2017 NCSBN APRN Roundtable - Defending Your Lane, the Misaligned APRN

Video Transcript

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Event
2017 NCSBN APRN Roundtable

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Presenter
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- [Carolyn] Thank you. It's a pleasure to be with you here today. I'm curious as to who I am here with today, so could you raise your hand if you are with one of the state regulatory agencies? Yeah. And then how about certification organizations? How about academics? Well, and it seems like there must be some overlap here. How about health networks or hospitals? Is there any category I didn't address? - [Woman 1] Professional organizations. - Oh, yeah, professional organizations. Okay, thank you. And then to give you a little bit more about where I'm coming from. Yeah, I practiced as a nurse practitioner for a long time and eventually, I'm really full time into law and there really wasn't any time to really keep practicing as a nurse practitioner and I was unable to keep up my hours or I chose not to, let's put it that way. I feel like I'm a better lawyer than a nurse practitioner, frankly. But at any rate so I let my certification go, but I practiced wholeheartedly for 16 years and in terms of my legal work, every day I get questions from nurse practitioners and others, sometimes nurse midwives, sometimes PAs, and rarely nurse anesthetist. But I get questions every day via email or phone about scope of practice and should I take this job given what my preparation is. I have probably reviewed 500 employment contracts. I probably do two a week and it's been at least 20 years, so at least 500. I go into hospitals that have hired many, many nurse practitioners and then at some level don't know what to do with them. Either they don't know that they can bill for them or they want to bill for them and they don't know what they can bill for, or they have there can be stark law issues about giving away nurse practitioners as prizes to private physicians essentially, there's scope of practice issues. So I go into hospitals and health networks and I advise them. I do a lot of advice letters from physician practices, from nursing home companies, even from insurance companies that are trying to set up some new program. But it's these questions that I get from nurse practitioners that kind of bring me here today. By the way, can I have my slides up? So I get the kind of questions that Lisa was talking about that have come up already today. So what we're going to do is talk about the concerns that APRNs have when they accept employment outside their education. We're talking about defense now. So my view, Penny's view is patient safety and I'm concerned about patient safety as well. But my thought is always, how am I going to defend this person if I have to? If this person is misaligned and something goes wrong, to me, one of the first things the attorneys for the plaintiff's side are going to bring up is, was this person qualified and authorized to do this work? And I'll say right up front that I don't know of any cases where this has been a major point of the litigation. Now that may...it may just be that we don't know that that occurred. When we get
reports of cases, often they come from appeals, a written report of an appeal decision and so there are many cases that are not appealed and we have no written report of the case. I’ve been collecting cases against nurse practitioners for 20 years and I usually get my cases from a newsletter where attorneys can send in reports of their cases. So I’ll get a newsletter of say 200 cases a month, not all against nurse practitioners or advanced practitioners, it’s been 200 medical malpractice cases a month and I extract from them the cases against nurse practitioners and occasionally will get the cases from insurance companies. So we get our cases, those of us who follow this, except for people like Penny who have access to databases, we get our cases from the insurance companies which will report them for educational purposes, or from appeals reports, or from reports from lawyers. And sometimes like if it's from reports from lawyers, they don't always have all the details we want to know. But I try to take the cases I learn of and analyze them for what went wrong and what can we do about it and what can we learn, those who didn't get sued that time, what can we learn to prevent us getting sued in the future? So when I hear from APRNs who are considering taking a job where their credentials aren't exactly right, I'm always thinking of how am I going to defend this person if it came to that. And then we're going to talk about some of the legal challenges to APRN practice. So, there can be a problem with misalignment if the payers have specific requirements about who can get paid for a particular service and the one that comes to mind is Medicare and they put out a directive a few years ago where they said that only those who are certified in mental health should be billing or can be billing for mental health services. So one example that's if you have an FNP who is working for a psychiatrist, the question is can that person or should that person be billing for the work that's around mental health CPT codes? Secondly, if the clinician or the practice is sued, as I said, one of the first things the plaintiff's lawyers would want to address is, was this person actually qualified to do this work? And, again, I can't give you a case where this has come up, but I keep expecting to see something like that come up. And then third, I'm told that well, credentialing is now usually done by a medical staff in a hospital. Sometimes it's still under nursing, but Medicare and other regulators are pushing for it to