2018 NCSBN APRN Roundtable - Cowgirl Up! Wyoming's Change Model for APRN Practice Alignment Video Transcript

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Event
2018 NCSBN APRN Roundtable

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Presenter
Jennifer Burns MSN, RN, NE-BC, PHNA-BC, Practice and Education Consultant, Wyoming State Board of Nursing

- [Jennifer] So, Maureen is correct, I actually grew up here in Rosemont, I went to school here. And always wished for two things, to have a casino, and to have the Cubs win the pennant. So, thankful for that, however, I was in Wyoming when that occurred.

Been in Wyoming about two years now. And I would like to share with you, in this presentation... oh, that goes backwards, a little bit about my new home state because it's very beautiful, it is also windy and cold, so we got that in coordination.

All right. So, Cowgirl Up, what that means is to be strong, to get on the horse. Wyoming nurses are strong and independent. Wyoming was the first state to have a female governor and a female justice of the peace in 1870.

Cowgirl up. So, a little historical background about our change process. First, Wyoming is an independent APRN practice state since about 1983, and I... Yes. I suspect it was prior to that even further.

I do have the first APRN, the first nurse practitioner in the United States graduated from the first class in our state, and I've met her. And she graduated, I think, in 1971. But we have a culture of independence in Wyoming. It's a low-populated state, we only have half a million people. And our APRNs are increasing in number substantially.

Three years ago, we had 450 APRNs, yesterday, I have 820. There are only 320 physicians' assistant in the state.

And physicians, about 4,000. However, I think only about 3,200 actually practice. We have one university, University of Wyoming, which offers a doctoral FMP, and psychiatric nurse practitioner program, we have no acute care program. And we are a new Enhanced Nurse Licensure Compact state.

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About a year ago, there was a question that came in through our information line. It was an email from a nurse practitioner and this is what she asked. "I am a primary care nurse practitioner, I've been offered a position as a hospitalist in a medical facility. I have much experience in the acute care environment as a registered nurse. Am I within my scope of practice if I accept this position?"

By the way, we only have 29 acute care facilities in the state and a good portion of them are critical access hospitals. Interesting question. When I read that, I thought, "Why is that even a question?" So, brought it to the practice committee, and we spent some time stepping back and reviewing why is this a question, talking about this, who is this person?

And then, we realized, out of the seven of us or out of the seven board members, each board member knew at least five or six family nurse practitioners who were possibly working in the acute care environment as hospitalists or in the ICU.

So, that was the scope of the problem initially. We realized that if anything were to be done such as discipline, it could cause an access-to-care problem in the state immediately. They decided on a phased-in communication and education project.

And they decided not to seek out discipline of these individuals, but absolutely, if a complaint were filed, that they would review their scope of practice complaints per the NPA. So, I'd like to walk you through our communication plan.

The first piece was, it was my responsibility to explain to all the board members, because we do have one public member, and we had an LPN who were not fully understanding of the consensus model of the history behind APRN graduate education foundational. So, I explained that, and we came up with some possible solutions.

Since we only have four powers, regulate and make the rules, license, discipline, and the education piece, we had four possible solutions. The board voted and decided that they would not open their own complaints at this time against those individuals who were practicing as hospitalists. However, they would like to create what amounted to a lengthy communication project with the community, with the licensees, stakeholders, employers, and association.

And that's what they did. I pulled a few different models to look at. And I decided that the ADKAR model, which was written by Jeffrey Hiatt, and they're out of Colorado. You may know this model, it's a pretty popular one.

It might be the best fit for us because it identified changing a process...no, not changing the process, but changing a perception for people involved in that process. And they do so by awareness, creating desire, giving them the knowledge, the ability, and reinforcement through business needs, concept design, implementation, and post-implementation.

So, again, this is the perspective of those we wish to educate. Change. Wyoming territory was instrumental in changing our young American nation. The Oregon Trail was forged by thousands of pioneers traveling treacherous terrain in search of a better life.

