2019 NCSBN Annual Meeting - Committee Forum: APRN Consensus Resolution Report Video Transcript

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Event
2019 NCSBN Annual Meeting

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Presenter
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- [Maryann] Well, it is my privilege to give you a report on the APRN Consensus Model Forum, which was held on April 10th, Chicago, Illinois and moderated by Dr. Stephanie Ferguson. I want to take a moment to review for you the resolution that was passed in August of 2018 by the delegate assembly, stated, "Whereas the APRN consensus model is 10 years old, and whereas inconsistencies exist in the regulatory interpretation and implementation of the model among various states, and whereas the 2017 NCSBN roundtable meetings, reveal these inconsistencies, therefore be it resolved that NCSBN convene a forum of state board regulators with expertise in APRN issues to discuss these inconsistencies, as well as challenges and strategies.And be it further resolved that following this forum, the NCSBN Board of Directors evaluate how to address the challenges boards of nursing are experiencing in relation to the implementation of the APRN consensus model, and be it further resolved that the progress of these activities be reported to the NCSBN annual meeting."

And so I stand before you to give you that report. Seventy-five members of NCSBN were in attendance at the meeting on April 10th. Each board was invited to have two participants and most of these were either/and executive officers and an APRN representative from the board.

And to give people time to think about the inconsistencies, the challenges that they were facing at their state, we initially sent out a form to them to fill out. And it listed all the important aspects of the consensus model in there, all the major aspects that we all are trying to address and get passed on a state by state basis.

So we thought we would give everybody a chance to think about and it will lay some groundwork for the discussion. And then the day of the meeting, we went through each of those areas of the consensus model, step by step, and had a discussion about each one. And so I'm going to summarize for you this afternoon, exactly the conversations and the important issues and discussion that resulted.

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First of all, title. And these, I'm capturing really what the essence of these discussions were on these slides. Two things were discussed, licensees want to be called NPs rather than APRNs, and there was a discussion about CRNAs wanting to change their title to nurse anesthesiologist.

This is the result of those two issues. First of all, it was believed that changing the APRN title will have an impact on federal regulations at CMS that impact billing. Number two, states are still striving to adopt the model and we need to strive towards consistency.

Three, the public is still learning the titles and changing them now would really cause more confusion than anything else. And it was believed by the group that changing CRNA title to nurse anesthesiologist would only exacerbate existing tensions with physicians. Roles and population foci.

The issues in discussion. Many states and representatives talked about the fact that the model does not allow for NPs to be educated across the spectrum of care, that they have to pick a role and a specific population. It was discussed that market need is driving something different from the model.

We need to support access to care in rural communities. Some believed that there was a need for a generalist category of APRNs and gave the example of physician assistants not being restricted to a role and population and some also even cited physicians not being restricted. But ultimately, and what I tell you is what evolved after a lot of discussion in this category.

These were the primary beliefs that emerged. The setting the APRN works in should be irrelevant because some people still believe that the setting should dictate what an APRN does. And again, it's according to her knowledge and certification. Acute primary care foci should not be tied to setting, but to rather the practice of the APRN.

It was pointed out that PAs are educated as generalists, a very different education of APRNs and they require supervision. APRNs may have a more narrow scope, but are taught to be independent. APRNs must be careful to differentiate themselves from physicians who do have 10,000 hours of generalist training.

And finally, it was brought to the attention of the group that recent research suggests that when barriers are removed, APRNs do fill the provider gap in rural underserved areas without compromising education and certification. I think this was something that many people in the group strongly believed and a conclusion that was arrived at that there is a regulatory responsibility to hold licensees accountable for what they have been prepared to do through their education and certification.

And it was also suggested that there be a scope of practice decision tree available for APRNs. Licensure. And as you know in the model, the model now is that an APRN must hold licensure as an RN and APRN and there was a division.

On this particular topic, there were definitely two opinions. Some people believe that both licenses are necessary, and some believe only an APRN would be necessary for an advanced practice registered nurse. But what came out in the discussion was the history of why two licenses were recommended and put into the model.

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And number one, was related to discipline because it was believed that if an APRN is disciplined due to an error that she makes and her license is suspended for a period of time, she can at least still work as an RN, having an RN license. And number two, it was pointed out that requiring an RN license assures that every APRN, especially internationally educated nurses, have passed the NCLEX.

Education. As I'm sure you recall, the education requirement for an APRN is that an APRN must have a master's degree or higher, education must provide the three Ps, advanced physical assessment, physiology, and pharmacology.

So let me tell you what those issues and discussions were. Some people at the meeting were that all APRN programs should be in person, then an online program should not be allowed.

And again, I'm trying to bring you, if you weren't there, as close to the discussion as possible. Some of these were just pointed out by a few people. But again, I'm trying to capture for you what was brought up. Some brought up the question of are the three Ps still sufficient as basic requirements?

Should there be a grade requirement in these courses? And should they be specialized by role and population? And at the conclusion, it was brought out that if the three Ps are specialized, and an APRN wishes to change the population foci, then they need to repeat those three.

So they can't just go on and get a new population, but they would need to repeat a lot of extra coursework. Certification. The model requires that an APRN, obtain and maintain national certification in a role and population foci.

A lot of the discussion was really centered around questions that were raised. What to do if a certification exam is retired? Should there be a generalist exam? Many people believed that that would really be of assistance in preparing APRNs, and some of the concerns also were that recertification is inconsistent, that there is no universal definition of a currency of certification.

And I might add, that we were kind of left with those questions. A lot of those may be better answered by the certifiers. Finally, independent practice and prescribing. As you know, the model recommends that every APRN have an independent or full practice authority, as we call it now, and prescribing privileges.

And so somebody pointed out that there is a negative connotation of the term independent practice, that can be interpreted and implied that APRNs do not consult with colleagues, and therefore, the term full practice authority is ideal. I do believe we are moving away from that term, independent practice.

It still remains in the model, but I know most states when they're putting forward legislation do refer to it as full practice authority. And finally, there was a discussion about holistic nurses. Every state board has received a letter from Holistic Nurses wanting to have that specialty become part of the model, to have a specific population for holistic nurses.

And the belief was that they are already covered under the model. So in summary, this event, I think, I received much feedback from the participants that it was a very good opportunity for discussion. But at the end of the day, there was agreement that the consensus model should not be revised.

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Many states have strived towards fully adopting the model and making changes would be disruptive and confuse the public. And if I can tell you that if there were underlying threads that were woven throughout the day, everybody talked about consistency, uniformity, the need to protect the public, and the need to continue to promote the model.

Do you have any questions? - [Lisa] Hi, Maryann. Lisa Emmerich from Ohio. The report that came from this day, I may have missed it. Is it in the business book?

- It is not in the business book, but every Board of Nursing was emailed a copy.

- May I ask, was there a reason it is not in the business book?

- Nothing specific, but the only reason was, we reported that to the board of directors in July, and it was too late to get it into the business book. But if you would like a copy of it, I would be happy to send it to you.

- Thank you very much.

- Anyone else? Thank you.

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