Summary of the APRN 407 Proposal

*This document is being provided to provide a concise document summarizing the 407 application. Please refer to the application for all of the information pertinent to this application. Questions can be directed to Patti Motl, Chair of the Board of Nursing (*402-709-8687*) or Linda Stones, BON Practice Committee Chair. (402-613-7761)*

WHAT IS THE PROPOSAL?

Modernize licensure and regulation of APRNS in Nebraska

(1) Create a single APRN Practice Act
(2) Align scope of practice for all APRNs with the national Consensus Model for APRN Regulation
(3) Position Nebraska to enter the APRN licensure compact

This proposal is not limited to nurse practitioners as suggested in the Director's response to the Applicant Letter of Intent.

WHAT ARE ADVANCED PRACTICE REGISTERED NURSES (APRNs)?

(1) Fo**ur Roles**

	Number licensed in NE 7/2020
Certified Nurse Practitioners (CNPs/NPs)	2621
Certified Registered Nurse Anesthetists (CRNAs)	676
Certified Clinical Nurse Specialists (CNSs)	85
Certified Nurse Midwives (CNMs)	56

Nurse practitioner (NP) is the licensure title in Nebraska

(2) Graduate Education

CORE Educational Requirements

a. Advanced Physiology/Pathophysiology
b. Advanced Health Assessment
c. Advanced Pharmacology

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CORE Competencies

1 Role
1 Population Foci

Family/individual across the lifespan
Adult-gerontology
Pediatrics
Neonatal
Women's health/Gender related
Psych/Mental Health

(3) **Certification** corresponds with role and population foci and is a requirement for initial and ongoing licensure
(4) **Scope of Practice** includes health assessment, diagnosis, and management of a plan of care, including prescription of pharmacologic and non-pharmacologic interventions according to role and population foci
(5) **Practice specialization** follows licensure (Diagram 1)

WHAT IS THE CONSENSUS MODEL FOR APRN REGULATION?

The 2008 Consensus Model for APRN Regulation: **Licensure, Accreditation, Certification and Education (LACE)** is the product of a four-year collaboration between the National Council of State Boards of Nursing and nurse leaders from twenty-three nursing organizations. The Consensus workgroup recognized that APRNs would play an increasingly

significant role in Improving access to high quality, cost-effective care, but inconsistent standards in APRN education, regulation and practice would limit mobility from one state to another. Consumers ultimately benefit the most from uniformity in APRN education and competencies and consistencies in regulation for public protection.

APRN regulation includes four essential elements (LACE)(Inset)

a. Licensure (Authority to practice)
b. Accreditation (Formal review and approval of education programs and certification programs)
c. Certification (Formal recognition of knowledge, skills and experience)
d. Education (Formal preparation in a graduate degree or post graduate program)

WHAT DOES APRN CONSENSUS MODEL ALIGNMENT MEAN?

The APRN Consensus Model provides states with a framework and guidance to adopt uniformity in the regulation of APRNs. Consensus between the states was originally projected to have been accomplished by 2015. A numeric system is used to assign progress towards implementation of the Model. Nebraska currently has 25 of the 28 points required to fully align with the Model (Diagram 2).

The Model scoring system assigns a point for CNS independent practice because the Nebraska CNS Practice Act is silent regarding physician supervision (and prescriptive authority). Full practice authority has replaced independent practice as a descriptor in the literature.

The following proposed APRN scope of practice changes represent Consensus Model alignment:

(1) Full practice authority for CNMs
(2) Prescriptive authority for CNMs and CNSs
(3) Removal of Transition to Practice requirements NPs

The proposal does not include home births for CNMs and does not make any scope of practice changes in CRNAs.

WHY IS APRN CONSENSUS ALIGNMENT IMPORTANT FOR NEBRASKA

Close the gap. The vision for 'mid-level' practitioners as alternative providers to a declining physician population was articulated by the Nebraska Board of Health forty years ago—long before the current reliance on APRNs in our health system and the Consensus Model. Incremental legislation has provided CRNAs and NPs (95% of licensed APRNs in this state) with full practice authority. Full practice authority means practice under the authority of their own license, including prescription of pharmacologic and nonpharmacologic interventions. Prescriptive authority supports development and implementation of a plan of care and medication administration for some APRN roles and population foci. (Diagram 3)

Improve access to essential health care services. Fragmented APRN practice authority creates confusion for the public and stakeholders—employers, other providers and health care professionals. The forecast is that full practice authority facilitates the movement of APRNs into our Nebraska communities. Three decades later, CRNAs practice in 99% of the ORs in the state and are the only anesthesia providers in 95% of Critical Access Hospitals (CAHs). Although comparatively early in the transition (LB 916 in 2015), workforce data indicates that the increase in NPs in the state parallels the growth seen in other states that have undertaken similar legislation to remove practice barriers.