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They had to reach Independence Rock, Wyoming, by July 4th to be certain of fair weather through the Rocky Mountains. This split rock can be identified from a few hundred miles away. So, the initial action plan was to educate employers, APRNs, and the public. Review first evidence-based practice and certification standards.

I went through all our rules, all the MPA, everything going back, read the entire consensus model, making sure we were on track that what we had already said was proper and in place. Educating APRNs on the Nurse Practice Act and the administrative rules and regulations.

We wanted to educate the legislature regarding the roles and scope, however, we have put that off probably for about another year or two before we reach out to the legislators, because I think there'll be a lot more communication when the APRN Compact comes into play.

Investigated any national trends that would affect this regulation. And I started encouraging discussion about rural and frontier nursing needs and issues. Always want to engage in communication with national nursing leaders. Dr. Chapel just left, but she and I have had several conversations about this and where it began.

So, awareness is the first step in our change process. How did we create awareness of the population foci requirements of the Nurse Practice Act and the rules? The first thing we did was invite all the APRNs to focus groups. We had eight cities, and every APRN within the county surrounding that city got an invitation.

And the invitation was fairly simple, "Come meet with staff members of the board, we want to hear three things, four things. We want to hear what your..." I told them the questions ahead of time. "We want to hear what your knowledge is on the Nurse Practice Act, the rules.We want to hear about your population foci and other issues that pertain to your practice and what's important to you."

We had, it doesn't sound like a lot, but I think it was 58 out of 750 APRNs at the time attended. We had one focus group that was well attended by about 20 APRNs. But mainly they were about five and six in each city, which worked out really great because it was very condensed and we can talk one-on-one.

We actually sat at a table. It was a very collegial and, kind of, friendly environment. And we found out a lot of things which I'll show you on the next slide. Some of those focus groups, even though there were four and five people, lasted four and five hours, which was nice. It was a lot of information, good connections were made.

We started putting articles in our publication, the Wyoming Nurse Reporter. We sought out meetings with the APRN Association leader of the state. She was very eager once the focus group started happening, she'd heard about them. She came over, several times, to talk to me about what the data showed.

And I was invited to present at their conference in the fall on this subject. The grapevine. That was probably the most beneficial piece of what started all of this. We had to be careful in everything we said, everything we wrote about had a real positive attribute to it.

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When people start hearing about these focus groups, they immediately went negative, "Uh-oh, the board is doing something." Hopefully, I think a lot of times, I was able to call those individuals and assure them, "You know, we just want to come and talk to you, we want to hear what you're doing, we have some questions.And if you want to remain anonymous, that's fine, too."

And they didn't, they had a lot to say. We had, as I said, they were very casual. We sat around at the table, we had refreshments. The raw data showed... I tried to write down phrases that we could evaluate after the fact, so I call that assessment, and I call that scanning.

However, no survey, no paper survey was ever completed. And there was a reason for that. Initially, because we are the Board of Nursing, we didn't want to upset or scare people by putting out surveys and asking really in-depth questions about your population foci, so we opted not to have any paper surveys.

So, the top 10 takeaways from the forums. Really surprising, I learned quite a bit. We have some more work to do going forward and in other areas. Hospital bylaws require, and all hospitals have bylaws that require MD oversight.

Coming from an independent state, every single hospital has bylaws that says, "The medical director signs off on the APRN's work." And what was more interesting, the APRNs never voiced having a problem with this. They told us also that the public is very unfamiliar with the APRN role.

This is absolutely true and I think we're going to do some communication to the public going forward because they really don't know what the roles are, and what is a nurse practitioner, especially a doctor of nurse practitioner. Speaking of, most APRNs had a master's degree, and they did not feel that continuing their education towards a DNP was advantageous because it didn't get them a higher salary, and it was a lot of extra work.

There also seemed to be a disconnect among the APRNs. Although we are small in number, they complained that, first of all, very few of them knew each other unless they were working on the same team. They were not involved in the association, I think our association has only 50 members.

