# *2018 NCSBN Scientific Symposium* - Practice: Panel Discussion Video Transcript



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**Presenter**
Moderator: Nicole Livanos, JD, Senior Associate, State Advocacy and Legislative Affairs, Nursing Regulation Administration, NCSBN

- [Nicole] Okay. So, to get started, my first question is actually for Puay. I wonder about how APRN Regulation and practice works in Singapore. Does the Singapore Nursing Board regulate advanced practice nurses?

Is their scope defined in law? Tell us a little bit about APRNs in Singapore. - [Puay] Okay. Good morning, everybody. Just for information, Singapore is in Southeast Asia, and we have a population resident of about 5.6 million people.

And it's a small country. We are only about 279 square kilometer. So you can see it's really small. Okay, for the Singapore nursing body, we are a statutory board of the Ministry of Health, and we are 18 years old. We only form in 2000. We have, in Singapore, about 200 APN.

We call them Advanced Practice Nurse. And of this 200, we put them into 4 track: adult, which is Med Surg, acute mental health, and community. Majority of our APN practice in the hospital setting.

So, yes, we have a APN register they need to be an RN first before they become an APN. And they are all Masters prepared, 100%.

- Great, thank you. And as far as the restrictions go, in Singapore, do you find that advanced practice nurses are restricted by laws in facility settings? How is their practice restricted, if at all?

- Okay. Singapore is unique. The fact is that we work in collaboration the chief nurse of the Ministry of Health is also the registrar of the board, which is then my boss, okay the registrar of the board. And 80% of our nurses are employed in institution, and the institution are mainly public-owned which is autonomous.

But how should I say? Financed by the ministry. So we have a unique relationship. Policies, regulations, and operations are set in collaboration. So for us, as a director of nursing of the hospital previously, we do not restrict because the Singapore Nursing Board has a set of scope of practice for the advanced practitioners and the guidelines.

These are not in our law but is approved by the board. And the board sets the guidelines from input from all area, the policymaker, the regulator, and of course, the employers that employed this APN.

So we want them to do more just now one of the audience mentioned about doing nursing roles nursing job. I think at the end of the day the APN is a nurse and therefore, we believe that they should be doing complex nursing work. And that is our aspiration for our APN back in Singapore where they are at the highest level of clinical expertise.

And we expect them to lead our fellow nurses to perform that role.

- Great, thank you. So it seems in Singapore that APRNs practice to the extent of the scope of practice regulations put out by the board versus what Jeannie was raising were further restrictions put on APRNs at the facility level and may go above and beyond what the state is requiring. It's very interesting. Gloria, I have a question. Jeannie raised an interesting observation in her study that regardless of whether a state was fully restricted, reduced restricted, or independent, facilities may decide to maintain status quo or impose further or different restrictions on APRNs.

We know in 2017 Senate Bill 61 in South Dakota removed the requirement for collaborative practice agreements for nurse practitioners and nurse-midwives. Since implementation, have you heard of any of these facility restrictions remaining on APRNs or further restrictions being placed on APRNs in the state?

- [Gloria] Well, in our major healthcare systems in our state, they still have restrictions on APRN practice. And what they commonly do is they have the PAs and then they have the CNPs and the CNMs. And they group them all into a category and they call them APPs.

So, you know, when you're visiting with your administrators from the hospital, they're always talking about the APPs, and we know that includes everyone. And they frequently do require, as part of their credentialing process, that they have some kind of an arrangement with a physician, but I'm not aware that they have to pay for that arrangement with the physician.

I think the healthcare system, you know, requires them to collaborate with the physician in the system, and then, you know, that's how they're allowed to work. So I don't know that they're required to pay for that. Before we changed the law and everyone had to have a collaborative agreement, mainly the people that were paying for the agreements were those that were employed outside of a institution, and they had to get their own collaborator, and then they had to pay for it.

So I think, you know, the law really has benefited those people that are not employed in those healthcare systems but those that want to be out and having their own business and being independent. And the educators are having an easier time recruiting NPs into faculty positions because they don't have to have a collaborative agreement.

And they had to have it to get the license, so it was, you know, tied to their license. So they really could not practice without the collaborative agreement, and now they can. But unfortunately, the healthcare systems are going to do whatever suits them best. And, you know, as a regulator, I really can't have too much impact on that, but I think that nurse practitioners are going to have to deal with that issue.

