



AGENDA

Advisory Committee on Advanced Practice Registered Nursing October 28, 2019 10:00 a.m. to 2:45p.m.

Charge: The committee shall advise the Board regarding the practice and regulation of advanced practice registered nurses and may make recommendations to the Committee on Prescriptive Governance.

- | | |
|---|-----------------------|
| 1. Welcome/Introductions/Announcements | 10:00 a.m.-10:20a.m. |
| a. Public Participation Guideline | |
| 2. Journal of Nurse Practitioner Articles | 10:20 a.m.-10:50 a.m. |
| 3. Public Comments | 10:50 a.m.-11:10.m. |
| 4. Guest: Josecelyn Graves, OAAPN | 11:10 a.m. -11:30p.m. |

Lunch 11:30 to 12:30

- | | |
|--|----------------------|
| 5. General Information/Updates | 12:30 p.m.-1:00 p.m. |
| a. Legislative Report to the Board | |
| b. 2019 RN and APRN Renewal-ends 10/31/2019 | |
| c. Sample/Summary of APRN Practice Questions | |
| d. Draft FAQs (tentative) | |
| 6. Draft Interpretive Guideline | 1:00 p.m.-1:30 p.m. |
| a. Written comments | |
| 7. Public Comments | 1:30 p.m.- 2:00 p.m. |

Speakers will have no more than five minutes, and perhaps less, at the discretion of the Chair, based on the number of speakers and time available.

- | | |
|---------------------------|--------------------|
| 8. APRN-CRNA Title | 2:00 p.m.-2:20p.m. |
| 9. Schedule 2020 Meetings | 2:20 p.m.- 2:30.m. |
| 10. Other | 2:30p.m.-2:45 p.m. |
| 11. Adjourn | 2:45 |



MEMORANDUM

TO: Advisory Committee on Advanced Practice Registered Nursing (APRN Advisory Committee)
FROM: Lisa Emrich, Program Manager
DATE: September 19, 2019
RE: Revised Draft CNP Interpretive Guideline

Attached, please find the Revised Interpretive Guideline (IG) with Attachments A and B. The changes to this draft are summarized as follows:

- The CME definition of critical care was replaced with a summary of “acute care” taken from the WHO Bulletin article (see the IG footnote).
- As a result of the change to the critical care language, the term “acute care” is used to describe the higher or “red” level of care identified in Attachment A.
- Paragraph A 3.b. was made more specific by adding the word psychiatry to precede pediatrics, and by referencing that the certification of the psychiatric-mental health nurse practitioner is by the American Nurses Credentialing Center.
- In paragraph B the word “national” was inserted before “certification.”
- In the second paragraph below the Accountability and Responsibility of APRN-CNPs bolded header, the words “and setting” were removed.
- Additional statutory citations that apply to APRNs were added at the end of the document: Sections 4723.50; 4723.51, and 4723.53, ORC.

The prior “chart” is now titled Attachment A and contains individual graphs for each type of national certification. The verbiage in the vertical line was changed to “Illness/Condition/Severity/Stability” with color ranges of green to red maintained. Waved lines without a lined border were also used as reflected on the applicable graphs.

Attachment B of the IG is the Reference list with links to the certifying organizations. This attachment remains largely unchanged. The links to the national certifying body information and test plans are live links, so that any person may access the publicly available test plans and information directly from the certifying organization’s website. It was not possible to link the NONPF competencies as membership was required to access that information link directly from that website.

As discussed at previous meetings, separate from the IG, staff are looking into a Frequently Asked Questions document. If that document is completed prior to the October 28, 2019 meeting date, it will be forwarded to the committee members and interested parties at that time.

This draft IG is being distributed and posted in advance of the October 28, 2019 meeting of the Board’s APRN Advisory Committee for review, consideration and comment. Any comments regarding the draft IG should be sent to PracticeAPRN@nursing.ohio.gov with the phrase “Draft IG” included in the subject line of the e-mail. Comments may also be postal mailed to the Board at the address listed in the header to this document and sent to the attention of the “Practice Unit.” The Board requests that comments be received no later than 8:00 a.m. Friday October 18,

2019, to allow time for staff to compile and forward those comments to committee members in advance of the October 28th meeting.



Interpretive Guideline (DRAFT 9 6 2019)

Title: APRN-CNP Licensure, National Certification and Management of Patient Conditions

This Interpretive Guideline is provided as guidance to APRN-CNPs seeking to meet their scope and standards of practice in the State of Ohio relative to patients' stage of growth and development, gender and managed conditions as established in Sections 4723.41, 4723.43(C) and 4723.431 of the Ohio Revised Code (ORC) and administrative rules adopted thereunder.

For purposes of this Interpretive Guideline, the higher (red) level of the care required by the patient's condition as used within **Attachment A** will have the same meaning as the term "acute care" explained by Hirshon, Risko, Calvello, de Ramirez, Narayan, Theodosios & O'Neil¹ as:

[t]he most time-sensitive, individually-oriented diagnostic and curative actions whose primary purpose is to improve health. A proposed definition of acute care includes the health system components, or care delivery platforms, used to treat sudden, often unexpected urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention. The term acute care encompasses a range of clinical health-care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization. (pg. 386)

- A. APRN-CNP authorized practice is dependent on the following:
1. A current, valid Ohio APRN-CNP license issued by the Ohio Board of Nursing (Board);
 2. Maintenance of national certification by a national certifying organization approved by the Board;
 3. Entry into a standard care arrangement with a collaborating physician or podiatrist who is:
 - a. Authorized to practice in Ohio
 - b. Practicing in a specialty that is the same as or similar to the APRN-CNP's nursing specialty; or whose practice is psychiatry, pediatrics, primary care or family practice if the APRN-CNP is certified as a psychiatric-mental health nurse practitioner by the American Nurses Credentialing Center.
- B. APRN-CNP defined practice includes provision of the following within the APRN-CNP's specialty and consistent with the APRN-CNP's education and national certification:
1. Preventive and primary care services;
 2. Services for acute illnesses;
 3. Evaluation and promotion of patient wellness.

¹ Hirshon, J., Risko, N., Calvello, E., de Ramirez, S., Narayan, M., Theodosios, C., & O'Neil, J., (2013). Health systems and services: the role of acute care. *Bull World Health Organ* (91) 386-388. Accessed August 28, 2019 <https://www.scielosp.org/pdf/bwho/2013.v91n5/386-388/en>

- C. APRN-CNP practice is consistent with the master's or doctoral degree program that qualified the APRN to take their national certification exam, and in accordance with their national certification as provided in Section 4723.41, ORC.²
- D. National certification for APRN-CNPs may be in one or more of the following patient populations pertaining to physiologic age, gender, and presenting state of health as indicated on **Attachment A**:
 - 1. Family Across the Lifespan (Primary Care) (ANCC and AANPCB)
 - 2. Adult-Gerontology Acute Care (ANCC)
 - 3. Adult-Gerontology Primary Care (ANCC and AANPCB)
 - 4. Pediatric Acute Care (PNCB)
 - 5. Pediatric Primary Care (PNCB) (ANCC: retiring)
 - 6. Neonatal (NCC)
 - 7. Women's Health Care (NCC)
 - 8. Psychiatric/Mental Health Across the Lifespan (ANCC)

Accountability and Responsibility of APRN-CNPs

Section 4723.43(C), ORC, defines the scope of practice for the certified nurse practitioner. Chapters 4723-4, 4723-8, and 4723-9, Ohio Administrative Code (OAC), hold advanced practice registered nurses responsible for practicing in accordance with their education and clinical experience, national certification, the Nurse Practice Act (Chapter 4723., ORC) and rules adopted under the Nurse Practice Act.