And they felt very disconnect, so much so that they had trouble finding help for peer-to-peer reviews. Access to care issues were our, I wouldn't say rampant, but we have some counties where there are no providers in Wyoming, and APRNs are not filling the void.

And that, I found very strange. Federal statutes restrict reimbursement. We always talked about that, nobody can order diabetic shoes. You all know that?

Everybody talks about it, but what's being done about it? So, this is not for Wyoming or the state to do, it's obviously a federal statute, but nationally, it has an impact. Blurring of hospital roles. Our previous speakers talked about urgent care, we have ER, acute care, primary urgent care.

Which is primary and which is acute care in an urgent care? Where is that kind of line? We have a little bit of blur there. We have APRNs with varied and extensive nursing experience. I have APRNs who have been nurse practitioners since the beginning.

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They are highly qualified and capable. And the two top is that employers did not understand the four APRN roles or population foci, and that was where the rubber meets the road. APRNs are passionate.

I put this here because when we started with the focus group invites, people wanted to know about it, they talked about it, there was a flurry of conversation in this state that would get back to me. So, that was great, they're passionate. Awareness.

Wyoming has always been aware of the awesomeness of our state's geography. Devils Tower is the nation's first National Monument. It received its name from an Indian legend, a grizzly bear chased two Cheyenne girls up a rock.

And the Great Spirit protected the girls by making the rock grow. And as the rock grew, the grizzly bear took its claws and was trying to climb the rock, hence the stripes on the rock. And that is the folktale behind that. If you've ever seen it, it's almost as big as the Empire State Building, and you can see it for hundreds of miles away.

Hundreds. Desire. Wyoming created the desire to change in APRNs and employers. Our goal was compliance and of course public safety, because in order for the public to be safe, we have to have compliance with the MPA and the rules. We wanted to remind stakeholders first of the MPA and the rules because you don't read it every day, you don't even refer to it unless you have a situation.

We wanted to let everybody know that this is a national standard, it was based on the APRN consensus model, and affirmed that there are no changes in the rules, nobody moved your cheese. Okay?

We shared authoritative documents and allowed time for the recipients of those documents for internal consideration and reflection. Here's what the rules say, here's our advisory that explains it even further. And by the way, this was created in 2007, we're not changing anything going forward.

Whenever we spoke to somebody, in written or verbal form, always used collaborative language and positive affirmations. Desire. Theodore Roosevelt in 1903 on his presidential campaign, on horseback, introduced him to Wyoming's abundant wildlife and Yellowstone.

He desired to preserve the area for future generations and was quoted as saying, "There can be nothing in the world more beautiful than the Canyon of the Yellowstone and the three Tetons.And our people should see to it that they are preserved for their children and their children's children forever with their majestic beauty all unmarred." Knowledge.

How did WSBN provide knowledge of the APRN population foci requirements? The goal was to make sure that the information first was clear, it certainly was clear to me when I read it, and that the recipients understand the foundations of graduate education.

Now, I did not pass out the APRN consensus model document, however, about on page seven or eight, there's that diagram that you're all familiar with, the foci and the rules. I did use that in some of my communication pieces because it summarized everything, so that is a good tool to use.

We also asked the Dean of the University, and professor Hart, and Burman, to write an article. And it

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was specific to Wyoming, what Wyoming APRNs need to know about population foci. We've published that in the WNR. And then, we resubmitted, redistributed the advisory opinion on population foci, which was created in 2007.

And when I did that, I did point out that it was created in 2007, and it's remained the same since. The employers' information phase. So, previous to this, the information was sent, more or less, to the APRNs themselves, and now, in the fall, we started reaching out to the employers.

And that, again, is where the rubber, kind of, met the road. Employers thought that the APRN model was comparable to the physician's assistants or medical model. As a matter of fact, I've never met one employer who did not know this about their education.

The goal was to ensure that they were clear on the education model without causing a panic among leaders or their APRNs. We started with a memorandum to all the acute care facilities who employed APRNs.