- Great, thank you. Jeannie, if you were in South Dakota and you had the opportunity to advise facilities in South Dakota, what would your advice be to them or if you had kind of one golden ticket to eliminate a restriction on APRNs what would your advice be?

- [Jeannie] You know, I think this is a nationwide issue. I mean, I don't have the evidence, but I just I think it is. I mean, it's just the hospitals and healthcare systems carry a lot of weight, and they can pretty much regulate how they feel appropriate. I think though, if we can get APRNs and bedside nurses more involved in the organization, as was recommended by the IOM, to have them on boards in that hospital so that their voices are heard have them...

Rhonda Hughes mentioned today during her keynote and I thought about this. Having those nurses in the clinical area doing research with academes to show that what those APRNs are doing in those hospitals are improving care and lowering costs, I think would be a big driver. But right now, I think overall, I mean, nurses were telling us that nursing administration doesn't know what their role is.

If nursing administration does not know what an APRN can do within their facility, how is medicine going to know? How's the CNO...well, hopefully, the CNO would know. I don't know. How about the, you know, the Chief Executive Officer? Nobody's going to know what their role is. And I think the only way to do that is to follow those recommendations.

Let's get some of them on the boards in those hospitals, and let's get them out there so that they're doing research to show that the work that they're doing in hospitals is contributing to the quality of care at a lower cost. Because unfortunately, dollars and cents that's what a lot of administrators and policymakers understand.

- And I know that Susan and Beth found, in their research, that a lot of the restrictions or that a lot of nurse practitioners did not know how they were regulated, did not know and were confused by the state regulations over them. So maybe there is this disconnect between, you know, at all levels of how are we regulated? What's state regulation? What's facility regulation?

We need to make a better argument.

- Can I add to that previous question?

- Yes, please.

- Go ahead. - [Susan] Just to clarify, the NPs we interviewed understood pretty much what the state laws were. It was the people they were working with that didn't understand them so their supervisors and the heads of the organizations. And just to clarify another point, it is true that most of the NPs in the organizations did not pay out of their pocket for the supervision, but it's still a cost.

It's a cost to the organization for that time, and it can justify salary differentials etc. The ones in private practice certainly paid out of pocket. In California, just around the, you know, having an impact two of our biggest medical centers in Northern California, I won't name them, but have fairly new roles which is a direct opposition of Advanced Practice Nursing or advanced practice, so it includes the PAs and the NPs.

As a person on that Hospital leadership group, now I know one of them actually doesn't have any direct reports which is a little odd because the NPs are not and the PAs are not reporting to that person. But it's a role that I think has some potential, as you said, to kind of get in there in the leadership.

They're doing studies, they're doing...they're looking at their data, they're trying to clean up the systems that show that, you know, what they actually did isn't what got billed. Some of my doctoral students are looking at that. It's great doctoral research. So I think that's part of it too which is to get in those roles and then do the research.

- Great.

- Which is not the question you had for me but...

- No, that is perfectly fine. So, Susan, your map showed the psych mental health shortage areas in the United States. And we also know and from Rhonda's presentation this morning that there's, you know, a shortage of nurses. There's a shortage of primary healthcare, maternal care, psych mental healthcare providers across the country.

Do you think that that shortage is going to have any impact on these restrictions and possibly lifting some of the restrictions on APRNs in the future? It's for anybody. -

[Beth] So, I do think if we can make the case about that to policymakers, it could potentially have a big impact. Because if you look at that map, you know, the places where, you know, APRNs have full practice, authority tend to be, you know, areas where there are significant shortages.

And that often seems to be something that moves legislators, you know, that we need to be able to make services more available to people. So I think we have to make that case. I think if we can make it, it is potentially something that influences policymakers.

- Can I answer that?

- Yes, please.

- You know, when the two of you were presenting, I was sitting in my seat and I was thinking how can we make this happen with segmental...almost every university in this country is looking for segmental health faculty. They don't have them. Who's going to teach these providers? No, I mean, you know, we have an issue because, I mean, you got to look at the foundation.

If there's nobody to teach, how are we going rectify this problem? And mental health is such an issue in this country. Globally, it's an issue. And what can we do? I mean, do we... - [Woman 1]

Raise their salaries.