be done under the medical staff and I'm told that the medical staff often does not understand APRN credentials. So they're the ones who are in charge of, you know, giving the stamp of approval for an APRN coming to work for a hospital and they may or may not know what they're actually doing. It could be a problem. And then what I'm hearing about from my nurse practitioner colleagues is, one example is a nurse practitioner, a friend of mine, who is working in a sleep practice and she had a patient about whom she had a GI question. Now this nurse practitioner has a background in internal medicine, this one at the sleep practice, but it was something GI related that was outside of her knowledge base so she sent the patient to a gastroenterologist. And she gets a report back, not from a gastroenterologist, but from a nurse practitioner working for the gastroenterologist and the nurse practitioner didn't know any more than my internal medicine friend about this GI problem. Basically, she said, "I don't know." And so the nurse practitioner... I hear nurse practitioners basically criticizing other nurse practitioners saying, "You know, when I send someone to a specialist, I really want a response that's more than...from a person who knows more than I know." Okay, so then we have the patient's perspective where you may get a patient going in to see a gastroenterologist and is seeing a nurse practitioner and they may be misled about just how qualified this person is. It's probably just not discussed, but I see a public relations problem coming down the pike on this. And then the problem of APRNs don't know what jobs they can safely take. So among those of you who are in regulatory positions, how many of you have had significant push back? Well, first of all, let me put it this way. If you tell a nurse practitioner who's querying you about whether they can take a particular job based on their credentials, if you take a stand on that, how many of you have gotten push back? Yeah, and I just heard yesterday of a case where an executive director of a board of nursing, this was a few years ago, did take a stand and said that FNP should not be practicing in acute
care in hospitals and received push back to the extent that she was fired. Push back from, I don't know, it was from legislators, or from the state health department, whatever. She was fired. She sued for wrongful discharge and the court held that she was wrongfully discharged and she got a little bit of money, 150,000 or something for being wrongfully discharged. Now, I mean, I don't know there may be other factors involved in her being fired, but what came out in the newspaper was that part of the reason she was fired was that she did stand up and say that, you know, FNP should not be practicing in acute care and that this was seen as getting in the way of progress of nurse practitioners. Now, just a little bit more about where I'm coming from. I am in no way wanting to get in the way of nurse practitioners. You know, I testified before state legislatures in trying to get bills passed, I've personally lobbied when I lived in Maryland, I mean, I was standing there in the state house, you know, all the time. I'm in no way wanting to get in the way of nurse practitioners, but what I'm fearing is, I mean, here we are, we've come so far getting full practice authority and I think we're coming to a tipping point where pretty soon most of the states are going to have full practice authority. So we're coming from a point of view where we've been attacked publicly by the medical organizations for trying to expand our practice and we've made success and now I feel like we need to look inward and evaluate the safety of the people that we're putting out there and really take it upon ourselves to critique ourselves, I guess, and don't leave us open for critique from other types of providers. Thanks, yeah. Okay, so just some more lists of questions you get. Women's health care nurse practitioner who was hired to do medication management for a psychiatrist's patients. Okay, so I think the question of psychiatry and mental health is kind of a burning question because all the people who do primary care, do mental health work in that they take care of anxiety and mild depression and so on. But then when you get into the question of, you know, are you going to treat major depression? Are you going to treat schizophrenia? Are you getting into the psychotropic drugs? Those who are certified to do that kind of thing would say that no, primary care providers should not be getting into the psychotropic drugs and all. And then a women's health care nurse practitioner doing this seems really over the line to me. Then we have a pediatric nurse practitioner working alone at a satellite office in pediatric endocrinology. Another example is I had a call last week from the Nursing Rheumatology Society and they wanted to talk to me because there are a lot of nurse practitioners, they say, in their organization who wanted to have their own practices in rheumatology. That seemed strange to me. I didn't actually speak with them. A family nurse practitioner working in critical care, happens all the time. Adult nurse practitioner practicing in dermatology, happens all the time. It's only a problem among the dermatologists who do not have FNPs working for them. The dermatologists who have nurse practitioners working for them think it's great. I had a dermatologist society ask me to come and speak with them because those who do not hire nurse practitioners thought, how can a nurse practitioner perform the same functions that a third year dermatology resident could not do? That just didn't seem right to them. But there's no certification for nurse practitioners in dermatology that I know of so we see that