The need for services provided by CNMs is implicated by an upward trend in the state infant mortality rate. Twenty-five (25) of Nebraska's 64 CAHs no longer offer obstetric services. Clinical nurse specialists, the most versatile of all APRN roles are vastly underutilized in our hospitals and clinics. Clinical nurse specialists excel in the delivery of services for

advanced age, chronic disease and disability which typifies some portion of the population in nearly all health care systems.

Regulatory simplification. Five sets of APRN statutes and corresponding regulations have evolved incrementally with legislative changes over the years. The result is dated and inconsistent language, and provisions with separate and too often, conflicting requirements for licensure and practice between groups of APRNs. Advanced practice registered nurses with full practice authority in other states encounter barriers—supervision, no prescriptive authority and transition to practice requirements—for licensure and practice in Nebraska.

Progress toward regulatory simplification has been initiated with Executive Order No. 17-04, in 2017. APRN regulations have been combined into one document with implementation pending. *This proposal does not include retirement of the APRN Board.*

Improve licensure portability.

Nursing practice is defined as occurring where the patient is at the time that services are provided. As a long-standing member of a RN/LPN Compact, Nebraska is no stranger to a nursing Compact licensure. Even before the COVID-19 pandemic accelerated interest in compact privileging, many Nebraska health systems relied on locum tenens and a traveling workforce.

Nebraska was one of 33 states that waived licensure requirements for rapid deployment of nurses across state lines. With the Centers for Medicare and Medicaid (CMS) stepping up early to remove regulatory barriers to services provided by APRNs and estimates of 1000s of percentage increases in claims for telehealth services for the same period a year ago, the need for Compact licensure is clear. With recovery and the long-term effects of the pandemic not yet known, clinical outcomes, along with shared consumer and provider satisfaction will factor in sustaining telehealth services.