- Exactly. But if you can't get anybody to teach it, how are our new nurses going to appreciate the fact that mental health is such a valuable component of the system if we can't find people to teach it? I don't know who's teaching it, but if you look at university employment opportunities, almost everybody's looking for mental health faculty. What can we do about that? I mean, I know I'm a little off target with that, but that's a problem.

It's a professional problem.

- Well, I was going to say that, you know, in 2017, we did sell our legislation to legislators on the premise that we could help relieve some of the shortage areas. And psych mental health is a huge shortage area in South Dakota. If you looked on that map, we're, like, very dark blue. The problem is we only have 36 psych mental health nurse practitioners in our state.

And so what's happening is that...and we have a family nurse practitioner program right now at our state university. That was the only nurse practitioner program in our state for quite some time. So these family nurse practitioners are graduating and they are getting jobs in psych-mental health areas which, you know, creates a little bit of a dilemma for us as regulators because we're trying hard to follow the consensus model.

And we only license people in their role and in their focus area. But then, you know, what happens is they take a job in another setting. And when we did our legislation, we put that transition to practice program into our legislation as a fig leaf. It's only 1,040 hours of collaborative practice, but we opened up the collaborators so that they could be more than physicians.

They can be nurse practitioners and nurse midwives. So the dilemma that we have is we get a...so for the first 1,040 hours, they have to have some kind of an agreement with a collaborator, and they're coming in as a family nurse practitioner with a collaborative agreement with a psychiatrist who's going to, you know, supervise. So what do you with that?

Do you tell that person, "Sorry, you're not a psych mental health NP, so you can't work in that area." We have taken the stance that we are not going to stop people from being employed because we don't know what their scope is going to be in that job, you know. And it's really my feeling that it's up to that nurse practitioner to be accountable for the care that they deliver and to practice within their scope, you know, no matter how they're licensed and certified.

So we've got a little bit of an issue. And we did deny a collaborative agreement for a family nurse practitioner with a psychiatrist. And the next thing you know I'm getting called from the legislators who are busy on their mental health task force saying, "All right, you came and you told us that these people could help to solve this problem, and now you're denying these collaborative agreements."

And we've had to say, "You know, we may have counseled them to get a collaborative agreement with a practitioner that was comparable practice to how they're licensed and certified. But we have not denied them the opportunity to work or to have a collaborative agreement." So it's a real dilemma for our state and for the people that are working and counseling these NPs on what is appropriate practice.

And I would say you're right that the institutions do not know the focus areas for these Nurse Practitioners. And when you know that they pool them all with the PAs, you know, there's two different scopes that you're dealing with.

And so they don't want to be bothered with that. They just want the practitioner that can do the work.

- And as a great reminder, if South Dakota was up on the map right now for Nurse Practitioners, it would be green. And yet we see all the challenges that they're facing in mental health as well as working within regulation. You had a question. Do you mind going to the mic behind you? - [Woman 2] More of a comment.

It might be one or two comments, or it may just roll into one long one. But that is very important what you brought up. And I'm from Pennsylvania, a small Catholic University. We have a family Nurse Practitioner Program, but I'm finding a lot of my family Nurse Practitioners are wanting to go into psych.

And we do talk about and educate on some of the management. But we look at more of the medication management versus the cognitive behavioral therapies and the other therapies that are out there. So they're really not fitting within their scope, and now we have these certifications with this psych mental health certification, and this Nurse Practitioners do need to have that certification, I fully believe just to be able to practice to the best of their knowledge and the extent for the patients in terms of quality and safety.

The other thing that really kind of just was an aha moment for me when you started talking about that you have all of 36 psych mental health Nurse Practitioners and that's probably pretty well from state to state. And now I know my program we're looking at opening up a psych mental health track in two years.

How many? Because we know that this is a dire need that we have within our states. And if you only have 36 psych NPs, then I know we only have a few within the state of Pennsylvania, how are we going to fit all of these for clinical preceptors? And that's really just more of a comment and something to think about because we're really going to have to think about getting these students placed and trained.

Sorry. It was one long one. Thank you. Puay, do you want to talk about...?

- As I hear about the psychiatric, yes, back home we are also having this issue of training APNs mental health. Because, every year, we run the program but each program we may have 40 candidates and psychiatry we need a minimum number of...by right to be profitable to run the program, you need at least 12.

