB 1115, § 58; Laws 2005, LB 256, § 71; R.S.Supp.,2006, § 71-1726.01; Laws 2007, LB185, § 12; Laws 2007, LB463, § 808; Laws 2017, LB88, § 77.

38-2317. Nurse practitioner; licensure; requirements.

(1) An applicant for licensure under the Advanced Practice Registered Nurse Practice Act to practice as a nurse practitioner shall have:

- (a) A license as a registered nurse in the State of Nebraska or the authority based upon the Nurse Licensure Compact to practice as a registered nurse in Nebraska;
- (b) Evidence of having successfully completed a graduate-level program in the clinical specialty area of nurse practitioner practice, which program is accredited by a national accrediting body;
- (c) Proof of having passed an examination pertaining to the specific nurse practitioner role in nursing adopted or approved by the board with the approval of the department. Such examination may include any recognized national credentialing examination for nurse practitioners conducted by an approved certifying body which administers an approved certification program; and
- (d) Evidence of completion of two thousand hours of practice as a nurse practitioner which have been completed under a transition-to-practice agreement, under a collaborative agreement, under an integrated practice agreement, through independent practice, or under any combination of such agreements and practice, as allowed in this state or another state.

(2) If more than five years have elapsed since the completion of the nurse practitioner program or since the applicant has practiced in the specific nurse practitioner role, the applicant shall meet the requirements in subsection (1) of this section and provide evidence of continuing competency as required by the board.

Source: Laws 1981, LB 379, § 19; Laws 1984, LB 724, § 20; Laws 1986, LB 926, § 55; Laws 1993, LB 536, § 70; Laws 1996, LB 414, § 30; Laws 1997, LB 752, § 173; Laws 2000, LB 1115,

§ 46; Laws 2002, LB 1021, § 57; Laws 2003, LB 242, § 101; Laws 2005, LB 256, § 59; R.S.Supp.,2006, § 71-1722; Laws 2007, LB185, § 6; Laws 2007, LB463, § 809; Laws 2017, LB88, § 78.

Cross References

- **Advanced Practice Registered Nurse Practice Act**, see section 38-201.
- **Credentialing**, general requirements and issuance procedures, see section 38-121 et seq.
- **Nurse Licensure Compact**, see sections 71-1795 to 71-1795.02.

38-2318. Nurse practitioner; temporary license; requirements; military spouse; temporary license.

(1)(a) The department may grant a temporary license to practice as a nurse practitioner for up to one hundred twenty days upon application:

(i) To graduates of an approved nurse practitioner program pending results of the first credentialing examination following graduation;

(ii) To a nurse practitioner lawfully authorized to practice in another state pending completion of the application for a Nebraska license; and

(iii) To applicants for purposes of a reentry program or supervised practice as part of continuing competency activities established by the board.

(b) A temporary license issued pursuant to this subsection may be extended for up to one year with the approval of the board.

(2) An applicant who is a military spouse may apply for a temporary license as provided in section 38-129.01.

Source: Laws 1984, LB 724, § 22; Laws 1993, LB 536, § 72; Laws 1996, LB 414, § 37; Laws 2000, LB 1115, § 53; Laws 2002, LB 1021, § 59; Laws 2005, LB 256, § 66; R.S.Supp.,2006, § 71-1724.01; Laws 2007, LB185, § 11; Laws 2007, LB463, § 810; Laws 2017, LB88, § 79.

38-2319. Nurse practitioner; license; renewal; requirements.

To renew a license to practice as a nurse practitioner, the applicant shall have:

(1) Documentation of a minimum of two thousand eighty hours of practice as a nurse practitioner within the five years immediately preceding renewal. These practice hours shall fulfill the requirements of the practice hours required for registered nurse renewal. Practice hours as an advanced practice registered nurse prior to July 1, 2007, shall be used to fulfill the requirements of this section; and

(2) Proof of current certification in the specific nurse practitioner clinical specialty area by an approved certification program.

Source: Laws 1981, LB 379, § 21; Laws 1983, LB 472, § 6; Laws 1984, LB 724, § 21; Laws 1986, LB 926, § 56; Laws 1988, LB 1100, § 105; Laws 1993, LB 536, § 71; Laws 1996, LB 414, § 36; Laws 2000, LB 1115, § 52; Laws 2002, LB 1021, § 58; Laws 2003, LB 242, § 103; Laws 2005, LB 256, § 65; R.S.Supp.,2006, § 71-1724; Laws 2007, LB185, § 10; Laws 2007, LB463, § 811.

38-2320. Nurse practitioner; liability insurance; when required.

(1) Nurse practitioners shall maintain in effect professional liability insurance with such coverage and limits as may be established by the board.

(2) If a nurse practitioner renders services in a hospital or other health care facility, he or she shall be subject to the rules and regulations of that facility. Such rules and regulations may include, but need not be limited to, reasonable requirements that the nurse practitioner and all collaborating licensed practitioners maintain professional liability insurance with such coverage and limits as may be established by the hospital or other health care facility upon the recommendation of the medical staff.

Source: Laws 1996, LB 414, § 35; Laws 2000, LB 1115, § 51; Laws 2005, LB 256, § 64; R.S.Supp.,2006, § 71-1723.04; Laws 2007, LB463, § 812.

38-2321. Nurse practitioner; right to use title or abbreviation.

A person licensed to practice as a nurse practitioner in this state may use the title nurse practitioner and the abbreviation NP.

Source: Laws 1984, LB 724, § 27; Laws 1996, LB 414, § 32; Laws 2000, LB 1115, § 48; Laws 2005, LB 256, § 61; R.S.Supp.,2006, § 71-1723.01; Laws 2007, LB185, § 8; Laws 2007, LB463, § 813.

38-2322. Nurse practitioner; licensed on or before August 30, 2015; requirements; transition-to-practice agreement; contents.

(1)(a) A transition-to-practice agreement shall be a formal written agreement that provides that the nurse practitioner and the supervising provider practice collaboratively within the framework of their respective scopes of practice.

(b) The nurse practitioner and the supervising provider shall each be responsible for his or her individual decisions in managing the health care of patients through consultation, collaboration, and referral. The nurse practitioner and the supervising provider shall have joint responsibility

for the delivery of health care to a patient based upon the scope of practice of the nurse practitioner and the supervising provider.

(c) The supervising provider shall be responsible for supervision of the nurse practitioner to ensure the quality of health care provided to patients.

(d) In order for a nurse practitioner to be a supervising provider for purposes of a transition-to-practice agreement, the nurse practitioner shall submit to the department evidence of completion of ten thousand hours of practice as a nurse practitioner which have been completed under a transition-to-practice agreement, under a collaborative agreement, under an integrated practice agreement, through independent practice, or under any combination of such agreements or practice, as allowed in this state or another state.

(2) A nurse practitioner who was licensed in good standing in Nebraska on or before August 30, 2015, and had attained the equivalent of an initial two thousand hours of practice supervised by a physician or osteopathic physician shall be allowed to practice without a transition-to-practice agreement.

(3) For purposes of this section:

(a) Supervising provider means a physician, osteopathic physician, or nurse practitioner licensed and practicing in Nebraska and practicing in the same practice specialty, related specialty, or field of practice as the nurse practitioner being supervised; and

(b) Supervision means the ready availability of the supervising provider for consultation and direction of the activities of the nurse practitioner being supervised within such nurse practitioner's defined scope of practice.