The APRN-CNP must apply the Nurse Practice Act and rules regulating the practice of nursing (Chapters 4723-1 to 4723-27, OAC) to their specific practice. Further, the APRN-CNP must utilize good professional judgment in determining whether or not to engage in a given patient care and management activity, consistent with the law and rules.

In this Interpretive Guideline, the Board does not announce a new policy but instead gives APRN-CNPs specific instructions regarding their obligations under existing law and rules.

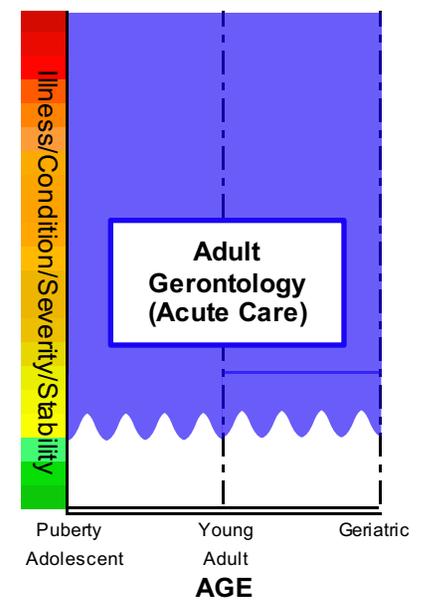
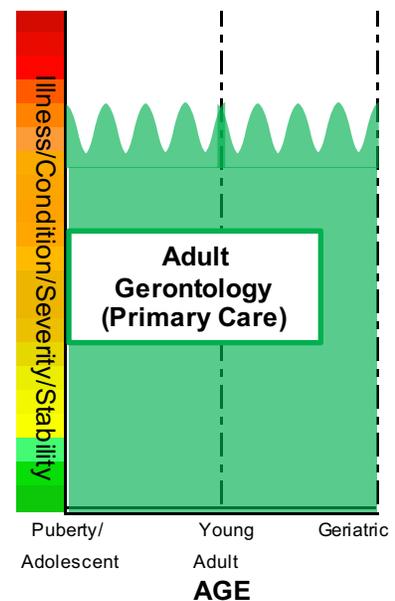
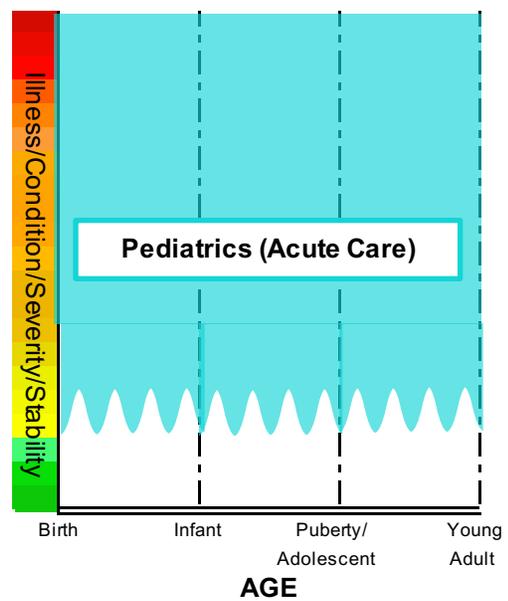
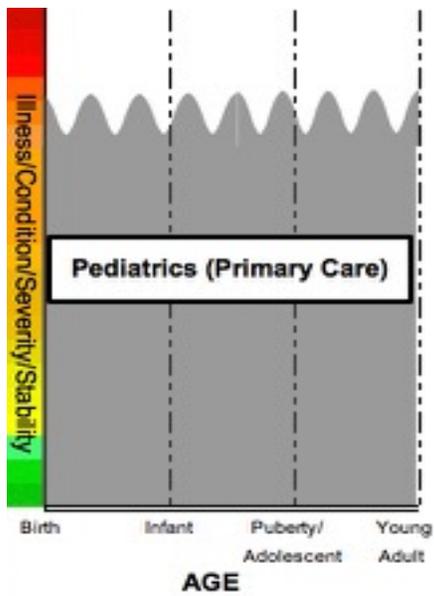
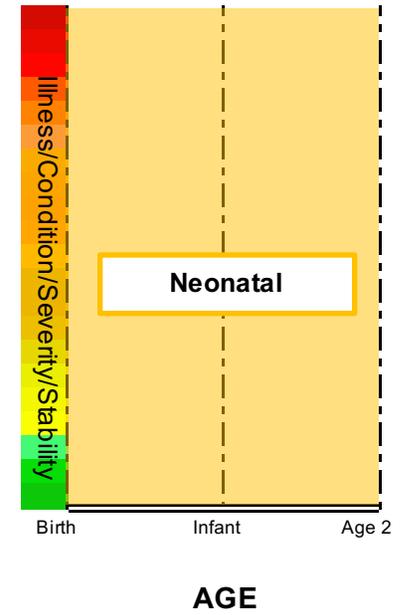
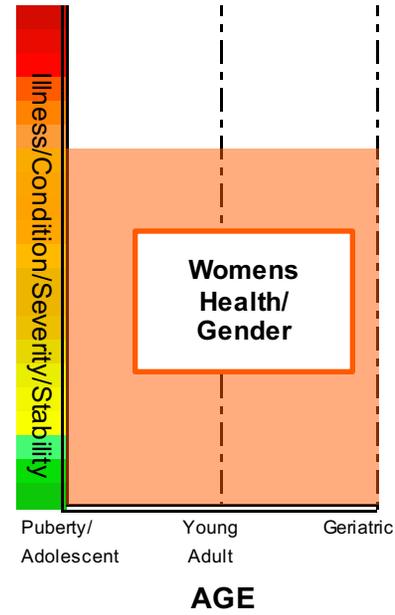
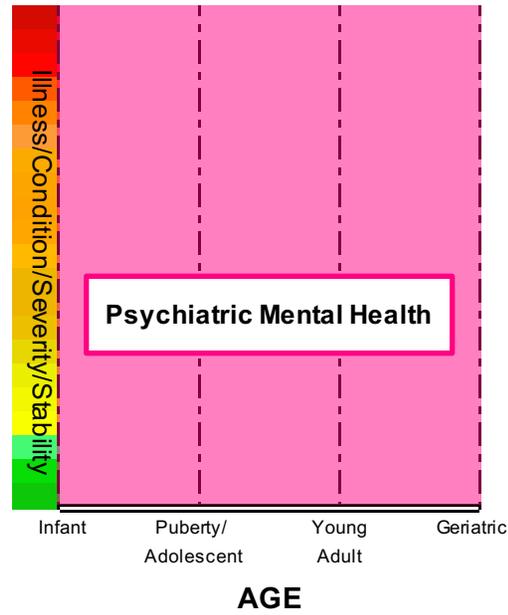
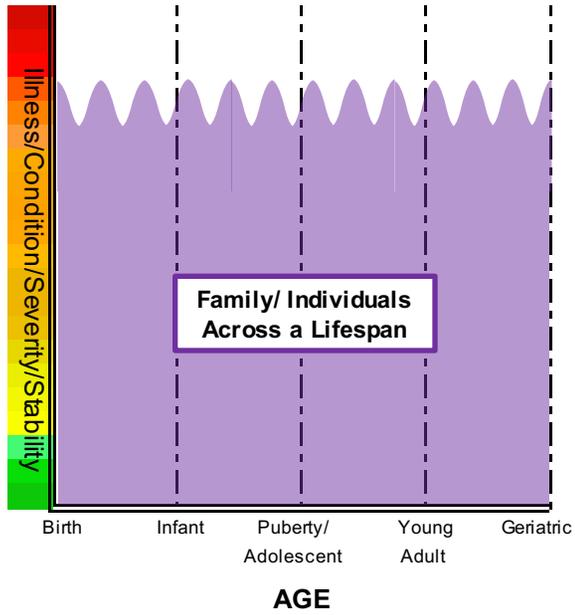
APRN-CNPs should also review the following:

ORC Sections 4723.01; 4723.151(B) and (C), 4723.41; 4723.43; 4723.431, 4723.44, 4723.48, 4723.481, 4723.4810, 4723.481, 4723.488, 4723.489, 4723.492, 4723.50; 4723.51; 4723.52; 4723.99.