all the time. And then we have women's health care nurse practitioners being asked to provide primary care in clinics for STDs. Why? Because practically, people who come in for STDs often have other things going on like ear infections or bronchitis and the health departments just want the nurse practitioners who are there, the women's health care nurse practitioners to be able to treat some primary care problems. So and then adult nurse practitioner asked by an urgent care clinic owner to see children, gerontological nurse practitioner asked to see younger adults, pediatric nurse practitioner asked to see 23-year old. Now in this case it was someone who had aged out of a specialty heme-onc clinic. So this nurse practitioner was in a great position to take care of this 23-year old because she had taken care of him in his teenage years and was the only one who really knew his complexities of problems. So in this case, they asked the Board of Nursing and the Board of Nursing said, "In that case, yes. You can see your aged out pediatric patients
in that kind of a situation, but that's a specific instance. And then this is one of my favorites. This new grad FNP with no history in neuro was given this great job opportunity to work in a neurologic practice, a neuro practice and they wanted her to see patients in the office, but they also wanted her to run over the hospital to see patients who were in possible impending stroke, which to me is, if not acute care, critical care. She wanted to know if she should do this and well, my first...well, she said to the neurologist who wanted to hire her, "Well, how am I going to learn this?" And he said, "Don't worry about it, we'll take care of that." So my first response was well, it doesn't matter so much what I think, but you better ask the Board of Nursing what they think. And I think she said, "Well, I did contact the Board of Nursing and I got a very vague response." And after hearing about the push back that you're getting if you take a stand, I guess I understand the vague response. At any rate I said, "No, I would not personally take a job where as an FNP, especially a new grad FNP, I am asked to do what is essentially critical care." Now, we had a situation or we've had a situation in the past where there really wasn't acute care certification. I mean, clearly there is now, but 25 years ago there wasn't. So anybody working in acute care, any nurse practitioner was likely to be an adult pediatric or family nurse practitioner. And so we're not... I don't feel that worried about a family nurse practitioner who was hired 25, 30 years ago to work in acute care and, you know, all that time, all that experience. I don't feel that bad about that. But a fresh FNP right out of school, asked to supervise cardiac stress tests, that makes me queasy. Clearly you can learn that, but it makes me queasy nevertheless. So the questions I pose are, is there a consensus on what education, certification, and precepting is needed for APNs working in these specialties or in acute care? And whose place is it to determine what the correct preparation is for any given job? And does anyone who...does anyone provide guidance on the correct education and certification for any given job? And so, in trying to answer these questions, I was looking at the consensus model and you know what that says and then what does it say about specialties? It says, "Education and assessment strategies for specialty areas will be developed by the nursing profession, the organizations, and the interest groups. And competency at the specialty level will not be assessed or regulated by the boards of nursing but rather by the professional organizations." So some of you were here from professional organizations. And then it goes on to say, APRNs specialty education and practice build upon or in addition to the education and practice basically we get the basic education and then we build on that. But it says state licensing boards will not regulate the APRN at the level of specialties in this model. But yet, professional certification in the specialty area of practice is recommended and this can be acquired either by more education or assessed in a variety of ways including examinations. So to summarize all that, basically competence in a specialty area could come from education or experience, the licensing boards are not going to regulate the specialties, the professional organizations are to set the standards, this is in the consensus model, and certification in the specialty is strongly recommended, and the competency could be assessed through exams, portfolios, or peer reviews, and there should be a match between education and clinical experience, and the specialty. So I went looking for just how many certifications do we have so that people could feel that they actually were prepared to work in a specialty and this is the list I came up with. I don't think this is comprehensive. Does anyone know of any other certifications that are available? - [Woman 2] Emergency care. - Good. Okay. Emergency care, great. Okay, so if you're not in one of these areas, and I don't see rheumatology in here, I don't know how you're going to prove your competency other than your portfolio. So a portfolio would be a nurse practitioner's completion of continuing education, if it's about procedures it would be how many have I performed, how many have been...how many of my procedures have been supervised and so on. These are the areas where I didn't find any certifications available. Am I wrong? - [Woman 3] [inaudible] - Okay, yeah, right. RN level. Okay, I didn't find any advanced level. So basically, right now as I see it, it's being left to the employer and the APRN to figure it out. Should that be where it should be? That decision making.