Source: Laws 1996, LB 414, § 33; Laws 2000, LB 1115, § 49; Laws 2002, LB 1062, § 46; Laws 2005, LB 256, § 62; R.S.Supp.,2006, § 71-1723.02; Laws 2007, LB185, § 9; Laws 2007, LB463, § 814; Laws 2015, LB107, § 6; Laws 2017, LB88, § 80.

38-2323. Nurse practitioner; actions not prohibited.

Nothing in the Nurse Practitioner Practice Act shall prohibit a nurse practitioner from consulting or collaborating with and referring patients to health care providers not included in the nurse practitioner's transition-to-practice agreement.

Source: Laws 1996, LB 414, § 34; Laws 2000, LB 1115, § 50; Laws 2005, LB 256, § 63; R.S.Supp.,2006, § 71-1723.03; Laws 2007, LB463, § 815; Laws 2015, LB107, § 7.

38-2324. Nurse practitioner; signing of death certificates; grounds for disciplinary action.

In addition to the grounds for disciplinary action found in sections 38-178 and 38-179, a license to practice as a nurse practitioner may be denied, refused renewal, limited, revoked, or suspended or have other disciplinary measures taken against it in accordance with section 38-196 when the applicant or licensee fails to comply with the provisions of section 71-603.01 and 71-605 relating to the signing of death certificates.

Source: Laws 2012, LB1042, § 3.

- 71-1704. **Transferred** to section 38-2301.
- 71-1705. **Repealed.** Laws 2005, LB 256, §103.
- 71-1706. **Transferred** to section 38-2302.
- 71-1707. **Transferred** to section 38-2312.
- 71-1708. **Transferred** to section 38-2306.
- 71-1709. **Repealed.** Laws 1996, LB 414, §52.

- 71-1709.01 **Transferred** to section 38-2307.
- 71-1709.02 **Transferred** to section 38-2309.
- 71-1710. **Repealed.** Laws 2007, LB 463, § 1319.
- 71-1711. **Repealed.** Laws 1996, LB 414, §52.

- 71-1712. **Transferred** to section 38-2311.
- 71-1713. **Repealed.** Laws 1993, LB 536, §128.

- 71-1714. **Transferred** to section 38-2313.
- 71-1715. **Repealed.** Laws 1996, LB 414, §52.

- 71-1716. **Transferred** to section 38-2308.
- 71-1716.01. **Transferred** to section 38-2304.
- 71-1716.02. **Transferred** to section 38-2303.
- 71-1716.03. **Transferred** to section 38-2310.
- 71-1716.04. **Repealed.** Laws 1996, LB 414, §52.

- 71-1716.05. **Transferred** to section 38-2314.
- 71-1717. **Transferred** to section 38-2305.
- 71-1718. **Repealed.** Laws 1993, LB 536, §128.

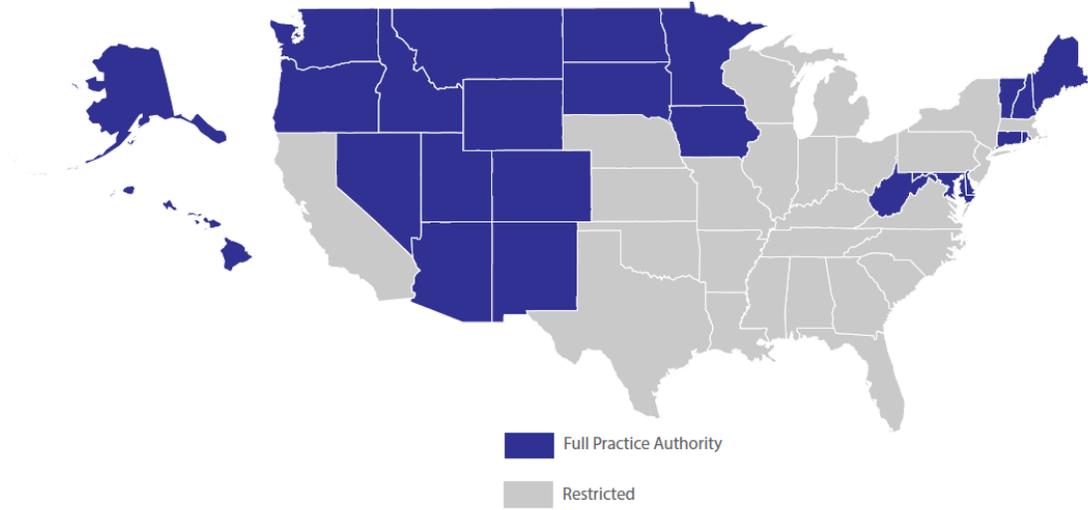
- 71-1718.01. **Transferred** to section 71-17,134.
- 71-1718.02. **Transferred** to section 71-17,135.
- 71-1719 to 71-1720. **Repealed.** Laws 1993, LB 536, §128.

- 71-1721. **Transferred** to section 38-2315.
- 71-1721.01 to 71-1721.06. **Repealed.** Laws 1996, LB 414, §52.

- 71-1721.07. **Repealed.** Laws 2007, LB 463, § 1319.
- 71-1722. **Transferred** to section 38-2317.
- 71-1723. **Repealed.** Laws 2007, LB 463, § 1319.
- 71-1723.01. **Transferred** to section 38-2321.
- 71-1723.02. **Transferred** to section 38-2322.
- 71-1723.03. **Transferred** to section 38-2323.
- 71-1723.04. **Transferred** to section 38-2320.
- 71-1724. **Transferred** to section 38-2319.
- 71-1724.01. **Transferred** to section 38-2318.
- 71-1724.02 to 71-1726. **Repealed.** Laws 2007, LB 185, § 54.
- 71-1726.01. **Transferred** to section 38-2316.
- 71-1726.02. **Repealed.** Laws 2007, LB 463, § 1319.

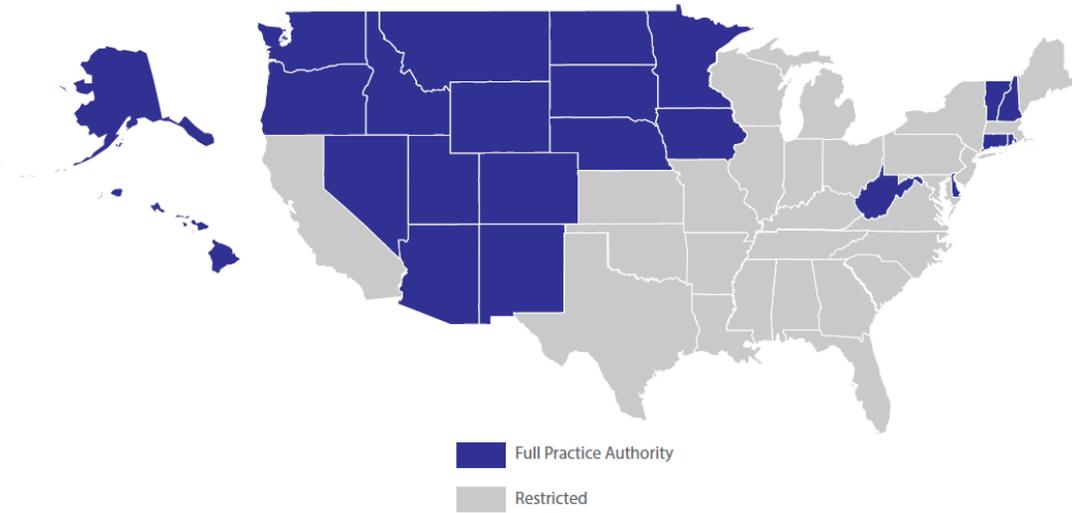
Appendix E
Maps of Full Practice Authority (NCSBN, 2020)