OAC Chapters: 4723-4; 4723-8; 4723-9, 4723-13

² Section 4723.46(A)(4), ORC, requires that Board approved national certifying organizations have testing requirements that are developed in accordance with accepted standards of validity and reliability, and are open to registered nurses who have successfully completed the education program required by the organization.

Attachment A: National Certifications



Attachment B: References and Links to Organizations

American Academy of Nurse Practitioners Certification Board. Adult-Gerontology Primary Care Nurse Practitioner Examination Blueprint. Retrieved February 19, 2019 from <https://www.aanpcert.org/certs/agnp>

American Academy of Nurse Practitioners Certification Board. Family Nurse Practitioner Examination Blueprint. Retrieved February 19, 2019 from <https://www.aanpcert.org/certs/fnp>

NCC, 2019 Candidate Guide: Women's Health Nurse Practitioner. Retrieved February 19, 2019 from https://www.nccwebsite.org/content/documents/cms/whnp-candidate_guide.pdf

NCC, 2019 Candidate Guide: Neonatal Nurse Practitioner. Retrieved August 20, 2019 https://www.nccwebsite.org/content/documents/cms/nnp-candidate_guide.pdf

Pediatric Nursing Certification Board; Acute Care Pediatric Nurse Practitioner Certification Exam Detailed Content Outline. Updated September 8, 2016. Retrieved February 19, 2019 from https://www.pncb.org/sites/default/files/2017-02/2014_CPNP-AC_Content_Outline.pdf

Pediatric Nursing Certification Board; Certified Pediatric Nurse Practitioner-Primary Care Exam Detailed Content Outline. Effective September 15, 2018. Retrieved February 19, 2019 from https://www.pncb.org/sites/default/files/resources/2018_CPNP-PC_Exam_Content_Outline_FINAL.pdf

Test Content Outline Family Nurse Practitioner Board Certification Examination. ANCC. Effective Date: February 9, 2016. Retrieved February 19, 2019 from <https://www.nursingworld.org/~4acd24/globalassets/certification/certification-specialty-pages/resources/test-content-outlines/familynp-tco.pdf>

Test Content Outline Psychiatric-Mental Health Nurse Practitioner Board Certification Examination. ANCC. Effective Date December 23, 2015. Retrieved February 19, 2019 from <https://www.nursingworld.org/~4aee2e/globalassets/certification/certification-specialty-pages/resources/test-content-outlines/psychnp-tco.pdf>

Test Content Outline Adult-Gerontology Acute Care Nurse Practitioner Board Certification Examination. ANCC. Effective Date January 25, 2017. Retrieved February 19, 2019 from <https://www.nursingworld.org/~4acca/globalassets/certification/certification-specialty-pages/resources/test-content-outlines/adultgerontologyacutecarenp-tco.pdf>

Test Content Outline Adult-Gerontology Primary Care Nurse Practitioner Board Certification Examination. ANCC. Effective Date December 23, 2015. Retrieved February 19, 2019 from <https://www.nursingworld.org/~4acbba/globalassets/certification/certification-specialty-pages/resources/test-content-outlines/adultgerontologyprimarycare-tco.pdf>



Ohio Board of Nursing

www.nursing.ohio.gov

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

MEMORANDUM

TO: Advisory Committee on Advanced Practice Registered Nursing (APRN Advisory Committee)
FROM: Lisa Emrich, Program Manager
DATE: October 22, 2019
RE: Written Comments for Revised Draft CNP Interpretive Guideline

As of the date of this Memorandum, the Board has received written comments from three APRNs regarding the disseminated Revised Draft CNP Interpretive Guideline. Attached, are comments received from:

- Kevin Letz, APRN-CNP
- Amanda Rumpke, APRN-CNP
- Meredith Foxx, APRN-CNP, APRN-CNS

Subject: FW: Draft IG

Date: Wednesday, October 16, 2019 at 8:42:43 AM Eastern Daylight Time

From: OBN PracticeAPRN

To: Emrich, Lisa

Comment on draft APRN IG.

From: Kevin Letz <drkevinletz@gmail.com>

Date: Tuesday, October 15, 2019 at 5:33 PM

To: OBN PracticeAPRN <practiceaprn@nursing.ohio.gov>

Subject: Draft IG

I have a number of comments related to this document and more so with the chart. Both should assist in clarifying the topic although I do not think this has been met and I believe further complicates. I would opt toward something consistent with the decision model as noted by Balestra. My recommendation would be to start over versus publishing this.

This IG does not mention management of chronic conditions which require treatment across the care continuum regardless of APRN-CNP certification. I would assert that most chronic conditions are complex or become so in the face of an acute condition, in my mind, this is a fact that is true regardless of setting.

This IG does not speak to how much SOP for each certification overlaps which makes the IG less useful in my opinion.

My interpretation of Attachment A leads me to believe acute care prepared APRN-CNPs would be practicing outside their SOP when treating medically stable patients. Would this preclude the acute prepared APRN-CNP's discharge of a hospitalized patient in the hospitalist role? Additionally, the FNP should be allowed to function as a hospitalist and transfer care at which point a patient becomes unstable or critical.

From a credentialing perspective, Attachment A effectively requires every hospital-based APRN-CNP to have dual certification in primary care and acute care. Not only is this not realistic, this is not necessary based on mountains of evidence. The included articles articulate that care should be related to patient need rather than setting, unfortunately Attachment A effectively makes this argument setting specific.

Under D: National Certification, not all APRN subtypes are listed. Specifically those that have certification with all tests which have been retired i.e.: Adult Acute Care, Geriatrics, Adult Primary Care and Pediatric Primary Care by ANCC etc. but may be retained thus should be grandfathered.

My background is that of an NP, former Dean, Professor and institutional leader in advanced practice providing leadership to over 1000 NPs.

Thanks for your consideration,

Kevin Letz

DNP, MBA, APRN, CNE, CEN, FNP-C, ANP-BC, PCPNP-BC, FAANP

Subject: FW: Draft IG comments

Date: Monday, October 14, 2019 at 2:24:21 PM Eastern Daylight Time

From: OBN PracticeAPRN

To: Emrich, Lisa

Comments on draft APRN IG.