And I believe, most of them, there might have been 1 or 2 out of the 29 that, at that time, didn't employ APRNs, but that has changed since. After that memo went out, the president of the hospital association asked to come into the office and talk to us.

He stayed about two hours. He was asked by his people to get some further explanation. I met with him for the first two hours and explained this, he was very accepting. Like I said, we used positive words, positive affirmations. We know that everybody wants to be compliant, we really do.

He came back two times after that, more information, he would go and help. He ended up being an excellent collaborator and helped us. After talking to his people, they requested that we create a webinar on how to credential your APRNs, they wanted to learn more, they wanted to have something they could share.

They invited me to staff meetings to talk to everybody. They invited me immediately over to the local hospital. As soon as they got the letter, they said, "Would you come and do a presentation?" The association also sent out their own newsletter article, which I wrote for them, which mirrored the memorandum. So, we were always on the same page. And the pièce de résistance was the court case that I gave the CEOs of the hospital.

I might not pronounce it right, I kind of got a cross between Dolly Parton and Al Pacino accent, it's Billeaudeau versus Opelousas General Hospital. And it was, I believe, 2016 precedent out of Louisiana, which stated that acute care facilities are responsible for properly credentialing their providers.

That got everybody's attention. So, knowledge. The University of Wyoming was founded in 1886 when Wyoming was still a territory. It opened its doors to 42 students and 5 faculty members. And befitting the University of The Equality State, both students and faculty included women from the first day, so that's 1886.

And that is Pistol Pete, one of our mascots. And the horse that...oh, I forgot the horse's name. Piston Pete. Ability. So, how did WSBN support the ability to change enhancing compliance with the Nurse

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Practice Act?

Our goal was to provide suggestions and tools so employers and APRNs could become compliant without having to utilize disciplinary measures. By the way, during this period, we have only had one complaint of an APRN working outside her scope of practice, it was a population foci, and that was decided by the Disciplinary Committee.

But one complaint came in. We started encouraging graduate coursework in acute care by providing postgraduate programs list. As I stated, the university does not have an acute care program, but many of the states, especially Colorado, have online programs, hybrid programs, very easy postgraduate acute care certificate programs, reasonable in cost.

So, we provided that list. We offered to review job descriptions and privilege cards, current job opportunities, current job roles. And I received a lot of phone calls from the HR people who were directed by their CNO or CEO to please call Jennifer at the board, show her what we have, and work it out.

It was at that point that I realized that they were just given the directive and not fully the explanation of why this is. So, coming up, I am presenting to the credentialing group in Wyoming, because again, very eager to learn about this role separation, role alienation. And one-on-one discussions. Every piece of communication, every presentation I did, I encouraged the APRNs to talk to me one-on-one. "Please call me, let's talk about your situation, let's talk through it."

This is a very collegial approach, I want the APRNs to feel comfortable. I want, if they intend to stay in acute care, to help them and encourage them to get that second certification. And they were very, after calling me, first, very nervous, but at the end of the conversations, very happy they called.

Ability. Wyomingites are able to withstand wind gusts of up to 60 miles per hour, this is quite common, 60 miles per hour. We really don't mind the wind because we have over 300 days of bright sunshine. So, I don't know if you all saw this on Facebook, it was circulating. There is a video of this truck, underneath that truck is a police officer, the video is taken from another police officer's car.

So, they pulled up, he got out of the car, and was walking to the car that you can't see. And right after he got out of the car, the wind blew over the truck onto his squad car. And this was about 40 miles from where I live, there is a stretch there, it is so very, very windy.

And, of course, we do close the roads, but that truck driver didn't listen to the closure and almost crushed that police officer. I had some repeat questions from the employers. They wanted to know what defines the setting versus the population.

And they had specific questions, well, what's an ER? Is that primary care, is that acute care? What about the oncology clinics that are attached to the hospitals? And over and over again, what about the cardiologist who hires a nurse practitioner, can she go into the hospital to see the patients and do rounds?