CNM



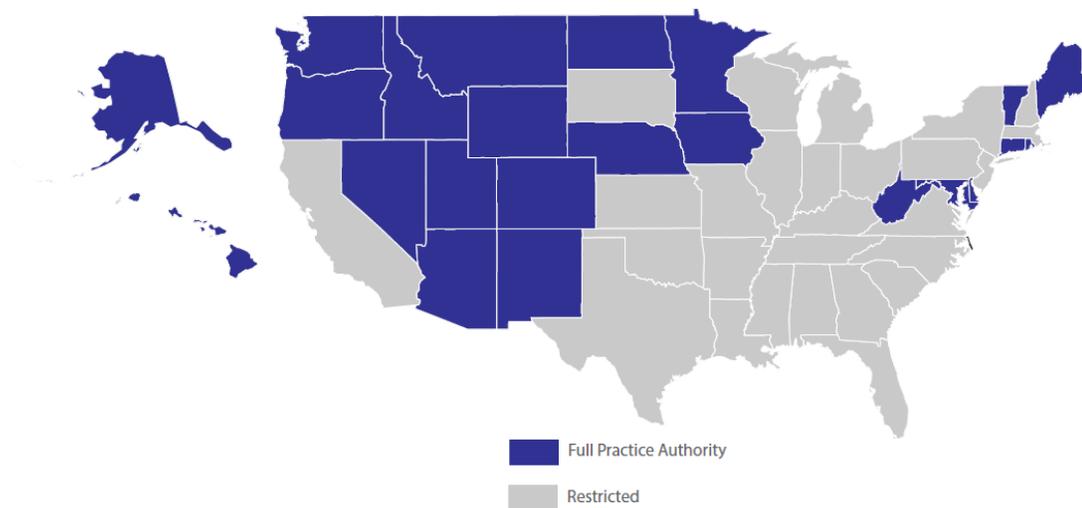
Updated as 2/3/20

CRNA



Updated as 3/25/2020

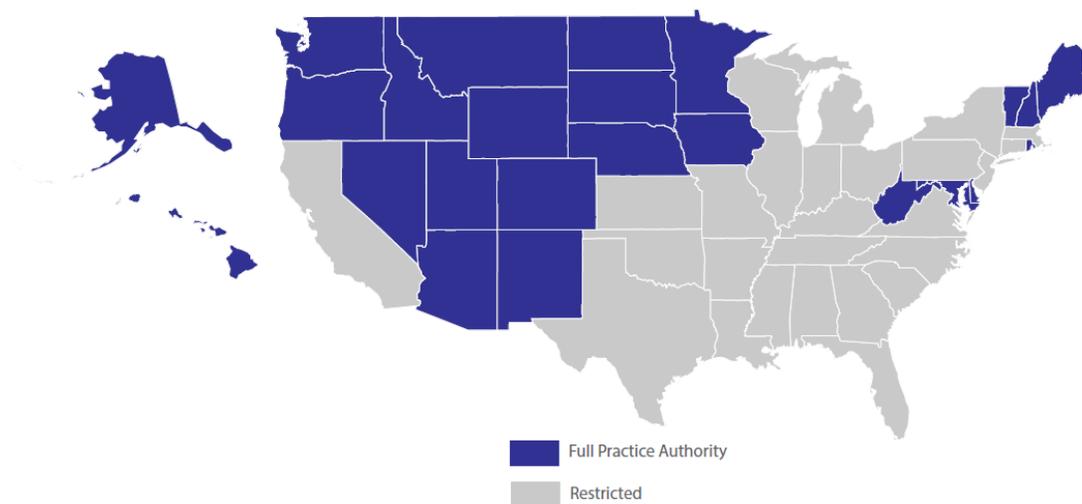
CNS



Updated as 2/3/20

Note for CNS: Nebraska is listed as full practice authority, but the statute is silent on prescribing