And the questions that they’re addressing is does the APN have the certification in the specialty? Is the certification a valid measure of the competency? I believe, I hope I'm not misspeaking, but I believe the urology certification that I talked about is not specifically APRN level. So that's why I say is the certification a valid measure of the competency? And if the APN is not certified, what are the risks? And then how can the employer assess the competency? So what I'm hearing is you may not be competent, but we'll teach you and then the question is does that occur? Because when I go into large hospital systems and neonatology comes to mind, one hospital had me come in and speak with many of their neonatologists and many of their neonatal nurse practitioners and one of the problems the nurse practitioners raised was the lack of orientation on boarding and training and that was with a big organization. So I wonder how it is with a small practice. And then other questions for the individual APRN and the employer to answer are, does the APRN have the knowledge to differentially diagnose and manage the conditions likely to be encountered? That ties in with our previous session. And what are the clinical competencies and skills required to treat these conditions? And how has the APRN achieved and demonstrated competence? And what is the standard for a practitioner in this field? Does the APRN meet those standards? And has the APRN completed a specialty preceptorship or fellowship? And then what are the consequences of accepting treatment responsibility for these patients and does the APRN have a formal relationship with the provider who is adequately trained and immediately available? This comes from Missouri Board of Nursing. And then is the patient safety at risk? And then I ask, this is my defense position, do the APRN and the employer understand that if they're sued, the first thing the plaintiff's attorney is likely to ask is, "What are your qualifications to perform this service?" So take a quick look at federal law to see what federal law has to say about this. First of all, qualifications under federal law, the qualifications for an APRN are found in the reimbursement law and they are that certification is required and a master's degree is required. In terms of scope of practice, the feds defer to state law so they don't really get into it. In terms of medical staff, we find law in Medicare's conditions of participation, which mean if a hospital if you want to be reimbursed by Medicare this is what you have to do. And the current law says that medical staff may admit advanced practice nurses to their staff. They don't have to, but they may. So they made it clear that they may. And that Medicare is pushing for the credentialing to be done by the medical staff and that's when I come, that's why I said, "But yet, the medical staff often doesn't quite know much about APRNs." And then the other statement on credentialing from the feds comes in the form of this reimbursement criteria for mental health services which I spoke of. And then in terms of state law, it's funny before I even knew that Lisa was speaking I went for this Ohio APRN decision making model, but here's an example of what one state is doing. Lisa tells it better than I. And then Florida had something on their website about how nurses could file for a declaratory statement if they're worried about their match. So I don't know, I didn't find that every Board of Nursing had a process for helping nurse practitioners figure it out, but I see that some do. In some states, we really don't have a clear scope of practice for nurse practitioners. There's none in California. Basically, nurse practitioners do whatever the standardized procedures says they can do and the standardized procedure is a document that is drafted by the physician, the nurse practitioner, and the organization. In Tennessee and Michigan APRNs can prescribe, but it doesn't say in state law what else they can do. So in the states that don't have clear definition of what a nurse practitioner can do, the holes are filled through delegation documents or collaborative agreements or standardized procedures. So here's what can happen with grandfathering. There was a nurse practitioner who had a diploma from a hospital and was certified by the hospital as a PNP in 1997, okay, an older nurse practitioner and she was grandfathered in as a nurse practitioner without having to get her master's or a baccalaureate degree and she opened her own practice and entered into collaborative agreement with the physician. The nurse practitioner never collaborated with the physician. She saw this, on this case at any