From: "Rumpke, Amanda" <AXRumpke@mercy.com>

Date: Monday, October 14, 2019 at 1:50 PM

To: OBN PracticeAPRN <practiceaprn@nursing.ohio.gov>

Subject: Draft IG comments

Esteemed members of the APRN Advisory Committee,

As an APRN practicing in the state of Ohio and a member of, and an advisor for, credentialing committees for our ministry, I have included some of my own comments on the recently proposed APRN Scope of Practice IG. I appreciate both the opportunity to weigh in with my thoughts as well as your consideration of my concerns.

1. The first article included by Ms. Balestra writes that additional coursework is invaluable to better understand complex conditions. Under paragraph labeled "B" where it discusses defined practice related to APRN-CNP's education, education is not defined. I believe this to be the essential root of the argument and should be spelled out to include APRN educational programs, formally organized educational experience and return demonstrations and/or skills check-off as is specified in the existing OBON decision-making model. As a result, it may make more sense to simply modify the existing decision-making guideline to be more consistent with the decision-making model used by Oregon (as referenced by Balestra) instead of creating an entirely new IG.
2. This IG does not mention management of chronic conditions which require treatment across the care continuum regardless of APRN-CNP certification. I would assert that most chronic conditions are complex or become so in the face of an acute condition, in my mind, this is a fact that is true regardless of setting.
3. This IG does not speak to how much SOP for each certification overlaps which makes the IG less useful in my opinion.
4. The OBON white paper published in the Fall 2016 issue of Momentum emphasizes that only acute care prepared APRN-CNPs should function in the role of hospitalist however my interpretation of Attachment A leads me to believe acute care prepared APRN-CNPs would be practicing outside their SOP when treating medically stable patients. Would this preclude the acute prepared APRN-CNP's discharge of a hospitalized patient in the hospitalist role? From a credentialing perspective, Attachment A effectively requires every hospital-based APRN-CNP to have dual certification in primary care and acute care. Not only is this not realistic, this is not necessary based on mountains of evidence. The included articles articulate that care should be related to patient need rather than setting, unfortunately Attachment A effectively makes this argument setting specific.
5. The included article by Mr. Miller asserts that "The..AC/ACNP could take on the role of the AGPCNP in the primary care setting, but the AGPCNP could not take on the role of the AG/ACNP in the hospital setting". First, this statement is confusing to me but more over it is a statement that certainly is not supported by Attachment A.
6. Under D: National Certification, not all APRN subtypes are listed. Specifically those that have certificated with a now retired test i.e.: Adult Acute Care, Geriatrics etc. This IG also does not discuss those APRN-CNPs which have been grandfathered in.

Amanda Rumpke MSN APRN-CNP

BSMH System Director Advanced Practice & Continuum of Care
1701 Mercy Health Place
Cincinnati, Ohio 45237
N3097
Cell: 513-829-3624
Office: 513-952-4856

CONFIDENTIALITY NOTICE: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Subject: FW: Draft IG
Date: Thursday, October 10, 2019 at 2:55:49 PM Eastern Daylight Time
From: OBN PracticeAPRN
To: Emrich, Lisa
Attachments: image001.jpg

From: "Foxx, Meredith" <FOXXM@ccf.org>
Date: Thursday, October 10, 2019 at 2:37 PM
To: OBN PracticeAPRN <practiceaprn@nursing.ohio.gov>
Subject: Draft IG

Thank you for taking my comments into consideration on the CNP Interpretive Guideline. As an APRN in Ohio, and a leader of APRNs I am appreciative of being able to share some of my thoughts in regards to this interpretive guideline.

1. I am still not clear on "Attachment" A, with regards to the 'waved lines without a lined border' and how CNPs will interpret this attachment. Is it truly meant to be a guide?
2. A. 2. Why would this document not refer to the list of national certifying bodies already recognized by the OBN, and refer to the NP ones?
http://www.nursing.ohio.gov/PDFS/AdvPractice/APRN_Bd_Approv_Nat_Cert_Orgs.pdf I feel like this is a risk, since a list already exists.
3. 3. b. this wording continues to be confusing, (the 2nd part) I believe I am interpreting it to be that a psychiatric-mental health NP can enter into a SCA with a physician who is psychiatry, peds, primary care or family. IT is the wording that is confusing, could this be more explicit?
4. B. should "education" reflect formal graduate education (when applicable) what about clinical training, that is described elsewhere and is vital to this document, where is chronic care? Care of patients with chronic conditions, I feel like this is a big miss.
5. C. what about "grandfathered" CNPs still practicing in Ohio?
6. D. again, why wouldn't we use the existing document of certifying bodies:
http://www.nursing.ohio.gov/PDFS/AdvPractice/APRN_Bd_Approv_Nat_Cert_Orgs.pdf

Thank you for taking my comments under advisement.

Meredith Foxx



Meredith Foxx, MSN, MBA, APRN, PCNS-BC, PPCNP-BC, CPON | ACNO Advanced Practice Nursing/Nursing Quality & Practice | Nursing Institute | Cleveland *This*
Clinic | 5001 Rockside Road 8th Floor IN8-108. | Independence, OH 44131
| (216) 986-4863 or (216) 704-6719 foxxm@ccf.org

document may contain confidential, privileged information protected by the Quality Assurance, Peer Review and Risk Management Report privileges as outlined in Ohio revised code 2305.24, 2305.25, 2305.252, 2305.253 and 2317.02, and has declared in Ware v. Miami Valley Hospital (Montgomery, 1992)

Please consider the environment before printing this e-mail

Cleveland Clinic is currently ranked as one of the nation's top hospitals by *U.S. News & World Report* (2019-2020). Visit us online at <http://www.clevelandclinic.org> for a complete listing of our services, staff and locations. Confidentiality Note: This message is intended for use only by the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under

applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please contact the sender immediately and destroy the material in its entirety, whether electronic or hard copy. Thank you.



Ohio Board of Nursing

www.nursing.ohio.gov

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

MEMORANDUM

TO: Members of the Advisory Committee on Advanced Practice Registered Nursing
FROM: Lisa Emrich, Program Manager
DATE: October 23, 2019
RE: Additional Comment on Draft Revised Interpretive Guideline

Attached, please find a comment submitted by the Ohio Association of Advanced Practice Registered Nurses receive by the Board October 22, 2019.



LISTEN. SOLVE. EMPOWER.

P: 330.253.5060 F: 330.253.1977 W: bmdllc.com
75 East Market Street, Akron, Ohio 44308

Jeana M. Singleton
Partner
P: 330-253-2001
F: 330-253-2012
E: jmsingleton@bmdllc.com

October 16, 2019

VIA ELECTRONIC MAIL ONLY TO PracticeAPRN@nursing.ohio.gov

The Ohio Board of Nursing
17 S. High Street #660
Columbus, Ohio 43215

RE: Comments to the Proposed Interpretive Guideline Entitled "APRN-CNP Licensure, National Certification and Patient Management"

To Whom It May Concern:

Our firm serves as general counsel for the Ohio Association of Advanced Practice Nurses ("OAAPN"). OAAPN is a trade organization representing the interests of Advanced Practice Registered Nurses ("APRNs") across the State of Ohio. Thank you for the opportunity to provide comments on behalf of OAAPN regarding the revised Draft Interpretive Guideline entitled "APRN-CNP Licensure, National Certification and Patient Management" that was provided on or around September 19, 2019 ("Proposed Guideline").