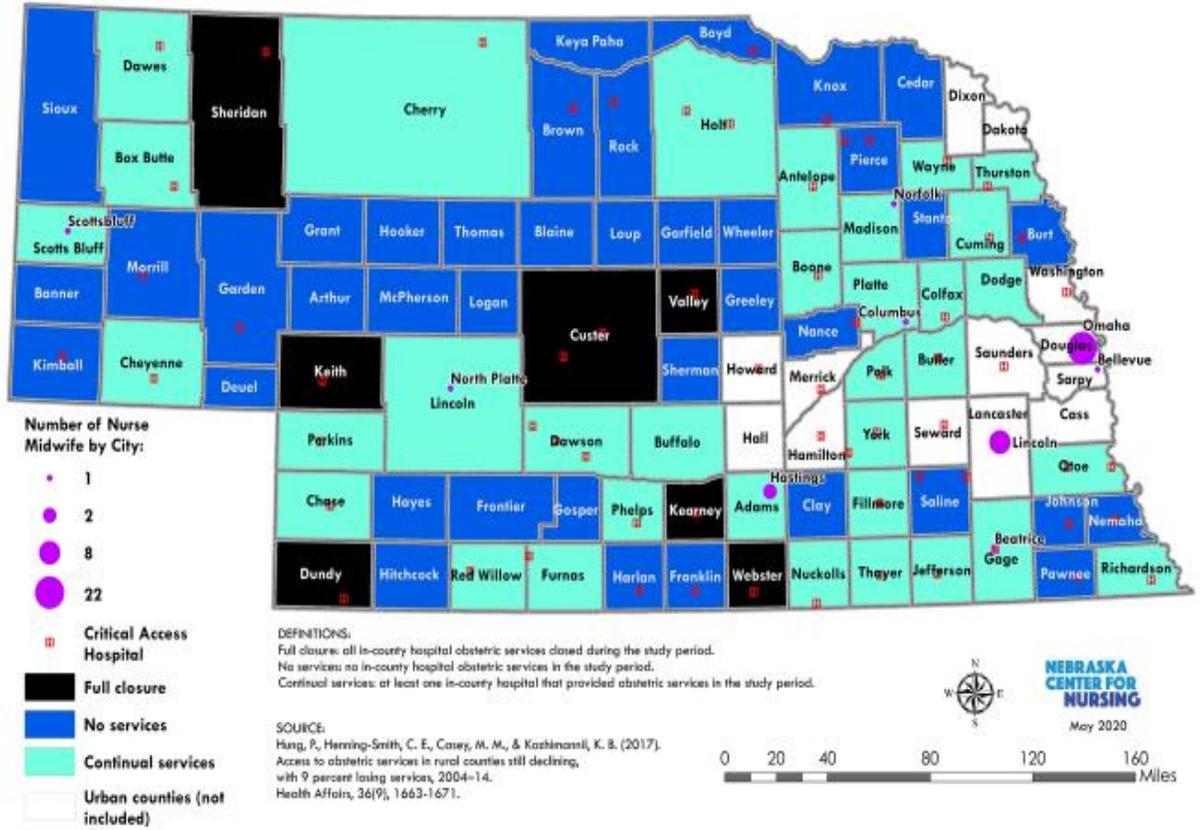
CNP



Updated as 2/3/20

Appendix F

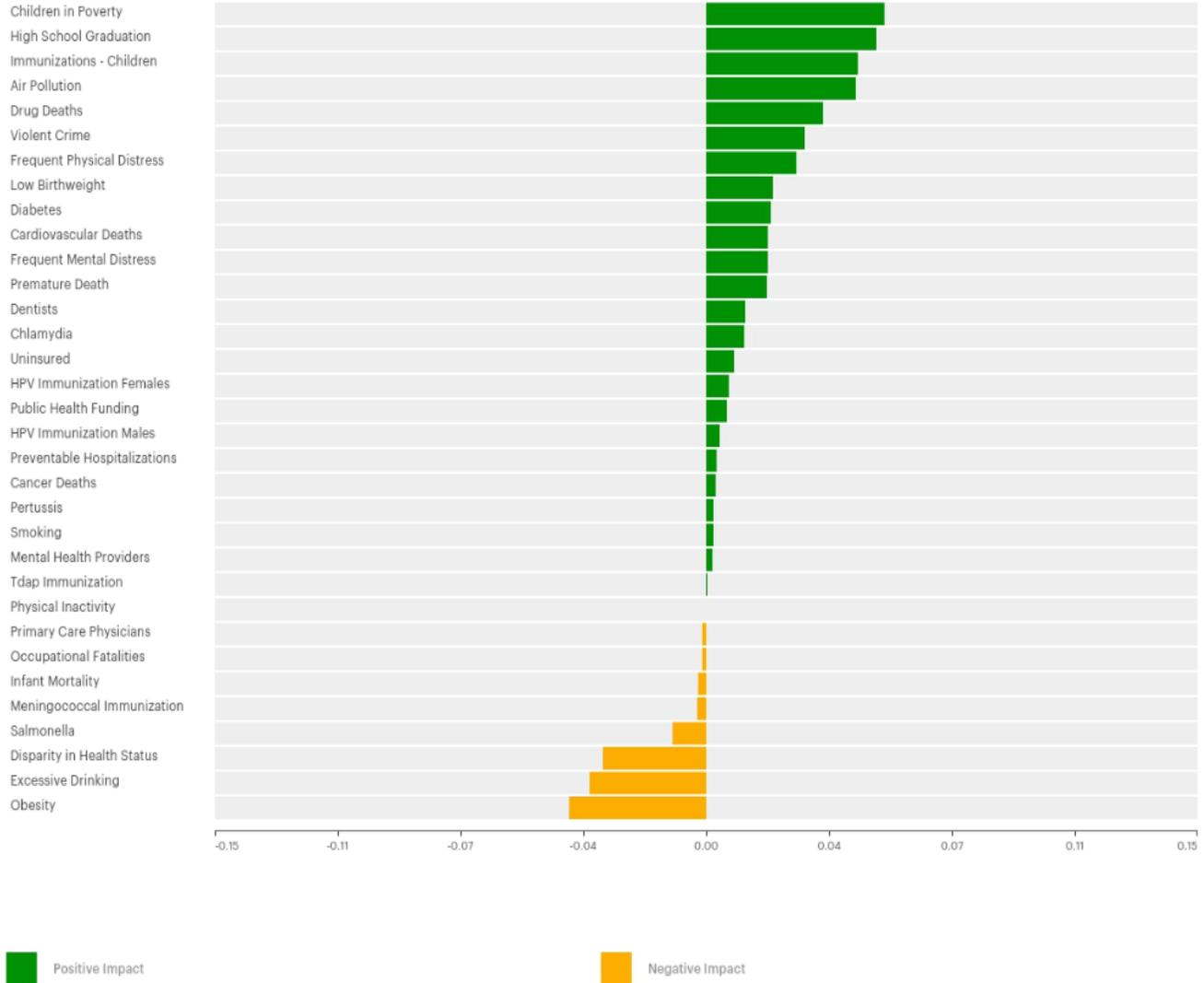
Location of Certified Nurse Midwives, and Critical Access Hospitals in Nebraska



Appendix G Nebraska Healthcare Rankings

Figure 1 Core Measures for Nebraska 2019

Core Measures Impact: Nebraska, 2019 Annual Report

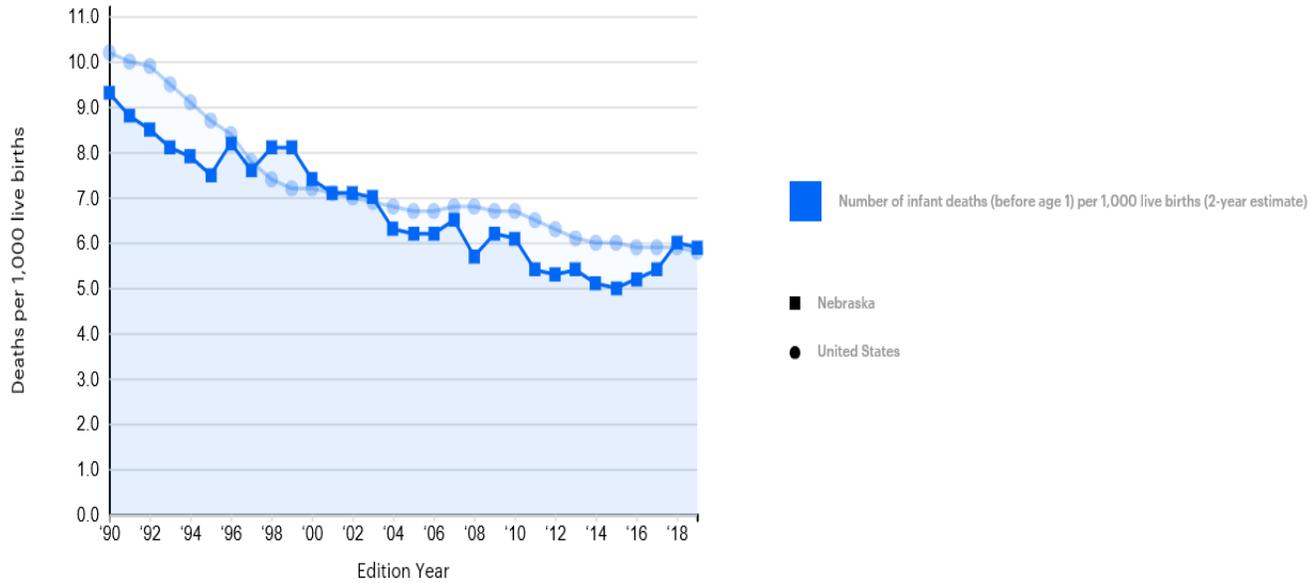


SOURCE:

- CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files, 2015-2017
- CDC, Behavioral Risk Factor Surveillance System, 2018
- U.S. Department of Education, National Center for Education Statistics, 2017

Figure 2 Infant Mortality Trend in Nebraska

Trend: Infant Mortality, Nebraska, United States



Source:

• CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files; Natality public-use data

Figure 3 Outcomes Data for Nebraska

		2019 Value	Rank
Outcomes			
Cancer Deaths	+++	187.6	21
Cardiovascular Deaths	++++	236.4	16
Diabetes	++++	9.7%	12
Disparity in Health Status	+	32.5%	48
Frequent Mental Distress	+++++	11.2%	10
Frequent Physical Distress	+++++	10.2%	6
Infant Mortality	+++	5.9	24
Premature Death	++++	6,555	11
All Outcomes *	++++	0.072	20
Overall			
Overall *	++++	0.321	17

RATING	RANK
+++++	1 - 10
++++	11 - 20
+++	21 - 30
++	31 - 40
+	41 - 50

* Value indicates z score. Negative scores are below US value; positive scores are above US value. For complete definitions of measures including data sources and years, see ["Appendix: Rankings Measures Table"](#).