rate, she saw a baby for the first 14 months of life and saw the baby 32 times in that year. The mother asked for a physician to see the baby and the nurse practitioner told her she only needed to see a physician if they had to go to the hospital. Finally, the mother took the baby to a hospital where the baby was seen by the collaborating physician and was diagnosed with neuroblastoma. The nurse practitioner's records said that she documented symptoms of neuroblastoma, but it didn't occur to her that was what the problem was. But starting at six months she had documented some symptoms which should have led her to neuroblastoma. And neuroblastoma is treatable if diagnosed early, but that was not the case here. This was a six million dollar judgment against the nurse practitioner. And the nurse practitioner's malpractice insurer said the nurse practitioner's, oh sorry, this is... I'm just getting ahead of myself. So in that case the nurse practitioner was sort of minimally prepared, I'm not saying she was doing specialty, she was doing primary care, but it's the closest case I can find where it was an issue about the nurse practitioner's qualifications and preparation to do what she had been doing. It's not the greatest case, she'd been in practice for a long time, but it did come out in the court testimony that she didn't have a bachelor's degree, she didn't have a master's degree, she was grandfathered in. So it shows that it can be a problem in the defense. Again, I don't have a case that's perfect in that I don't have any cases where it has been an issue that an FNP, say is providing acute care, but I really think that's going to come.

[Woman 4] [inaudible] - Oh, loss of consortium is when your relationship is affected. Like if something happens to a wife, the husband will claim loss of consortium because the wife was in such a state that he didn't get the relationship he was supposed to have. Okay, so you'd think that malpractice insurers would have a position on this and in fact, they do. So this is from one of the insurer's claims study and they said the nurse practitioner's specified scope of practice is critical with respect to any theory of liability or potential allegations and may be asserted in litigation. It also forms the context within which a court will determine whether negligent conduct occurred and whether the nurse practitioner acted within scope of practice. And then they go on, but...so insurers do have a position on this. In that insurer's survey, 76% of those who had claims against them said they refused to perform procedures outside their scope of practice and those who did, said they performed outside their scope of practice because trained by a physician collaborator. So according to those who had been sued, they would never go outside their scope of practice and I don't know whether anything about the litigation had to do with a misalignment, we don't know. It will be fruitful research for the future. So to wrap up, some of the common legal challenges in this regard are that hospitals may be clamping down on letting FNPs have hospital privileges and are holding out for ACNs. I know some hospitals are. Some boards of nursing may be refusing to approve collaborative agreements based on a mismatch, but in the states where you don't have to have a collaborative agreement the Board of Nursing would not know about a mismatch unless there is a report. So, like Lisa said, it may be much more prevalent mismatching than we know about. There may be denial of reimbursement based on a mismatch, but we're not going to know about that in any global way. I mean, some bills are going to get denied in certain practices. And again, the plaintiff in a malpractice action could claim that the APRN is not qualified. So is it acceptable that these decisions are being made just between the employer and the nurse practitioner? And if there is no certification in a specialty, is on-the-job training sufficient to protect patient safety? And when NPs get on-the-job training rather than formal training, is there increased liability for on-the-job training? And then how do you best document on-the-job training? And if there is certification available, are you more liable if you're practicing in a specialty and you don't have that certification? And does it make sense that nurse practitioners working for specialists can, in some situations, perform and be reimbursed for procedures that a third year specialty resident could not? I mean these are things we're going to have to deal with because the challenges are going to come from the physician organizations. And then whose responsibility is it to answer these questions? Individuals? State boards? Nursing associations? Medical
Societies? State medical boards? Or these certification organizations? So this is an assortment of questions I have answered for Medscape. Every month I answer two questions, legal questions that are posed by anyone who wants to write in and this is an assortment of the questions I have gotten and answered so people are asking these questions. So I do not know the answer to the questions of whose job it is to do this, but I think somebody... I think it's worthy of discussion. Whose job is it? Can we keep it within our profession to come up with the answers to these questions and can we be ready to basically defend ourselves on our answers to those questions? Do we have questions? Or comments? - [Vincent]