Does a physician collaborative oversight rules or bylaws change any of this? The answer to that, of

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course, is no, any physician, we cannot send a contract waiving our rights under the Nurse Practice Act, waiving our responsibilities under the Nurse Practice Act.

Grandfathering. Is there a possibility that the current FMPs I have working on my hospitalist team can be grandfathered in some way? We do have a grandfather piece in our Nurse Practice Act, but it's from 1999 if you were prior to...and we have about 50 nurse practitioners and CNSs who were grandfathered in.

We actually have a nurse practitioner who does not have a master's degree, she has a bachelor's degree. What are our options? They wanted to know what can we do. At this point, when I'm asked what are our options by the hospital leaders, I give them examples, such as how about tuition reimbursement. Tuition reimbursement for your gals, and I say gals because most of them are women, who would like to go and get a postgraduate, a secondary certificate.

How about time off so they can do their clinicals? I'm trying to give them examples. And the most common question was, is this something Wyoming made up? Heard my little cheese. No, we didn't make it up, it's a national standard.

Reinforcement. How will WSBN reinforce the change in understanding and the desire to become compliant going forward? Always, always, always positive, collaborative discussions. We don't want to place the blame on anybody.

And quite frankly, I am more and more sympathetic to the APRNs who have taken a position in acute care environment because those are the jobs that are available. If you know the state of Wyoming, our larger cities are few and far between, and in between there, is a few hundred miles.

It's not like Chicago, where I can go to the next city and get a job in primary care, it's just not that way at all. I, as the P&E consultant, want to give support. I'll talk to anybody who wants to call me, I don't need your name, I'll talk to you like you're my best friend giving good advice. And that's the way, and it makes people feel better, more at ease.

Authoritative document sharing. The practice committee wrote all the communications together, and that is four people. And then, we would take that final product and run it through probably about four or five other people.

So, it was really a community effort on any piece of communication, we were scouring it for perfection. Open discussions. And my plan is to redistribute the advisory opinion prior to renewals this year. Reinforcement. A rodeo writer has to reinforce his grip, Cheyenne is home to the Cheyenne Frontier Days, a 10-day rodeo event that dates back to the frontier times, where the ranchers would come down to Cheyenne to trade by stock and compete in ranching games.

This happens every year, the third week in July. It is quite a festival. Has anybody been to Cheyenne Frontier Day? Big daddy of them all, okay, that's what we call it. It's really, really a sight to behold.

It's like walking back in time, but it's a fun event. Learning outcomes. We could have improved this process a couple ways. Going back, the reason we did not do pre and post measurements, again, we

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didn't want to upset anybody, we didn't want to take anybody's name and start analyzing numbers and so forth.

But probably had I thought it was so extensive, I would have gone back and done something like that. Initially, our acute care counts were off because what I did was I called all the facilities and asked them, "How many APRNs do you have on staff?"

And I didn't realize that they didn't really understand what an APRN was. So, made some assumptions on that. We had some problems with communication. The original memorandum to the employers, I wanted to stagger that communication, and I staggered it.

We had firewall problems, people were not getting the information, it was one person who would get it. And everybody was talking about this memo and why didn't I get my memo, and after speaking to the hospital association, he said, "Only a few people have gotten the memo, just send it to everybody right now." So, emails were lost, I didn't want to give it out through the mail because I didn't want a paper copy, I felt uncomfortable with that being mass-produced and so forth.

But what we did that worked really well was that, in every piece of communication, it was open, it was transparent, there was a collaborative approach to any wording or language that was used. And we kept reinforcing the assumption that everyone has the desire to be in compliance. And I said it just like that, "I know you want to be in compliance."

This was not a problem with the APRNs. I had one gal who called me and she said, "My CNO is questioning my certifications.I'm a family nurse practitioner, I'm on the hospitalist team, and I'm calling for your help."