At the outset, there are several basic premises that should be considered. First, given the fact that the debate on the topics underlying the Proposed Guideline has been occurring for years in Ohio, it is important to remember that there is still no evidence of patient endangerment or issues with APRNs systematically practicing in an unsafe manner without the Proposed Guideline. There is no evidence-based reason to require a APRN-CNP to be pigeonholed by a specialty certification. Ohio law requires a national certification, but that is not the same as requiring a specialty certification in a certain area to practice in that area. No other healthcare provider in Ohio (i.e. physicians, dentists, etc.) is required by their respective licensure boards to hold a specialty certification in order to practice in a given specialty.

The "practice of nursing as an advanced practice registered nurse" means providing care that "requires knowledge and skill obtained from advanced formal education, training and clinical experience." O.A.C. 4723-8-01(F). As such, we urge the APRN Advisory Committee

("Committee") and Ohio Board of Nursing ("Board") to remember this full definition. The current Proposed Guideline seems to minimize the relevance of "clinical experience" and focus primarily on formal education.

Second, if the APRN Advisory Committee ("Committee") and Ohio Board of Nursing ("Board") insist on moving forward with the Proposed Guideline, then it should be drafted in a way that applies to all APRNs, not just the APRN-CNP licensee. For example, clinical nurse specialists practice very similarly to certified nurse practitioners. Additionally, all APRN licensees are able to specialize and sub-specialize in a variety of ways. APRN practice specialties will continue to evolve and be added as new technology and treatments become available for patients on an on-going basis.

Third, we respectfully suggest deleting the Exhibit A graphs. It is not possible to capture every practice circumstance on the proposed Exhibit A graphs and to attempt such a feat may unintentionally limit an APRN's scope of practice in a patient care scenario that the individual is trained and qualified to treat. For example, the graphs do not account for children who may require gynecological exams or primary care house calls for a patient with a chronic condition. Furthermore, the graphs actually create legal liability for APRNs by creating a document that could be used in court against an APRN even though the APRN may have acted in a reasonably, prudent manner under the specific circumstances at hand.

Fourth, it is important to focus on the concept of current competence. While an APRN may hold a certain type of certification, it is possible that the APRN is not currently competent to perform certain procedures if the APRN has not maintained or obtained skills in a certain area. An APRN's certification only evidences testing in a limited body of knowledge that existed at the time of the certification exam. A certification does not account for new procedures, new skills, or new drugs that did not exist at the time of the exam. It also does not account for the APRNs ability to gain valuable experience and learn new skills after the certification exam. Like other healthcare professionals, APRN practice in Ohio is constantly evolving. Additionally, there are a number of safeguards already in place that ensure patient safety with regards to an APRN's current competence, namely the hospital credentialing process that happens on a regular cycle and the threat of malpractice litigation.

In order to address the basic premises previously discussed, OAAPN has created a revised version of the Proposed Guideline. OAAPN's revision would apply equally to all APRN licensees, regardless of role. It also allows for flexibility to account for unknown circumstances, evolutions in APRN practice, and current competence. OAAPN's revision is attached hereto as Exhibit A. This revision is based on a guideline implemented by the State of Oregon, as well as a scope of practice decision-making framework adopted by the National Council for State Boards of Nursing. See <https://osbn.oregon.gov/OSBNScopeTree/Default.aspx> and https://cdn.ymaws.com/www.oregonrn.org/resource/collection/717D7DC6-BD4F-4485-89BB-1C37DF019204/102_HANDOUT_scope_tree.pdf. See also, <https://www.ncsbn.org/decision-making-framework.htm>.

OAAPN respectfully requests that the Committee and Board adopt its revised version of the Proposed Guideline in lieu of the current Proposed Guideline draft. A simpler, more flexible interpretive guideline would provide all parties comfort regarding the Board's interpretation of an APRN's scope of practice, facilitate uninterrupted patient care which also protects patient safety, and promote patient access to care without superficial barriers. OAAPN also reiterates its offer to work collaboratively with the Board and Committee on this matter. If OAAPN can be of help in any way, please don't hesitate to ask.

Sincerely,



Jeana M. Singleton

CC: Joscelyn Greaves, APRN-CNP, OAAPN President

EXHIBIT A

Interpretive Guideline

Title: APRN Scope of Practice Decision Making Guidelines

This Interpretive Guideline is provided as guidance to Advanced Practice Registered Nurses (“APRNs”) seeking to determine whether or not a specific role, procedure or activity is within their scope of practice under Ohio law and administrative rules. Ohio’s Nurse Practice Act does not contain comprehensive lists of every health-related designation, procedures and activities that may be performed based on one’s nursing licensure/competency level.

Background:

Section 4723.43(C) of the Ohio Revised Code (ORC), defines the scope of practice for APRNs. Chapters 4723-4, 4723-8, and 4723-9 of the Ohio Administrative Code (OAC) hold APRNs responsible for practicing in accordance with their education and clinical experience, national certification, the Nurse Practice Act (Chapters 4723., ORC) and rules adopted under the Nurse Practice Act.

In this Interpretive Guideline, the Board does not announce new policy but instead gives APRNs specific instructions regarding their obligations under existing law and rules.

Board Statement:

Individual scope of practice is an APRN licensee’s demonstrated knowledge, skills, abilities, and competencies that have been developed and maintained through clinical experience and through engagement in independent and formal education experiences. The practice of advanced practice nursing occurs across a continuum of care environments and is actively responsive to the expansion of an APRN’s skillset and scientific knowledge. The practice of an APRN is also responsive to advancements in technologies; enactment of or changes to federal and state laws; changing client demographics; and multiple other factors. It is the responsibility of each licensed APRN to attain and maintain the knowledge, technical skill, ability, ethical principle, and clinical reasoning necessary for safe practice in their care environment.

Application of the Board’s decision-making guidelines will assist the APRN licensee to determine whether or not a specific practice designation, intervention, or activity is within the scope of practice for the licensee’s level of licensure, appropriate to occur in the care environment, and commensurate with the licensee’s individual scope of practice.

Scope of Practice Decision Making Guidelines for all Advanced Practice Registered Nurse

First Ask: Is the role, intervention or activity prohibited by Ohio Revised Code or the Ohio Administrative Code? If Yes, do not proceed.

Is the designation, intervention or activity consistent with professional nursing standards, evidenced-based nursing and health care literature?

No → STOP

YES ↓

Are there practice setting policies and procedures in place to support performing the designation, intervention or activity?

No → STOP

YES ↓

Has the APRN completed the necessary education or training to safely perform the designation, intervention or activity?

No → STOP

YES ↓

Is there documented evidence of the APRN's current competence (knowledge, skills, abilities, and judgments) to safely perform the designation, intervention and activity?

No → STOP

YES ↓

Would a reasonable and prudent APRN perform the designation, intervention or activity in this setting?

No → STOP

YES ↓

Is the APRN prepared to accept accountability for the designation, intervention or activity for the related outcomes?

No → STOP

YES ↓

If the APRN answers "Yes" to all of the above questions, then the APRN may perform the role, intervention or activity to acceptable and prevailing standards of safe nursing care.

4833-7262-6345, v. 1



Contents lists available at ScienceDirect

The Journal for Nurse Practitioners

journal homepage: www.npjjournal.org

Family Nurse Practitioner Scope of Practice Issues When Treating Patients With Mental Health Issues

Melanie L. Balestra, JD, NP



ABSTRACT

Keywords:

best practices
civil and disciplinary actions
family nurse practitioners
licensing issues
primary care mental health
scope of practice

In primary care settings, family nurse practitioners (FNPs) are often the first to see patients with mental illnesses. FNPs can diagnose and treat patients with uncomplicated mental illness, such as depression and anxiety, within their scope of practice (SOP). However, FNPs should be aware of areas that fall outside of their SOP, such as diagnosing and treating patients with complicated or severe mental illnesses or exceeding prescribing authority for psychiatric medications. Any breach of their SOP could lead to civil liability and disciplinary actions. FNPs should adopt best practices to ensure patient safety and protect their licenses.