Hi, Vince Holly, the president of the National Association of Clinical Nurse Specialists. It's unfortunate that these presentations are more geared towards the APRN role because this does cross over into this clinical nurse specialist practice. An example that I and a question for you is I have a colleague that is a pediatric clinical nurse specialist that work with kids with special needs. Many of those special needs then go on into early adulthood adolescence, early adulthood. She continues to see them because the services that she is providing is more along the lines of advanced nursing practice as opposed to medical care of these patients. What is the risk being certified in a pediatric clinical nurse specialist to see these patients as they go into adolescence and early adulthood? - Well, the same risk that I was talking about. It's all fine if nothing goes wrong. I mean, in a way, it's a testament to...and when I say nurse practitioners I mean clinical nurse specialists for the most part too. Sometimes the law is drastically different, sometimes it's the same. The program I went to in 1985 was for clinical nurse specialists, but we were able to sit for NP exam and that's what I did. So I'm not, you know, I'm not avoiding CNS issues, but yes, if a CNS is certified as a pediatric CNS and starts seeing adults it's a problem. Who has the authority to say whether it's okay or not? I think the boards of nursing. If they want or don't want to, then you're operating in a gray area and it's all fine as long as nothing goes wrong. And because we haven't had this come up more often in the courts, I'm thinking people are doing a pretty good job of collaborating or get the resources they need, but, you know, as we heard earlier nurse practitioner throngs are growing and it's going to become, I believe, a bigger issue even than now. So, yes? - [Janeen] Janeen Dahn from the Arizona Board of Nursing. Specifically primary care versus acute care. Acute care NPs working in primary care specifically an example of chronic pain management. We've had issues with establishing that scope of practice because while the NOF [SP] document does a pretty good job describing the remaining documentation out there specifically from like ACN or the professional organizations aren't very clear on this scope of practice and they defined acute care scope as dealing with complex issues, but they don't ever define complex. So we're having a difficulty in determining that scope and our legal advice has been in lawsuits and rule is going to be difficult to prove. - Yeah. So this is a question of acute care possibly performing primary care. Is that what... - Correct, yeah. - Yeah, and I've heard that in context of acute care nurse practitioner, can she or he perform Botox and the board in question said no because Botox is primary care. - But specifically, the issue is complex, the word complex. Nobody defines what complex is and, you know, [inaudible] can be complex, but it's primary care. - I don't have a better answer than any of you. It's something to be...it's like navel gazing. We can sit around and contemplate, and contemplate, and contemplate, and have differing opinions on it and I don't know that there's ever going to be a hard line rule able to be drawn. As much as you can do these algorithms like Ohio did, to me, the better, but I don't have any way to draw a hard line and the lines may get drawn if there are more cases, but we don't have case filed right now, really. - [Woman 5] Carolyn, can I respond to Janeen? - Yeah. - Janeen, one thing that we do kind of suggested sort of look at what's contemporary as far as scope of practice is just to take a look at our most recent job analysis study which we do have available and the test plans for whatever provider group you're looking at and that gives you the most current look at what kind of patients people are caring for, but I know we don't have an absolute specific definition of what is a complex patient but that
does show what kind of patients people are caring for. - Thank you. - Okay, how about in that corner? -