And I said, "Well, what is your goal,"because this was an uncomfortable start to a phone call. And she said, "Jennifer, let's not beat around the bush. I know I'm not where I'm supposed to be, how do I get there? What can I do?" And we talked for an hour, and she came up with her own solution, and was supported by her employers. We were also consistent in our responses.

I gave summary, I gave paragraphs to the board members in case they were questioned, so everybody was answering exactly the same way. And this was easy to do, show support for our APRNs. At the end of every presentation, I was very encouraging.

I said to the employers, "Hire more APRNs, they're great. They've great outcomes, excellent customer service.The poor midwives, there very few of them who get to practice in the facility, why not? Why not? They're fantastic." Always positive, positive. Forward-thinking.

So, maintaining the momentum, we are going to do 100% licensure audit, which is going to be easy for us because we only have 120 APRNs. But I'm going to tell them ahead of time, this summer, that this is coming. I'd like to have them all provide primary source verification of your certificates. I have a presentation with the credentialing members, who, again, are very eager to learn about this and to do the right thing when they're screening candidates and working on privileges.

The practice committee, although we're not writing new rules, but possibly in the future, we'll consider

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incorporating the actual consensus model itself in the rules. Solidify that. There are a lot of implication, especially all rural states, we have 820 APRNs, 450 are family nurse practitioners, I only have 85 acute care nurse practitioners in the state.

See that this is an acute care problem, which I'll talk about a possible solution. We track, every quarter, the students who are doing their clinical practicum in the state, and we keep track of that. Last quarter, I had double the amount, I had close to 50, and they were all family nurse practitioner students.

And each quarter, it's going up. I always monitor trends, I always talk about this, I'm constantly asking Maureen anything new, "We got anything new?" But we have the upcoming APRN Compact, this will stimulate conversation around APRN roles, this will allow us to do some education to the community, to the legislatures.

The question that I'm asking today, to end it all, is there a safe way to close this gap from FMP to acute care nurse practitioner in the current model? These APRNs are very experienced, they're quite capable. What they don't have is the formal education and the tool, the certification, to measure that.

We have a unique system in rural care, is very unique. Coming from Chicago, where I can step one side and see six nurse practitioners who work for one doctor, there's a nurse practitioner on every floor in every hospital, there is a nurse practitioner in every long-term care, that's what I came from.

Even though you're not an independent state yet, getting closer, doctors here love nurse practitioners. And I go to Wyoming, where we have access-to-care problems that you can't imagine. We have a critical access hospital, I didn't even know what that was when I came.

It's a free-standing emergency in ICU. We have one in the middle of the state, a nurse practitioner told me. I ran that hospital, and one night, I had three codes. She said after the second code, I called the physician who was on call and 100 miles away, and said, "You need to get in here and help me."

And he said, "You're doing such a good job. Keep it up." Because 100 miles in a snowstorm is not even feasible, so those are the things that we deal with, very different. Is there possibly another exam? Can we make a tool? Can we do profile, clinical check-offs, additional clinical hours?

Is there a bridge from primary care to acute care? I need a think-tank. The big ask, could an APRN task force be beneficial? I'm really wanting to evaluate what has happened since the consensus model, where are we now, what has changed since 2008, 2007, where are we headed?

Maureen, you passed me some statistics, did we double nurse practitioners in the last, how many years? Yeah, okay, double. Are our current models, and guidelines, and tools enough at present? Did we underestimate our needs?

Did we underestimate our APRNs? Did we overestimate our needs? I don't know. Are we prepared? We've got some influential people in the room, we've got Maureen here, we had Dr. Chapel here, and I'll get back to her on that. I don't see Dr.

Benton and Adrian, he's a popular guy, he's back there, too. Anyways, if you agree, I am going to ask

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you to respond Wyoming style. So, everybody who is ready, wants to do this with me, or after maybe we can get something together in our think-tank, respond, "Yeehaw."

One, two, three. Yeehaw. That's how we do it. I have also...can you pass it to the next slide? I have also provided you with some links to some of the documents that I utilize, but there are quite a number of additional ones.