• Data Unavailable

Appendix H

1991 – 2020 Comparison of Board of Health Task Force

Solutions to the Rural Health Crisis in Nebraska How have we progressed since 1991?

Mid-Level Practitioners: Alternatives to a Declining Physician Population

A Report of Findings by the Mid-level Practitioners Task force of the Board of Health and Draft Report of Findings by the Nebraska Board of Health June 1991 – Initial Report

This document will share information from a historical document as well as report out suggestions for regulatory reform from 1991 and provide a summary of where Nebraska is to date.

Preamble from the 1991 Report

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': Physician 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 63 state designated family practice shortage areas and 24 federally designated primary care health and manpower shortage areas.

60 Nebraska communities are actively recruiting a doctor, but others may 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 \$5,000 cash bounties for a doctor.

Despite the need, doctors are not going to the rural communities. 25% of U.S. doctors are not going to the rural communities. 25% of the 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 1980. Between 1975 and 1985, the number of U.S. doctors increased 32% overall, but rural physicians increased only by 14%. Current trends suggest that only 5-6 new doctors will start rural practices in Nebraska per year.

One of the problems is maldistribution. While 25% of the U.S. population is rural (33% in Nebraska), only 13% of doctors practice there.

There are several reasons for this. As rural communities drop in population, it becomes less feasible to support a physician. The poverty rate in rural areas general exceeds that of urban areas. While only 25% of the U.S. is rural, these areas represent 29% of Medicare recipients, two-thirds of all Medicaid and 85% of the working poor without insurance.

The Agenda predicts that 18% of Nebraska's primary care physicians will soon leave active practice and will need to be replaced with other physicians or physician extenders in order to maintain current levels of care.

Some rural doctors have responded by practicing at more than one site. Thayer County Hospital in Hebron has opened satellites in Chester and Bruning with a \$50,000 federal grant. However, 20 counties in the 3rd congressional district alone remained without a doctor in early 1990. 11 Nebraska counties had no physician care even considering satellite clinics.

Newsweek reported in February 1990 that overall, the prognosis remains bleak for the smallest communities, and that some small towns have come to rely on mid-level professionals (MLPs) such as nurse practitioners and physician assistants.

An important conclusion of the Agenda was that the state should consider more flexible licensure laws and regulations for MLPs. Less restrictive licensure laws for MLPs are required because it does not appear that Nebraska medical schools are training nearly enough primary care practitioners to replace those who retire or relocate to urban areas. Further, flexible licensure laws will also provide hospitals with more options for downsizing and restructuring. The increased use of MLPs was seen as one way of easing the shortage of physicians in rural areas.

Unfortunately, Nebraska has been identified in professional literature as a state that has placed unnecessary limitations on MLPs. This task force seeks to identify specific options for improved utilization of MLPs in our rural communities.

Background

There is a relatively small number of MLPs in rural Nebraska. There are 38 Nurse Practitioners (NP) excluding nurse anesthetists, 12 in rural areas. Of the 150 Physician Assistants (PA), 1/3 practice in non-metropolitan areas. MLPs are represented in a variety of medically underserved areas throughout the state.

Definitions

Physician Assistant: *an MLP working under a physician's supervision who performs delegated medical tasks historically done by the doctor. PA education programs may be at the associate degree or bachelors level, but may comprise the practical equivalent of 6 years work through 166 semester hours. PAs can do 60-80% of all medical services in ambulatory settings and up to 90% of health care for children.*

Nurse Practitioner: *an MLP working in collaboration with a physician who is an independently licensed registered nurse with advanced training. While some certificate programs exist, a masters degree will soon become a national requirement. The NP serves a dual function by performing independent nursing tasks and assuming responsibility for some medical functions historically done by the doctor.*

Certified Nurse Midwife: *an MLP working in collaboration with a physician similar to the NP who provides care for normal expectant mothers with consultation on abnormal cases. The CNM performs deliveries in hospitals and provides prenatal and newborn care. Although legislation credentialed CNMs seven years ago, none have yet practiced in Nebraska.*

Clinical Nurse Specialist: *is a registered nurse with advanced training at the master of science in nursing level who specializes in certain areas, such as pediatrics or family practice. While the CNS is recognized at the federal level, Nebraska has not yet credentialed this MLP who could provide many NP type functions.*

Educational Opportunities

An officer of the Nebraska Coordinating Commission for post-secondary education testified at a September 1989 Board of Health hearing that there was 'virtually no information' available on new or expanded programs to train MLPs.

The Agenda recommended that the University of Nebraska develop strategies to increase the number of PAs and NPs in rural health areas. PA demand generally exceed supply, and in response UNMC would like to increase the PA class size from 30 to 50 over the next three years, although retention of graduates has been a problem. Currently, there are 41 known openings for PAs in Nebraska.

UNMC plans to establish a family nurse practitioner program in Kearney as part of the Rural Health Education Network, in the fall of 1992. This will be a masters program initially matriculating 8-10 students.

Historical changes and events 1991 to 2020

The University of Nebraska Medical Center (UNMC) report on Rural Health 2030 (2017) provides a nice Segway from the 1991 plan to the present. Another UNMC report, 'The Status of the Healthcare Workforce in the State of Nebraska (2018)' provides a recent compilation of data on physician and mid-level provider distribution and characteristics.

Comparing the 1991 Board of Health report with the 2018 UNMC report, it is clear that the term Advanced Practice Registered Nurse (APRN) is misunderstood. In the 1991 report, the focus was on growing the NP workforce in NE, while mentioning the CNS and the CNM. For some reason CRNAs were excluded from this review. The Advanced Practice Nurse was also lumped into the category of mid-level practitioners, which was coined in that era and still remains in some physician circles, which creates confusion that PAs and APRNs are the same, and they are not.

In the 2018 UNMC report, all four groups were recognized as APRNs. The UNMC 2018 status report and the UNMC 2017 reports are both very physician centric, as is the vision for rural health 2030 in Nebraska. Since UNMC's primary product is physicians, this is to be expected. However, UNMC also educates PAs and NPs. It should be noted that UNMC *only* educates NPs, not the other three APRN roles. UNMC falls short from the vision put forward back in 1991 to promote rural health and education for APRNs. The 2018 status report is a great document to identify progression in physician assistant numbers and distribution. The majority of this comparison document will only discuss progression of APRN practice since the 1991 report.