[Sandra] Thank you. Hi, I'm Sandra Lee Schafer with the Hospice and Palliative Credentialing Center. This is just a comment that I know has come up with my colleagues that do the certifications. I noticed on your slide where you named the ones that had an advanced practice credential, you had ours wrong and what it brings to mind and the conversations we've had is since the APRN consensus model and we're kind of the second tier, we've seen a lot of changes in terms of who's sitting for our exams, the number sitting for our exams, and more recently there's a lot of confusion about what is an educational program that provides a certificate after taking the education versus a psycho-metrically sound certification program. The organization referenced is an awesome organization. They do great education, but they don't do national certification and I just know a lot of us have seen that my numbers, fortunately with my advanced practice, they've grown if anything since the consensus model, but I know that maybe not true for some of the others. But I think the confusion is of concern that if we all have trouble deciphering that and trying to teach our nurses and, you know, nurse practitioners, you know, the families patients it's just become a, you know, as one of my physicians said, you will all have this swirling of credentials flying around. But I think we do need to continue to educate ourselves as well as the nursing profession as they're getting through school and all. - Okay. If you'd like to tell me or tell the group how I did something wrong, go ahead because I'm want to correct it right here. - Well, no. What you have for Hospice and Palliative was that it was came from CAPC which is the Center to Advance Palliative Care. They're excellent, they've moved palliative care forward, but they do not provide certification. - Okay, and then some other organization does? - Yes, mine. - Okay, tell me your organization again so I know. - Oh, it's the Hospice and Palliative Credentialing Center. - Okay. - But it was one example, I didn't look through all the others, but I just think, you know, there's a lot of education as you mentioned that we have to do for ourselves. - Okay, thank you. Penny? - [Penny] I might actually have a comment or a question. So joint commission for hospital based advanced practice, so when I was the CNO in the hospital we had CRNAs, nurse practitioners, entry APNs and they went through the same process of the credentialing, the [inaudible] credentialing committee with OPPE which is the Ongoing Professional format. So is that not the norm that that happens, that when it's time come up to review credentials if you're in a hospital setting that that happens or is it different? - Is it not the norm that the credential according to JCAHO? Is that... - That it goes through the same process. Like if I'm a CRNA in a hospital and I need to be re-credentialed, do they go through the same process? Is that how it normally works? I don't know the answer to that. - And I'm not an expert on credentialing according to JCAHO either. - [Woman 6] [inaudible] - Great. - And also before Maryanne [SP] comes up to answer that question, I was thinking about the cases when you were talking about, Carolyn, outside the scope of practice and I do remember a couple of cases where and I think it was more PN, not sure it was an advanced practice nurse, where there was an issue around practicing outside the scope with regard to certificates. I'm actually going to go back and look for those cases and try to dive even more deeper into them. - [Maryanne] So just to Penny's question, in facilities that are credentialed by the joint commission, that is one of their standards that they adhere to FPP and OPPE which would include credentialing. What was interesting and, you know, you guys are feeling the pain of how we've all evolved in these roles, right? This year which was the university health care consortium they have this cap2 project and the idea was they looked at the hospitals that the university systems that they collect and share data on and in their first presentation, when they tried to look at these sorts of issues like are we all doing OPPE in the same way, what they found out from their CEO group was that they were only aware of 30% of their APRN hires. So these are facilities where these folks are working, right? Often they come in through medical practices which was sort of the evolution. So what they would say is, yes, we know of the standard from joint commission and we do our best to get to that, but we are still
discovering where our employees are and what they're doing. So that credentialing process is a bit behind. Carolyn mentioned that often the medical staffs are pretty unaware of how we are educated and prepared and that's true. In the last several years we have partnered with the national meds staff credentialing associations and their state based associations to help educate them about what the strategy of APRN consensus is and was and is intended to be. So they're catching up, but there's still some gap there. - Thank you. - [Woman 7] Okay. Thank you Carolyn for your very thoughtful presentation. I'd like to add a little something with a question inside. If specialty issues are going back to boards of nursing, I think I remember and most recently had a consulting case where an APRN had a masters degree and went before the board, the board is now made up of a lot of non nurses, right? So I want to point out the obvious. And in this case, I think it's very historically, I'm a historian, it's very historically relevant that the ANA has