If you would like to contact me, I've put my contact information there, I will be glad to share anything with you. And thank you very much for the opportunity to share. - [Maureen] You have any questions for Jennifer? -

[Female 1] A lot of Wyoming is Indian territory, so that means that, you know, that's federal land. So, how do you...I don't understand, fill that gap between state regulation, and so much of it is federal, American-Indian reservation.

- Indeed. So, an APRN working on the reservation, and they all have wonderful hospital clinics, we have an entire county that is an Indian Wind River Reservation. They are federal employees, so they have full scope of practice, and they're actually under federal. So, most of them are primary care, and I would imagine they're filled by FNPs.

So, that is the only...it's really not an issue for us. Other questions? - [Sheila] I do have a comment. I'm from Kentucky, Sheila Melander, University of Kentucky. I do think that we need to help provide each other with those options that are out there.

There are a lot of us that have post-master's certificate programs, we have some that are as low as 9 to 12 months. A lot of those universities, we do that at UK. We actually do gap analysis, so when you come, we give credit for that experience. But while requiring them to come and get the education they need to provide that care in those gaps, you know, where they are, but acknowledging that experience and expertise they have.

So, I think that we need to not hide that information, but be better stewards of all the universities that are doing that, and where the distance education ones are so we can help each other.

- Thank you, I will have to put that one on our list, too, because I know it's not on there. - [Female 2] And we have a list of those at AACN Certification Corporation, we have a list of programs that do have distance learning and postgraduate programs that have been approved.

- All right, thank you. I'll take that list. - [Penny] Hello, Penny Jenson. And good job on Wyoming, my family are homesteaders on the western side, where the wind doesn't blow over by Jackson Hole.

- Oh, okay.

- So, anyway, but a couple of things I just wanted to mention. Those of you, I know a lot of folks in the room, I led the full practice authority initiative for the Department of Veterans Affairs. And I just wanted to say a couple of the things that you mentioned really have been a problem with us in implementation. As of now, out of our 140 VA facilities, we have 58 facilities that have implemented

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full practice, 50 facilities are in the process, and we have 35% of our nurse practitioners that are actually privileged at this point in time.

We only have eight sites that are not implementing. And so, that's a big thing for us. But what we found along the way is exactly what you've talked about, we have people working in the wrong areas and some of the facilities, that's been a big problem for us when we were trying to implement in a couple of our larger facilities, we had up to 30 nurse practitioners who were working in acute care, who were family practice NPs.

And so, that's been one of our problems because we've actually had to remove a lot of those folks and put them in the population foci where they were educated to work. So, we're very interested in a think-tank because we definitely are having to move our NPs into other areas. And it's very disheartening for them who've been working in certain places and now they're not able to work there because we embraced the entire consensus model with our regulation.

- Indeed. And I had heard that the emergency room nurse groups and the holistic wanted a separate role. But I really would like to see a role that is called a rural health nurse, and it combines the two, acute care and primary care, with a little additional clinical work and so forth.

I think that would be ideal, we have a lot of rural and frontier states out west, this would be excellent for Alaska and Wyoming, and so forth. That's my vision. That's my vision. Yes, ma'am. - [Diane] I want to commend you for what you've done, it's excellent.

- Oh, thank you.

- I'm Diane Evans. I'm a family nurse practitioner and an emergency nurse practitioner, I'm board-certified in both. I teach an emergency nurse practitioner's specialty program. So, this is one way that we can close the gap, I think, especially in emergency care. And piecing together adult [inaudible] and acute care with family is not emergency-specific care.

And I think there's been a real misconception about what kind of patients we take care of in emergency settings. And North Dakota has had nurse practitioners losing their jobs to PAs, and it's happening in other states. And it's largely because there's been very little evaluation of the evidence-based data on what is the real census and what is the real practice in emergency settings.