© 2019 Elsevier Inc. All rights reserved.

American Association of Nurse Practitioners (AANP) members may receive 1.0 continuing education contact hours, including 0.25 pharmacology credit, approved by AANP, by reading this article and completing the online posttest and evaluation at aanp.inreachce.com.

Introduction

Scope of practice (SOP) is a cornerstone for professional regulation used by nurse practitioner (NP) licensing boards across the country, usually a state's Board of Nursing (BON). This concept defines the procedures, actions, and processes that NPs can perform as part of their professional licensure.¹ Regulations are handled by each state and can vary from state to state.²

By definition, the SOP for family NPs (FNPs) is broad, with FNPs caring for a wide spectrum of patients (from pediatrics to geriatrics) and domains (private practices to hospital clinics and other outpatient settings, both urban and rural).² In some rural or remote settings, FNPs may be the only health care provider available to patients.²

The SOP for FNPs could include providing mental health care services, and FNPs in primary care settings often are the first to see patients with common mental illnesses, such as depression and anxiety.³ In fact, FNPs are increasingly providing mental health care as demand from patients has increased. According to the National Institute of Mental Health, nearly 1 in 5 adults in the United States suffers from a mental illness (44.7 million in 2016).⁴ Among adolescents, an estimated 49.5% of young people aged 13 to 18 have had a mental disorder.⁴

Among mental illnesses, major depression is common, with approximately 16.2 million adults (6.7% of all US adults) having had at least 1 major depressive episode.⁵ Anxiety disorders also greatly affect US adults, with more than 31% having had an anxiety disorder sometime in their lives.⁶ Furthermore, this increase in patient demand has been exacerbated in recent years by a growing shortage of mental health care practitioners, including psychiatrists, whose numbers declined by 10% from 2003 to 2013.⁷

Although a legal or regulatory concept, the importance of SOP cannot be overstated. FNPs need to be familiar with their state's SOP to ensure patient safety as well as to protect their professional license, because acting outside of their recognized SOP in any patient care setting could expose them to civil liability and disciplinary actions brought by their BON, with the potential of having their professional licenses revoked.⁸ This is especially true when treating patients with mental illness or working with behavioral health issues, where an FNP may be trained and have the skills to diagnosis and initially treat mental illness but may be restricted by his or her SOP on the breadth and depth of care permitted.³

With that in mind, this article will outline several important SOP issues for FNPs working with patients with mental health issues and provide recommendations to help them ensure best practices and patient safety. The recommendations also will help them avoid blurring the boundaries delineated by their SOPs and protect their professional licenses.

FNP SOP Issues With Behavioral Health Care

Patients with mental illnesses, such as depression, anxiety, and attention-deficit/hyperactivity disorder, are often initially treated

by primary care providers such as FNPs.³ FNPs are well positioned to provide mental health care, going beyond mental health screening to initial intervention, which dovetails with the FNP philosophy of patient-centered care.⁹ However, FNP education covers only some aspects of mental health care and does not sufficiently prepare FNPs to treat patients with complex mental illnesses compared with psychiatric mental health NPs or other behavioral health specialists. FNPs should be aware of potential scenarios where the care they provide could breach their SOP. Below are some key examples of possible violations:

- Failure to monitor patient outcomes and refer patients to a psychiatric mental health NP, psychologist, or psychiatrist if symptoms have not improved, the patient is getting worse (acute decompensation) or is noncompliant, or the FNP disregards family members who have raised concerns about a patient.³
- Failure to refer patients with *common* mental illness, such as depression, when specifically required by a state's SOP.³
- Failure to refer patients with *complicated or severe* (complex) mental illnesses, such as personality disorders, or if a specialist is needed based on the level of care or emergent conditions that prompt a referral/psychiatric consultation.³
- Exceeding prescribing authority for psychopharmacotherapy (in states where FNPs are authorized to prescribe/furnish such medications) or psychotherapy.³
- Failure to focus only on direct medical problems, such as blood pressure or diabetes, when treating patients with substance misuse diagnoses.

Any of these scenarios could lead to an allegation of a breach in SOP and a complaint to a state BON, which in turn would trigger an investigation and potential disciplinary action. A BON investigation has serious implications for any FNP, who would require legal assistance (and the associated costs of hiring an attorney) and could face the possibility of losing his or her professional license.¹⁰

A look at closed/paid claims in connection with legal assistance provided to protect NPs licenses provides FNPs with valuable information about high-risk areas, including breaches in SOP. According to a 2017 closed claims data analysis compiled by Nurses Service Organization (available on its website), SOP claims have increased significantly, with total claims more than doubling from 9% in 2012 to 22.1% in 2017, with an average payment in 2017 of \$6,687.¹⁰ Within SOP allegations, allegations of “practice violates SOP and standards of care” were the most frequent (60.3%), with defense costs averaging \$7,030.¹⁰

Considerations When Integrating Mental Health Care Into Practice

FNPs should consider the following recommendations to help them determine whether they are practicing within their SOP when treating patients with mental illness and to protect themselves from civil liability and BON disciplinary/license issues. FNPs should:

- Thoroughly know their state's SOP for FNPs and conduct an annual review of their SOP to stay current of any changes.¹⁰ FNPs also should consider using tools such as a decision tree to determine whether they are practicing within the legal SOP. One example is the Scope of Practice Decision Making Guidelines for All Licensed Nurses from the State of Oregon.¹¹ Another example is the Kentucky Board of Nursing Scope of Practice Decision-Making Model for advanced practice registered nurses.¹² FNPs also are encouraged to study national organization standards of

practice and stay abreast of FNP literature and research, especially about integrating behavioral health care into primary care.

- Be rigorous and very specific in their assessment of patients with mental health complaints. They also should document all details such as the patient's assessment, treatment plan, and compliance with follow-up appointments.
- Use psychiatric assessment tools/questions, such as the Beck Depression Inventory-II,¹³ a widely used indicator of the severity of depression in adults, and mental health guide handouts available from the National Association of Pediatric Nurse Practitioners that are tailored by age and provide information on prevention, screening, intervention, and management of common mental health disorders.¹⁴
- Be aware of their prescribing authority in connection with psychopharmacotherapy.³
- Collaborate/refer with psychiatric health care professionals to expand care (ie, psychotherapy or psychopharmacologic therapy) when needed. Appropriate psychiatric consultations are a key part of helping FNPs stay within their SOP when treating patients with mental health issues. It is important to note that after the initial point of contact and diagnosis of the patient, followed by referral or psychiatric consultation, patient management and overseeing coordinated patient care may remain under the control of the FNP as the primary care provider.
- Be aware that charges of patient abandonment may be more likely to occur when treating a patient with depression. If a patient fails to make follow-up appointments, calls in for medication refills, etc, and the FNP feels that the patient would benefit from obtaining care from another primary care provider, the FNP must provide adequate notice so that the patient can locate another health care provider to avoid claims of patient abandonment. Alternately, if the patient is getting worse, the FNP should initiate a referral for a psychiatric consultation.
- Follow the FNP SOP when treating patients with substance misuse disorder, such as treating for blood pressure, diabetes, etc, but be aware that treatment of the addiction would be beyond the FNP SOP. Federal statute prevents NPs from prescribing some drugs for the treatment of opioid addiction and also limits the role of FNPs in serving as addiction treatment providers.¹⁵
- Use caution when prescribing alternative care. FNPs must ensure that they have a thorough understanding about the alternative care they are prescribing and monitor the patient when this care is added.
- Take additional coursework. Core mental health is covered in FNP curricula and certification requirements, but additional coursework is invaluable. FNPs can benefit greatly from in-depth workshops or continuing education courses on depression and anxiety so that they can determine when these diagnoses may be progressing or becoming so severe that patient care is no longer within their SOP and requires a referral (ie, common depression to severe depression or anxiety to panic attacks).
- FNPs should not treat any kind of *severe or complex* mental illness, such as schizophrenia, bipolar disorder, or personality disorder. These patients should be referred to a psychiatric consultation (physician or psychiatric mental health NP).
- Complete the studies and obtain the appropriate certification as a psychiatric mental health NP if they want their professional focus to be in mental health care.