identified this year as the year of self-care for the nurse and in this case this APRN was denied practice by the state of Pennsylvania because they didn't know what self-care was and this person had done an NYU degree in holistic nursing. There is board certification for holistic nursing at the advanced practice level, there's a scope and standard. I just wrote the third edition with six other colleagues of the ANA scope of practice for holistic nursing, I was on that team. So I'm just saying I don't know what we can do in terms of specialty. I'm also a CNS so I echo what Vince said about the specialty, you know, we're bouncing back to the specialty thing. So I thank you for bringing this to us because I think we still have a lot of work to do. So do you hear my question in that? - Well, how are we going to proceed? - With the boards, you know, in terms of specialty and counting on them to review when we can't even get to the California Board of Nursing because they don't have enough money, they're bankrupt, and they can't pick up a phone call, and they can't review us. I'm talking about people I'm consulting with in different states. So while it is a great suggestion, the rubber meets the road of what the heck do we do? That's what people ask me. And why am I not allowed to help people in my state because I really care? So I don't know if that makes sense. - It does make sense... - I'm a historian so I'm looking at what we did before we had all this stuff, right? And now here we are in a historical moment. - These aren't questions that can be answered instantaneously, but, I mean, people sitting around talking about it is always helpful. So that's what... I guess that's what I'm recommending. That we have more dialog and... I mean, the boards of nursing to me, I mean, it seems like they could be a driving force with this. - [Woman 8] [inaudible] - Okay. - [Marybeth] Thanks, Carolyn. Marybeth Singer from ONCC. I wanted to make two comments. Thank you for talking about specialty and I think not to put the burden on the boards because they are financially strapped and their mission is different. It's the professional organizations that have to help us bring specialty forward and help identify how to operationalize that and make it visible and use language that helps the public understand what our role is there, not just our physician colleagues because that's really where we are letting the rubber meet the road. Our patients are the consumers of our care and they can tell you what we do, right? The second thing is around competency and I think certification is important, but I think with the consensus model, specialty sits at the top of that pyramid and I think we are kind of getting to a place where we do need to identify how we add to the model and how we contribute to health care in that area. And my worry, always, has been how are we going to define that and in some ways sell it to our colleagues, you know. If you want to practice in a specialty, yes, you need to be certified in that specialty because it validates your competency and your knowledge. So those are my two comments. - Okay, thank you. This, right here. - [Jennifer] Jennifer Wright with the Louisiana State Board of Nursing. I had a couple of comments. One is that we're not the only profession that's struggling with this. - Absolutely. - In Louisiana, the Board of Medical Examiners actually recently promulgated rules because they have the same issue with physicians who have not had internships or board certifications in neurology or dermatology or they have an orthopedist who is staffing an ER, doing the full range of emergency
services. So it's not just APRNs and the Board of Medical Examiners came out with some specific guidelines and rules for physicians. We have put out an article about mainly what title we utilize and for APRNs to utilize the title for which they've been certified and licensed because we had some kick back during legislative sessions with a lot of questions, you know, self-proclaimed APRN titles maybe without certification. Orthopedic nurse practitioner, surgical nurse practitioner based on experience, but it is a conundrum to consider what do boards of nursing consider a certification that should be utilized in a title? Do we hold ourselves out with certifications that are not necessarily as psycho-metrically sound or accredited as others. So we do have an article, but I did want to mention that also malpractice cases are not the only source of information. Some of these cases about scope of practice wind up through board action that are not necessarily a malpractice case or even in our state negligent credentialing has become a growing practice because of our cap on malpractice reimbursement. That they're going after big facilities saying that the facility was responsible for credentialing someone who was not authorized or competent. - Oh, thank you, very helpful. Well... - [Woman 9] Very nice. - Oh, thank you.