Only 7% of patients that come to emergency departments get admitted. And only 1% of those go to the ICU. We do not need to train nurse practitioners in critical care for the ED, but they need to be trained in emergency-specific care for all lifespan, all ages, especially women, and especially kids.

- Right, indeed. And I believe that that was the...we ended up putting together a frequently asked questions list, and that was kind of what the answer was.

- I have something for you, too, I brought it.

- We know that only 7% actually get admitted and that was our answer. Well, are your patients coming in with dog bites, snake bites? Right away, see the nurse practitioner. But if this is a cardiac arrest,

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maybe we can have a acute care nurse, a hospitalist, come down and help out because we know they're going upstairs.

We know who's going upstairs, and we left it to them to figure that piece out because, you know, that medical home model because of the same problems we're having nationwide, more and more patients are coming for the small things or coming that they should probably see their physician for who's not available, right?

So, thank you. Ma'am? - [Caroline] Hi. I'm Caroline Buford, I am an attorney and former nurse practitioner, and my law practice is all about the legal issues affecting nurse practitioners. So, I get a lot of emails from nurse practitioners about scope of practice issues, women's health care, doing primary care, family nurse practitioner doing psych, etc., etc.

And also from our ends who are asked to do things that are questionably outside their scope of practice. So, I'm always looking for examples of how people have gotten into trouble, you know, as a learning situation, and I always say, "Well, you know, if you get sued, the first thing the plaintiff's attorney is going to say is, 'What's your qualification for even doing this?'"And then, I say, "And then you can give a report to the Board of Nursing."

But the thing is, I haven't come up with any cases and I have trouble finding any cases where boards of nursing have disciplined people. So, my question is, well, if anybody here knows of such case, I'd love to hear of them. And then, you mentioned one complaint. Can you just give me a general idea?

- Yes, I could. It was a nurse practitioner who was only acute...excuse me, adult-care-certified. She came from another state. I don't know if she was working through...she was working through some kind of agency. And she saw pediatric clients. And there was some kind of bad outcome to clients.

And the complaint from the parents were made to the corporation. And the corporation opened up her HR file and said, "Why are you seeing pediatric clients when you're an adult nurse practitioner?" And she said, "Well, you know, you credentialed me, you put me here.And don't tell the board."

And the agency itself was very well-versed on this issue population foci, they knew exactly, they called their insurance company, and the insurance company absolutely knew that this was a problem. And that is how the complaint came to us, and I believe it was a minimal...I don't remember if it was, like, a notice of warning or something like that, but it was low-level.

And that was the one case. Any other questions? Yes, ma'am. - [Jane] Yes. My name is Jane Towers.

I have worked on these issues for many years. And I'm one of a couple of people that are left that we're actually on the consensus document team. So, I just wanted to call attention to something if you don't mind. And that is that, in relation to the consensus document, when we worked on the whole issue of acute versus primary care because somewhere is a document, but we did an overlap to see what, how much overlap there was.

The line between where one group was and the other group was where they were doing something different was very small. And so, we really caution you to be careful when you're talking acute and

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primary that you draw your lines in a way that do not create problems for people who have been prepared to do the kinds of things they're doing. And the whole thing we focus on an awful lot, in relation to this, was that the setting was not what it was supposed to be, it was the role.

And we've been very strong about that and we hope that that will continue.

- Indeed. And thank you for that clarification, I guess. Thank you. And I did talk about blurring, and that's what we're finding, too, especially the cardiologist who has a nurse practitioner on staff, who he sends to discharge his patients. Well, they're an hour away from going home. Why could she do that? Right?

So, we are seeing that there is a lot of scenarios, but the main thing is, I think, it was a good model, I feel like it was successful, we have a little bit more work to do going forward. And we are very pro-APRN. And, you know, APRNs are the answer. We have 250,000 in the United States, our numbers have grown by 100% in just a few short years.

We've got to hopefully figure all of these details out and move forward, so I appreciate your support. And anybody who wants to get together and talk this, please give me a call. Thank you.

- Thank you, Jennifer, thank you so much.

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