BON and Disciplinary Actions in Connection With SOP Violations With Patients with Mental Health Issues

FNPs who perform patient care outside of their SOP put their licenses at risk. Any task performed outside of the FNP's SOP,

including mental health care, is grounds for disciplinary action by his or her state BON. Complaints could come from patients and family members of patients if they are unhappy with the way the patient is being treated, and the BON could charge that the FNP was practicing psychiatry.

The result of these actions could range from probation and suspension (with or without fines) to license revocation. In addition, SOP breaches could lead to more serious civil issues, such as claims of malpractice, because these types of actions usually occur after a patient undergoes some sort of severity (ie, suicide, admission to a psychiatric hospital).

The following case scenarios describe litigation or disciplinary actions, or both, taken by BON for charges of practicing beyond the SOP in connection with patients with mental health issues, the defense presented, and final outcome/sanctions ordered by the BON. Importantly, risk control recommendations also are included and could be used by FNPs seeking to improve and enhance their everyday practice strategies and risk management procedures when treating patients with mental health issues.

CASE SCENARIO: Pediatric Patient With Psychiatric Comorbidities

An FNP began seeing a female patient as an infant. The patient was easily upset, would cry, and was difficult to comfort. The patient continued to be upset and was emotionally withdrawn as she got older. She could be a very loving child but would scream when her mother left the room. In her early teens, the patient became increasingly sullen and angry. She would indulge in impulsive behaviors, such as having sex with a young man she barely knew. The patient had only a few friends and found it difficult to make new friends. At times, the patient seemed terrified without her mother. The patient started cutting behavior and experiencing panic attacks. The FNP treated the patient with antidepressants and quetiapine fumarate at age 16. The patient committed suicide at age 18 by overdosing herself on quetiapine fumarate.

A malpractice lawsuit was filed, alleging that the FNP had been practicing outside her SOP and should have referred the patient to a psychiatrist or psychiatric mental health NP early in the patient's life. An expert witness supported the plaintiff's claim. The lawsuit was settled on behalf of the plaintiff and was then reported to the BON. After an investigation, the BON placed the FNP on probation for practicing outside of her SOP. Risk control recommendations:

- Have parents keep a diary of a child's behavior when monitoring for mental illness.
- Continue to assess the child with psychological testing.
- Counsel parents if it is determined that the child's behavior is not normal.
- Refer the patient to a psychiatrist or psychologist for evaluation and treatment.
- Check with parents to ensure that referral recommendation has been followed.

CASE SCENARIO: Adult Patient With Pain and Depression

An adult mother of 3 children visited an FNP complaining that she had no energy and was having trouble getting out of bed in the morning. The patient also stated that she suffered from migraines and joint pain. After a physical examination of the patient, followed by much discussion, the FNP diagnosed the patient with depression and prescribed alprazolam for depression and hydrocodone bitartrate and acetaminophen (Norco; Allergan, Dublin, Ireland) for pain. The patient continued to call in for refills but did not show up for

appointments. When she did return, she stated that her pain had increased and she needed more hydrocodone bitartrate and acetaminophen. The FNP increased the dosage of hydrocodone bitartrate and acetaminophen. This pattern went on for several years. The patient eventually attempted suicide, and her husband reported the FNP to the BON, complaining that the FNP's inappropriate treatment of his wife caused her suicide attempt. After an investigation, the BON found that the FNP attempted pain and psychiatric management of a patient that was outside of her SOP. The BON also found that she failed to explore other treatment modalities and continued to prescribe a drug with an addictive nature. The BON placed the FNP on probation for practicing outside of her SOP. The BON determined that the FNP should have referred the patient to a psychiatrist, psychologist, or pain management specialist when the FNP realized that treatment was not adequately helping the patient. Risk control recommendations:

- Use a validated and reliable assessment tool that could help improve the diagnosis and management/treatment assessment of depression in the primary care setting. One example is the Patient Health Questionnaire-9, which is available for adults and adolescents and also is available in Spanish.¹⁶
- Use methods other than medication for pain control.
- Refer the patient to a mental health specialist or pain management specialist, or both, when treatment modalities are not working.

CASE SCENARIO: Adult Patient in an Addiction Facility

An adult man was admitted to a treatment facility with a diagnosis of an addiction to heroin. The patient had been in and out of several addiction facilities without success. An FNP was assigned to treat the patient medically for diagnoses of alcoholism and bulimia. The FNP ordered laboratory tests, and the results supported the bulimia diagnosis. A meeting was held at the facility to discuss transferring the patient to a higher level of care. Before the transfer occurred, the patient "collapsed with a seizure" and cardiopulmonary resuscitation was performed, but the patient died. The emergency department admission record stated that the patient was being treated by a physician (naming the FNP) and was being treated at the addiction facility for an eating disorder. However, there was no documented medical treatment for bulimia while the patient was at the addiction facility under the FNP's care. The facility's license was revoked. The BON found that the FNP was practicing outside her SOP, which constituted an extreme departure from the standard of care and that the patient should have been transferred to an acute care hospital. Further, the BON found that the FNP should never have accepted treatment of the patient. The FNP's license was revoked. Risk control recommendations:

- When caring for patients with a substance misuse disorder, treat only direct medical problems within the FNP SOP, such as high blood pressure, infection, or diabetes; do not treat the addiction.
- Take a thorough history upon initial patient assessment to determine whether there are any signs or symptoms of an eating disorder, such as predisposition for perfectionism or compulsivity or mood intolerance and impulsivity along with addiction behavior.
- Order appropriate laboratory tests and report any abnormalities to a psychiatrist.
- Refer the patient for in-hospital treatment immediately if test results are extremely abnormal.

Medical Malpractice and Disciplinary Insurance

The importance of buying individual professional liability insurance cannot be overemphasized.¹⁷ This topic has been previously covered in the professional literature and at conferences and remains relevant today; in fact, it is essential. Any FNP providing patient care needs to ensure that he or she carries his or her own professional liability coverage that goes beyond employer-provided coverage. This insurance should provide for malpractice coverage as well as for legal defense of licensing and disciplinary actions. It also is important that this insurance allows the FNP to select his or her own attorney—someone who is familiar with FNPs, SOP issues, and licensing boards. The ability to select his or her own attorney is critical if the action could negatively affect the FNP's professional license and prevent him or her from seeing patients.