What follows is a comparison of the Suggested Measures from the 1991 report as to where the State of NE is today.

	1991	2020
Educational Opportunities 1	The Agenda also recommended that within MLP training programs more emphasis should be placed on rural concerns to better equip graduates for rural practice. Unfortunately, national health care reimbursement structuring favors high-tech care, making it difficult for rural hospitals providing primary care to sustain sufficient cash flow to support traditional medical practices. MLP education programs should emphasize the ability to provide quality care in a less	Current Nebraska APRN Education Programs CNM – none CRNA – 2 CNS – 1 NP - 4

	1991	2020
	technology-intensive environment, since it is not financially feasible for rural facilities to invest in many of the new technologies that are available.	
2	MLP training programs should also preferentially recruit experience rural faculty so that students have ample exposure to role models portraying rural practice as a viable, attractive career option.	UNMC now has five campuses across the state: Scottsbluff, Kearney, Norfolk, Lincoln and Omaha. The UNMC College of Nursing has NP students across the state.
3	There are no Certified Nurse Midwife programs in Nebraska. To increase physicians' familiarity with CNMs and introduce future practitioners to our state, an elective clinical rotation opportunity could be established within the UNMC College of Nursing in collaboration with CNM schools to actively solicit midwifery students for experience in Nebraska.	There are still no CNM programs in Nebraska
4	Finally, to expand the pool of existing NPs, an education review course for NPs should be established through UNMC to permit inactive NPs to return to practice.	The existing pool of NPs has expanded through the current four educational programs in Nebraska. There are approximately 200 new graduate NPs each year.
Recruitment 5	The Agenda states that health professional with a rural background are more likely to consider a rural practice. In 1989, ½ of practitioners in U.S. communities of less than 2,500 people were born and raised in towns of smaller size. Special efforts must be made to identify, recruit, admit and retain students who come from rural communities. UNMC is beginning to approach this by the Rural Health Opportunities Program through Chadron State, and preferential consideration should become an affirmative action requirement of all MLP programs in Nebraska.	Rural Health 2030 notes this theme in its assessment of UNMC's current role in rural health. This report highlights the creation of the Rural Health Education Network (RHEN), from which several programs evolved: 1) the Rural Health Opportunities Program (RHOP), mentioned in 1991, to educate health care providers in rural settings; 2) the Rural Training Track (RTT) Medical Residency Programs for Family Medicine and Internal Medicine Professions; 3) creation of the Area Health Education

	1991	2020
		Centers; statewide 8 th Grade Science meet; and the Behavioral Health Education Center of Nebraska (BHECN)
6	<p>The state must search for innovative strategies to train health professionals, according to the Agenda. A potential crown jewel for affirmative action by the state exists in the Minority Health Initiatives Act, 42 USCA section 254t (1991 Supplementary Pamphlet), recently signed into law by President Bush. Called the “Pelli Amendment”, it established a 3-year demonstration program to grant funds to community organizations in health manpower shortage areas who agree to sponsor scholarships for <u>residents of the shortage areas to become physicians, nurse practitioners, certified nurse midwives or physician assistants</u>. In return, the student agrees to obligated service.</p> <p>The Program provides 40% federal dollars, and requires local communities to pick up 35-45% of the tab with state funds making up the remaining 15-25%.</p> <p>This Program offers potential relief to the problem of previous National Health Service Corps program practitioners leaving a community upon concluding obligated service, by now focusing attention on matching <u>rural</u> residents to rural practices. The Nebraska Department of Health should make this opportunity one of its highest education priorities as soon as possible, and information from this Task Force is being presented to the Rural Health Advisory Commission. Texas established a similar program exclusively utilizing state funds in its 1989 Omnibus Health Care Rescue Act, and local</p>	Much of this funding is now in the form of renewable federal grants, targeting educating health care providers to work in underserved areas.

	1991	2020
	<p>organizations are willing to respond to a call for action; Mercy Hospital in Council Bluffs, IA, is co-sponsoring a nursing scholarship with the State Bank & Trust Company for students at Iowa Western Community College.</p>	
7	<p>Lay public awareness about the potential community contributions MLPs could offer should be expanded by both the state and professional associations. A traveling panel of Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists should be assembled through cooperation with their respective associations and give public presentations to communities within shortage areas. Invitations for the panel could be solicited and coordinated through the Office of Rural Health</p>	<p>29 years after the initial task force, the four roles of APRNs are still not well known. Many know what a NP or CRNA is, but the CNS has become invisible in health care settings, and the CNM's are small in number and confused with Lay Midwives and Professional Midwives, for which neither of those compare to the education and certification of the CNM.</p>
8	<p>The Agenda recommended that school counselors promote health related occupations as early as the junior high level. Minnesota has established a Rural Hospital Subsidy Fund to provide grants to eligible school districts for high school student summer intern programs. The Department of Health should work with professional associations to examine programs like these for MLP professions and consider soliciting private funding sources to expand similar opportunities for rural Nebraska youth, such as the 'Holdrege Summer Program' at UNMC.</p>	
9	<p>Incentive programs can play an important role in attracting MLPs to rural communities, and the use of existing incentive programs should be widely promoted to both MLP students and rural communities. In 1990, LB 520 established the Nurse Incentive Program; newly certified NPs and RNs completing masters degrees in nursing are eligible to</p>	<p>Again, many incentives have moved to the federal level for distribution on a national plane, based on underserved areas.</p>

	1991	2020
	apply. This year LB 450 adds PAs to a medical student assistance program.	
Retention 10	Retaining graduates in Nebraska of UNMC's PA program should be given a high priority. According to a representative of the program, 27 of 30 students are Nebraska residents; but of those residents, only 60% are expected to remain in the state. Enlarging class size alone may increase the number of PAs in Nebraska by a flooding effect, but this seems an inefficient expense to taxpayers. UNMC should work with the Office of Rural Health to increase efforts to identify and establish attractive rural practice openings for its MLP graduates. A former Nebraska PA believes a perception exists that opportunities for PAs to attain actual placement in rural practice is poor, despite the need.	
11	Rural residents must be helped to identify specific strategies to support a new practitioner, such as avoiding the temptation to continue traveling to urban areas for elective health care until they are sure the new provider is going to stay. Rural communities must use the practitioner they recruit. Additionally, small towns should give top consideration to spousal influence on an MLP and every effort should be made to accommodate career opportunity on a dual basis.	
12	Poor pay has been cited as a major barrier to MLP retention. National PA salaries range in the area of \$30,000 - \$45,000, and PAs leave to make better incomes outside of Nebraska. One incentive to retain rural MLPs is to pay them a percentage of actual practice income so as to provide them a fair return based on effort and workload. NPs generate three to four times their salary for a practice	