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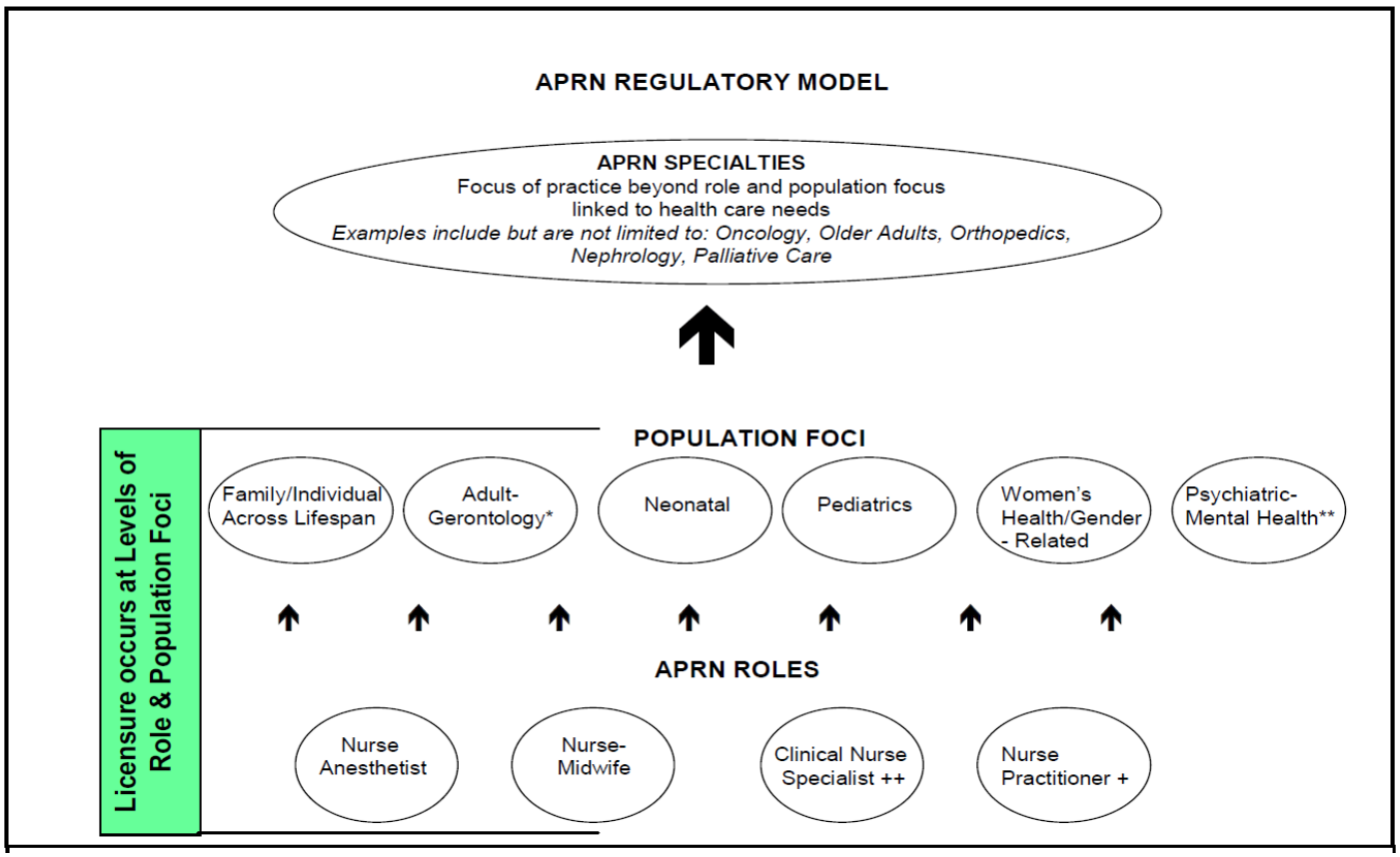
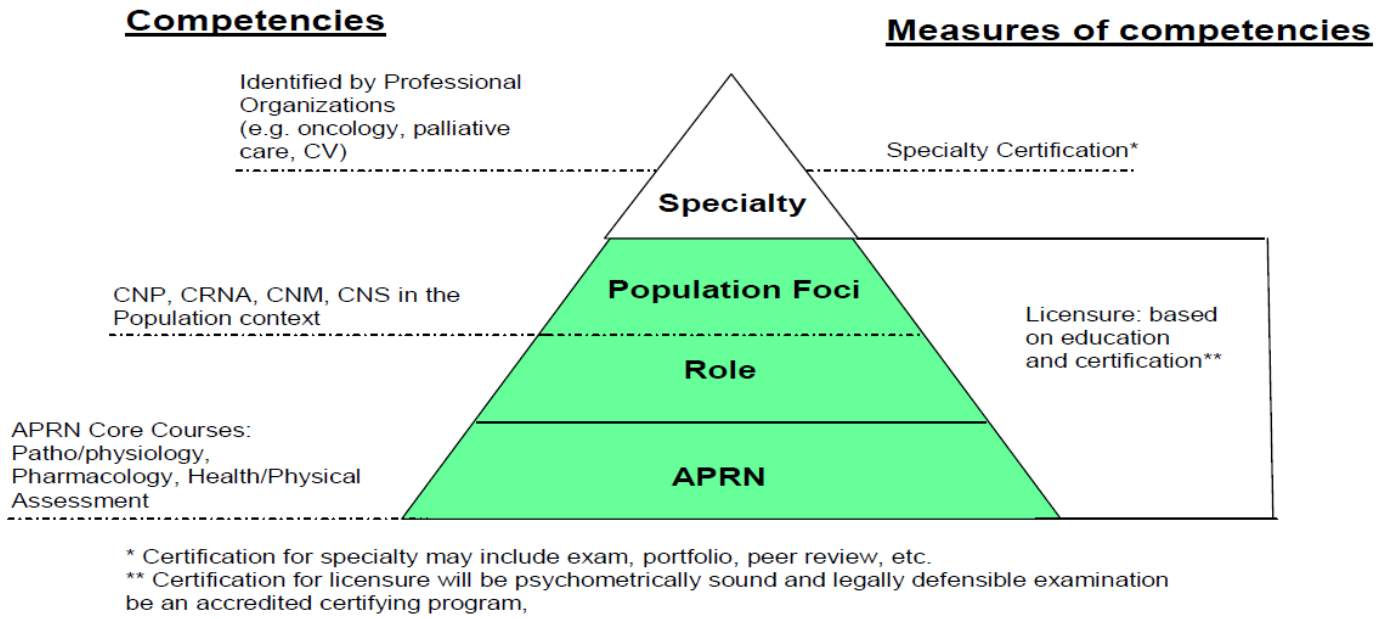
Diagram 1: APRN Regulatory Model.



From the APRN Joint Dialogue Group Report July 7, 2008.

Diagram 2: Relationship Among Educational Competencies, Licensure and Certification in the Role/Poluation Foci and Education and Credentialling in a Specialty.



From the APRN Joint Dialogue Group Report, July 7, 2008

Diagram 3: Summary of Current Scope of Practice for APRNs

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