But we are running at six because it's a national issue. And all the students are sponsored by the government, okay. So they do the program free but nonetheless, running six is tough. So as regulator, because we are looking at how do we put them in their collaborative agreement, and how can they practice at the top of their license?

We are really exploring if they have Advanced Diploma that means after your RN, you do a specialty in mental health you do APN in Med Surg that gives you your clinical skills, your advanced skill but do not give you your advanced psychiatric skill.

And we will allow you to practice in a psychiatric setting for the fact that because most of psychiatric patients are aging and they have multiple medical conditions which is complex to deal with. And we hope that we train the meds as Med Surg and later on, give them a grad dip or postgraduate in mental health.

We don't know. We are exploring because the numbers to run mental health is tough. We have about 600 RN mental health, and it's difficult to find the right candidate to do the Master's program.

And of this group, how many of them are Masters or PhD-prepared? So we do have a teaching faculty issue and of course, candidate issue. I think we share similar ideas. But when we talk about collaborative agreement, we encourage our APN and our employers to ensure that because APN and nursing track very clearly the director of nursing or the nursing division has an ownership of this APN.

They have to groom and develop them as leaders. But we encourage collaborative with our medical colleague because day to day they work hand in hand, and it's required. And I must say that at this moment, we have wonderful relationship.

They are pushing the APN to do as much as they can. And we said, "No, no, no. They are on the nursing track.Please allow them to help the nurses to up their skills into advance level." They would really want them to do the other side of their job. Fortunately back in Singapore, we do not have Physician Assistant that is not in our arena, so we are safe.

- You are safe.

- We are trying to ask nurses to do their job, but we are very clear with our track. So we say, "No, it's APN. Nursing track."

- So I think we've been in a room for about an hour and a half and no one said the word "opioids." So I'm going to say it. So, Susan, we want to jump to a different crisis. You analyze many different informants across the country during your studies and certainly many of them brought up the opioid crisis. How is the opioid crisis affecting psych mental health Nurse Practitioner work?

Have the practitioners found that in this environment they are further restricted because of certain opioid-related issues or rather have they been empowered and given more opportunity to work and treat those types of patients?

- Well, this could be another session and hopefully, it will be in a couple of years because we have a grant with a colleague where we are actually looking at NPs. Some of you may be familiar with the waiver opportunity for Psych NPs to get waivered to do medication and assisted treatment. -

[Woman 3] All NPs.

- All NPs to get medication-assisted treatment waivers and get the training. So we are looking at those data and doing some studies. So I think it's an unfortunate opportunity to bring the issue to state legislators. I mean it rings as heavily as this mental health shortage issue. We obviously have a lot of money going into this the Cures Act and some of the other big legislation is pouring a ton of money into...not always in directions that we would agree with necessarily.

But I think, you know, this is a time to really sort of push that issue, but we'll have more data, you know, in a couple of years on that.

- Okay, we're going back in the other direction. So California has some of the best data in the country, if not the best. I think you girls have to go back in there and make the business case for your Psych Mental Health NPs and base it on hospital data because your psychiatric patients shouldn't be hospitalized in the perfect world for segmental health issues.

And if you can show in areas where you have more NPs that that's not happening, that's your case. I mean, it saves the organization money. It, you know, the patients fair better I would think, rather than being hospitalized if they could be treated out patiently.

- Our scope of practice legislation is data resistant. Seriously. I mean that is where it is. We have tried so many times under so many different rubrics the access to care the, you know, Obamacare and expanding access etc.

It's about the money. The money continues to win. Yeah, it's a political...I mean, it's coming up again with some other work that we're doing. So what do you do when it's data resistant?

- We've got one minute remaining, and I know Gloria had a comment.

- Yeah. I just wanted to say that, you know, our State University is starting a psych mental health track, but they don't have the faculty to teach it. So what they have to do then is they have to contract with another university that does have the faculty and work in collaboration with them. And also I wanted to mention that on that mental health task force that our legislators are doing our prime sponsor of our full practice authority bill is the chair of that committee.

So she is very adept at being able to explain to them what the scope of practice is and why it's necessary for that psych mental health certification to be able to treat. So, it's looking positive for us, I should say.

- Unfortunately, that is all the time we have for today. Phyllis, I apologize. Hopefully, you can get a chance to ask. But thank you so much to our panelists for the great discussion.