	1991	2020
	and PAs bring in 2/3 to 3/4 of the revenue for a physician while being paid only 1/4 to 1/3 as much.	
13	Another incentive would be to enable MLPs to gain equity or partnership in their affiliated rural medical practices.	
14	The state should consider new incentive options to offer MLPs, such as subsidy payments . Rhode Island has established a Rural Health Practitioner stipend of \$500/month. The Michigan Essential Health provider Recruitment Program pays up to \$25,000 per year for four years in exchange for a two-and-one-half year practice in an underserved area.	This has not happened in NE.
15	Tax incentives are important to make the call for improved salaries more meaningful. A U.S. Senator from Nebraska has already co-sponsored a bill to provide federal tax credits of \$500/month to NPs and PAs who practice in rural areas for at least five years. Oregon grants a \$5,000 income tax credit to practitioners where at least 60% of their patients come from geographically and medically underserved areas.	This has not happened in NE.
16	Obstetrical malpractice indemnity may be a crucial factor in attracting Nurse Midwives to rural Nebraska. In Texas, the state assumes responsibility for the first \$100,000 in damages resulting from liability claims related to prenatal, obstetrical or emergency care for rural medical practices with at least 10% indigent care.	With the current tether of the CNM to an OB/GYN, one would think liability would be an issue for the MD; instead, OB/GYNs have sought to maintain control of the CNM practice via a collaborative agreement, when this limits CNMs to primarily urban practice areas.
Regulatory and Licensure Issues	Excessive processing time for licensure was identified as a major barrier in attracting MLPs to Nebraska. Current regulations require that licensure boards' review and act on every application individually. Since these boards meet for only a day or two every other month, an	This has changed significantly since 1991 through several legislative changes including LB 414 which created an APRN Board, LB 107 which eliminated the practice agreement for NPs, and creation of the Uniform

	1991	2020
	<p>application for a PAS may take two months and NP up to four months.</p>	<p>Credentialing Act in 2007. The current difficulty is the duplicate nature of the APRN having both the RN and APRN license, so discipline goes through two separate boards (RN and APRN). Nebraska is the only state with an APRN Board.</p>
17	<p>A basic package of approved procedures for each class of MLP should be identified, and the Bureau of Examining Boards (BEB) staff should be permitted to issue a basic certificate for those delegated acts upon receipt of an appropriately verified application. Further, BEB staff should be enabled to approve routine changes, such as a change in practice site or collaborative physician.</p> <p>Some states have developed a separate licensure board for Physician Assistants, and utilize a Board of Nursing exclusively for Nurse Practitioner regulation.</p> <p>Supervisory regulations have fallen behind time and technology. The Agenda called for evaluating alternative systems of supervision to provide the greatest possible flexibility in utilizing PAs and NPs working in rural areas.</p> <p>Telecommunication advancements now make it possible for a collaborating physician to provide oversight in any location at any hour of the day or night. The MLP can directly send fetal monitoring strips, medical records and utilize static imaging systems capable of transmitting actual x-rays. This capability has been demonstrated in the MEDNET telecommunications project by Texas Tech. A similar system in Nebraska, possibly using UNMC's SYNAPSE could be</p>	<p>As noted above AND approval via licensure to provide telehealth for APRNs has been slow moving. While the APRN RN license is part of a licensure compact, allowing mobility, the APRN Compact has been slow moving related to the hodge podge of scope of practice issues, which tend to differ among the four groups on a state by state basis. The goal is to adopt the APRN Consensus model language to streamline APRN statutes and scope, which would position Nebraska for the APRN compact.</p>

	1991	2020
	used to partially satisfy supervisory requirements and improve local confidence in MLPs.	
18	Time requirements for supervision may be too stringent for efficient MLP utilization in rural areas, and exceeds federal supervisory requirements for reimbursement. In Nebraska, a PA and the physician must spend a minimum of 1/3 of their time together. Under Federal regulations, the physician need only be present once every two weeks in a MLP staffed rural health clinic. State supervisory requirements of MLPs in rural areas should be adjusted to reflect federal Rural Health Clinic standards and permit telecommunication supervision where possible.	The only statutory supervisory requirements that exist are a Transition to Practice Agreement for the NP and a Collaborative Practice Agreement for the CNM. Both the CNS and CRNA do not have supervisory provisions in statute.
19	When PAs have been hired to staff a satellite clinic, there is a delay in getting them into rural areas due to the requirement that the PA and physician practice together for three months before the clinic can be in operation. In practice, a more realistic requirement would be a range of two to four weeks.	
20	Scope of practice for MLPs was not seen as a problem in Nebraska, with the possible exception of home deliveries for Nurse Midwives. Nebraska is the only state other than Wisconsin to impose this restriction.	Scope of practice actually IS an issue in Nebraska, based on the inconsistencies of each of the four APRN groups' individual practice act. The Consensus Model for APRN practice is the sought after model, and that not include home birth.
21	The need to permit dispensing of medication by MLPs in certain situations, particularly in rural areas with limited pharmacy services, should be examined. MLPs can already prescribe medication, but Neb. Rev. Stat. 71-1, 143 prohibits a physician from delegating such dispensing to any other person. This should be	

	1991	2020
	reconsidered to permit unit dose dispensing by MLPs (i.e., prescriptions prepackaged b a pharmacist containing a standard quantity of medication such as 40 penicillin tablets). This could be an important advantage for sick rural citizens who might otherwise have to travel to obtain medication.	
22	In remote areas without physicians, the ability for an MLP to dispense a small quantity (not to exceed a two-day supply) of Schedule II pain medications is an essential tool for managing life-threatening accident or injury. Enabling legislation should be considered to permit this option in medically underserved communities when a physician is unavailable.	
Utilize Existing Talent	In Nebraska, the supply of Clinical Nurse Specialists far exceeds that of Nurse Practitioners. CNSs, although not credentialed in Nebraska, are capable of offering some services similar to NPs. Federal authority provided for Medicare payment for services provided by a CNS, but has ruled that if state law is silent with respect to the licensure of the CNS, they would not be recognized for coverage by Medicare.	In 2020, this is the reverse, with NP numbers eclipsing the CNS.
23	The Clinical Nurse Specialist should be the subject of a 407 review with the intention of defining the CNS in statute and setting for the authorized procedures so that this potential source of talent can be adequately utilized in health shortage areas. The Nebraska Nurses Association is planning to submit an application to propose relevant legislation.	The CNS did not undergo a 407. Instead, a statute was adopted in 2007 which defines the CNS, but is silent on prescribing.
Third Party Reimbursement	Federal reimbursement policies have been visionary regarding MLPs, considering that up to 70% of a rural	

	1991	2020
	<p>practice can be Medicare. The Omnibus Budget Reconciliation Act of 1989 directed Medicaid to pay for services furnished by family or pediatric NPs whether or not such providers were associated with, or under the direct supervision of a physician. OBRA 1990 mandated that NPs and Clinical Nurse Specialists in rural areas are eligible to receive direct payment for services at 85% of the physician rate.</p> <p>The Federal government covers the services of MLPs in many situations involving Medicare, Medicaid, Champus and the Federal employee Health Benefit Program; generally in the range of 75-85% of prevailing physicians' charges.</p>	
24	<p>Private insurance coverage of MLP services is heterogeneous and may be an impediment to rural health. The legislature should consider adding MLPs to the categories of providers mandated for insurance coverage by Neb. Rev. Statute 44-513. MLPs have been shown to be cost-effective health care providers emphasizing preventive care and chronic disease management.</p>	
Institutional Opportunities	<p>The Agenda reported that over 700 rural hospitals have closed over the past 15 years, 6 in Nebraska since 1988 and 32 were losing money.</p> <p>Rural hospital expenses are high when forced to pay competitive salaries to meet staffing requirements of hospital licensure. Medicare reimbursement has been 20-30% overall lower than for urban hospitals and 12-13% lower when adjusted for differences in cost per case. OBRA 1989 began to eliminate these differences and they are to be phased out by 1995.</p>	<p>The LSRH model was adopted in NE as a waiver of CMS Critical Access Hospital designations began in 1998. To achieve a CAH designation, one must:</p> <ul style="list-style-type: none"> • Have 25 or fewer inpatient beds • Be located more than 35 miles from another hospital • Maintain an annual average length of stay of 96 hours or less for acute care patients

	1991	2020
	<p>A report issued by the General Accounting Office (GAO) found that it was high operating costs in the face of declining hospital admissions, and not disparity in Medicare payment policy, that was a major factor in rural hospital closures. In Nebraska, only 22 out of 100 licensed hospital beds were occupied in 1987, not including swing beds. A lack of physician limits on admission to a hospital and adjusting Medicare payments alone may not be enough to preserve the rural hospital.</p> <p>Rural hospitals are important to Nebraska. Sixty-eight of the state’s 100 hospitals have fewer than 50 beds. Recent hospital closures have included Rushville, Mullen, Wakefield, Burwell, and Oxford. The rural hospital can be a source of direct or indirect employment for up to one fourth of the working community in rural areas.</p> <p>In 1989, the Bauer Rural Health Care Consultants group told Congress that half of Nebraska’s rural hospitals should be converted to primary and emergency care facilities providing pharmacy, emergency services with a short stay infirmary, and home health care support. This could provide for 80% of the basic needs of rural residents.</p> <p>The Agenda called for the review of hospital licensure laws to encourage development of innovative models of care for hospitals to downsize or alter the scope of services provided. The Medical Assistance facility, of Limited Service Rural Hospital (LSRH) concept was mentioned.</p>	<ul style="list-style-type: none"> • Provide 24/7 emergency services <p>Along with this, in 1997, Congress created the Medicare Rural Hospital Flexibility Program to support CAHs. This allowed for:</p> <ul style="list-style-type: none"> • Payment/reimbursement and financial information • Regulations and information regarding CAH status and Flex Program • Key organizations in the field • Funding opportunities • Challenges to operation <p>APRNs play a critical role in providing care in CAHs. Employment trends include utilization of NPs and CRNA in the CAH, the CNS has had more urban, large facility roots. At issue is Nebraska’s climbing infant mortality rate. An all-time low was recorded in 2015, with the rate of 5 deaths per 1000 live births. In 2018, its rate was 5.9 and 5.8 in 2019. This is concerning as the state showed fairly steady downward progression since a 1990 rate of 9.3. Prenatal care is key to combating infant mortality. If the CNM were able to practice in CAH across the state, this could potentially have a huge impact on Nebraska’s rate.</p> <p>Current barriers to expanding CNM care across Nebraska:</p> <ul style="list-style-type: none"> • No education program

	1991	2020
	<p>The LSRH is a limited scope option for a small hospital in sparsely populated areas to convert into as an alternative to closure where compliance with licensure as a full services hospital is too burdensome. A LSRH provides care to ill or injured persons prior to their transportation to a full service hospital, or inpatient care for a maximum period of 72-96 hours. Each LSRH would be required to have a transfer agreement with a full service hospital.</p> <p>Easing regulatory requirements allows greater flexibility in staff such as reducing requirements for RN coverage from 24 hours to 8 hours per day, permitting the use of less expensive LPNs.</p> <p>A major feature of the LSRH is its ability to be staffed with Physician Assistants or Nurse Practitioners who may admit patients when a physician is not physically present. This approach could increase the occupancy rate and financial viability of the smallest rural facilities.</p> <p>The LSRH has been funded as a demonstration project with a Medicare waiver in Montana, and similar programs are expected to be approved by the Health Care Financing Administration (HCFA) this year in seven other states.</p>	<ul style="list-style-type: none"> • A collaborative practice agreement that must be with an OB/GYN <p>Misunderstanding of the difference between a CNM and a direct entry or lay midwife.</p>
25	<p>Nebraska already provides for classes of limited service hospitals in Neb. Rev. Stat. 71-2017.01, such as the Short Term Hospital or Emergency Hospital. The state should actively seek public and private funding to utilizes this concept as an alternative to losing hospitals in medically underserved areas. One possibility would be to permit full service hospitals to provide financial support to a</p>	<p>Since 1991, Congress established the Critical Access Hospital (CAH) program through the Balanced Budget Act of 1997. Since that time, Nebraska currently has 64 CAHs which provide adequate statewide distribution of services. However, 25 of the 64 CAHs no longer provide birthing services.</p>

	1991	2020
	<p>LSRH pledging to refer complicated cases. In exchange, the full service hospital is assured of additional inpatient traffic.</p> <p>Twenty communities are requiring assistance to establish Rural Health Clinics. Congress established these in 1977 to provide financial support for facilities using MLPs to provide primary health care services in rural, medically underserved areas by authorizing Medicare and Medicaid to pay for services provided by MLPs even though the clinic is not under the direction of a full-time physician.</p>	<p>Nebraska is also currently home to 142 Rural Health Clinics (RHCs) as well as 8 Federally Qualified Health Clinics (FQHCs).</p>
26	<p>The clinics may be part of a hospital or independent. Information available at the 1989 Rural Health Conference suggested Rural Health Clinics have been underutilized, and the Office of Rural Health should identify appropriate locations and actively promote their establishment to maximize the availability of rural health care to Nebraskans.</p>	
Conclusion	<p>Mid-level practitioners are not a substitute for physicians; but for many reasons, physicians are not entering rural areas. A recent Columbia University study found that simply increasing the number of doctors did not result in greater access to care for poor people and minorities. It suggested that ‘the country’s best hope for improving care to the poor lies in increasing the number of Nurse Practitioners, Physician Assistants, and other Allied Health Professionals’.</p> <p>Facilitating the expanded use of Mid-level practitioners may not be without political controversy. The AMA has opposed PAs prescribing or dispensing drugs, and opposed direct payments to PAs by Medicare or other payors. An Alaska</p>	

	1991	2020
	<p>physician wrote in the March 4, 1991 issue of <i>Medical Economics</i>, 'For years I've been dismayed at the American Academy of Family Physicians negative attitude toward Certified Nurse Midwives ...' Older Nebraska physicians may not appreciate the MLP concept; a retiring Hebron doctor was quoted recently in the <i>Omaha World Herald</i> saying 'You can't get doctors to come to rural areas. We have satellite clinics now manned by Physician Assistants. I don't like that. People want a doctor'.</p> <p>However, studies by neutral parties tell a different story. The 1986 Case Study by the Congressional Office of Technology Assessment felt the weight of evidence indicated that, within their areas of competence, NPs, PAs and Certified Nurse Midwives provide care whose quality is equivalent to that of care provided by physicians. Moreover, MLPs are more adept than physicians at providing services that depend on communication with patients and preventive actions. The Study observed that in addition to improving access to primary care in rural areas, MLPs increase access to primary care in a wide variety of settings for populations not adequately served by physicians. Clearly the improved utilization of Mid-level practitioners in Nebraska is worthy of serious consideration. Source: https://ota.fas.org/reports/8615.pdf</p>	