Conclusion

The prevalence of mental illness is increasing in the US, while at the same time there is a decrease in psychiatric providers. The result is that FNPs are going to see a variety of patients with mental health care needs. As such, FNPs need to be familiar with their state's SOP when providing behavioral health services, including prescribing limits and when referrals to specialists are needed. They also should use best practices to help protect their licenses and avoid any disciplinary action by their BON. Finally, if an FNP finds that he or she has a passion for this care area, he or she should consider getting a psychiatric mental health NP certification—an excellent combination for an FNP committed to providing mental health services in a primary care setting.

References

1. American Association of Nurse Practitioners. Scope of Practice. <https://www.aanp.org/images/documents/publications/scopeofpractice.pdf>. Updated 2015. Accessed August 15, 2018.
2. Nurse Journal. Role & Scope of Practice of a Family Nurse Practitioner. <https://nursejournal.org/family-practice/role-scope-of-practice-of-a-family-nurse-practitioner/>. Accessed August 15, 2018.
3. Parrish E, Staten R. Scope of Practice: The Similarities and Differences of Family Nurse Practitioner and Psychiatric Mental Health Nurse Practitioner Practice. *KBN Connection*. 2017;51:24-25. http://epubs.democratprinting.com/publication/?i=411466&article_id=2794182&view=articleBrowser&ver=html5-%22issue_id%22:%22411466%22,%22view%22:%22articleBrowser%22,%22article_id%22:%222794182%22. Accessed August 14, 2018.
4. National Institutes of Health. National Institute of Mental Health. Mental Illness. <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. Updated November 2017. Accessed August 27, 2018.
5. National Institutes of Health. National Institute of Mental Health. Major Depression. <https://www.nimh.nih.gov/health/statistics/major-depression.shtml>. Updated November 2017. Accessed August 27, 2018.
6. National Institutes of Health. National Institute of Mental Health. Any Anxiety Disorder. <https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder.shtml>. Updated November 2017. Accessed August 27, 2018.
7. National Council for Behavioral Health. National Council Medical Director Institute. The Psychiatric Shortage: Causes and Solutions. <https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage-National-Council-.pdf>. Published March 28, 2017. Accessed August 27, 2018.
8. National Council of State Boards of Nursing. What You Need to Know About Nursing Licensure and Boards of Nursing. <https://www.ncsbn.org/Nursing-Licensure.pdf>. Published June 2015. Accessed August 28, 2018.
9. Theophilos T, Green R, Cashin A. Nurse practitioner mental health care in the primary context: a Californian case study. *Healthcare (Basel)*. 2015;3(1):162-171. <https://doi.org/10.3390/healthcare3010162>.
10. CNA and Nurses Service Organization (NSO). Nurse Practitioner Claim Report: 4th Edition. A Guide to Identifying and Addressing Professional Liability Exposures. https://aonaffinity.blob.core.windows.net/affinitytemplate-prod/media/nso/images/documents/cna_cls_np_101917_cf_prod_sec.pdf. Published October 2017. Accessed May 25, 2018.
11. Oregon State Board of Nursing Interpretive Statement. Scope of Practice Decision Making Guidelines for All Licensed Nurses. https://www.oregon.gov/OSBN/pdfs/InterpretiveStatements/scope_decision_tree.pdf. Revised March 12, 2018. Accessed August 16, 2018.
12. Kentucky Board of Nursing. Nursing Practice. Scope of Practice Determination Guidelines. APRN Scope of Practice Decision Making Model. <https://kbn.ky.gov/practice/Documents/APRN%20Scope%20of%20Practice%20Decision%20Making%20Model.pdf>. Accessed August 25, 2018.
13. American Psychological Association. Beck Depression Inventory (BDI). Construct: Depressive Symptoms. <https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression.aspx>. Accessed November 6, 2018.
14. National Association of Pediatric Nurse Practitioners. Mental Health Guide Handouts. A Practical Guide to Child and Adolescent Mental Health Screening, Early Intervention, and Health Promotion, Second Edition. NAPNAP Handouts and Questionnaires. <https://www.napnap.org/ProgramsAndInitiatives/MentalHealth/MentalHealthGuide/MentalHealthGuideHandouts.aspx>. Accessed August 16, 2018.
15. Office of the Assistant Secretary for Planning and Evaluation (ASPE). Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners. Final Report. https://aspe.hhs.gov/system/files/pdf/167396/NP_SOP.pdf. Published November 16, 2015. Accessed August 31, 2018.
16. Substance Abuse and Mental Health Services Administration. *Patient Health Questionnaire*; PHQ-9 October 4, 2005. <https://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>. Accessed August 29, 2018.
17. Indest GF 3rd, Harr JL. Malpractice Insurance for Nurses. Why Nurses Should Buy Malpractice Insurance. <https://www.thehealthlawfirm.com/resources/health-law-articles-and-documents/malpractice-insurance-for-nurses.html>. Accessed August 16, 2018.

Melanie L. Balestra, JD, NP, works at the Laguna Beach Community Clinic and as an attorney at the Law Offices of Melanie L. Balestra, Irvine, CA. She is available at balestrahealthlaw@gmail.com.

In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.



Contents lists available at ScienceDirect

The Journal for Nurse Practitioners

journal homepage: www.npjjournal.org

Setting or Patient Care Needs: Which Defines Advanced Practice Registered Nurse Scope of Practice?

Kenneth Miller, PhD, C-FNP



ABSTRACT

Keywords:
adult gerontology/acute care nurse practitioner
family nurse practitioner
litigation
scope of practice
standards of practice

The purpose of this article is to provide insight into the roles and population focus of both the family nurse practitioner and the adult gerontology/acute care nurse practitioner. The article looks at problems that seem to be increasing in prevalence in terms of who should be taking care of primary care patients and who should be taking care of acute care patients. Solutions are offered that could keep both types of practitioners out of the sphere of litigation.

© 2019 Elsevier Inc. All rights reserved.

Scope of practice (SOP) is the key element in defining the limitations of the clinical role of advanced practice registered nurses (APRNs). The Pew Health Professions Commission defines SOP as the “definition of the rules, the regulations, the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge and experience may practice.”¹ This definition serves as a safety line to protect the public from misguided providers. As an adjunct to this definition and a further delineation of the regulations of the SOP, the Consensus Model for APRN Regulation identified 4 regulatory elements: licensure to practice in a given state (or states depending on participation in the compact state program); accreditation of the APRN program by a national organization; certification by a national body that confirms the applicant’s knowledge, skills, and experience; and education at the graduate or postgraduate certificate level.² Yet, despite these potential safeguards, there is still confusion by both employers and new APRN graduates as to their SOP. An example of this phenomenon exists when one confuses the adult-gerontology primary care nurse practitioner (AGPCNP) and the adult-gerontology acute care nurse practitioner (AG/ACNP) in terms of the roles. The latter (AG/ACNP) could take on the role of the AGPCNP in the primary care setting, but the AGPCNP could not take on the role of the AG/ACNP in the hospital setting. The scope determines the role. The purposes of this article are to look at 2 of the 4 APRN roles, namely the family nurse practitioner (FNP) and the AG/ACNP, and to explore the problems that are arising and offer some solutions to rectify these variances.

Each APRN student is educated with a specific population focus. For example, FNPs focus on family/individuals across the life span, whereas AG/ACNPs focus on adults and gerontology patients.^{3,4} At the completion of their program, students will sit for a certification examination as an assessment of their competence that is

congruent with their population focus and academic education. In short, FNPs have been educated to provide primary care, and AG/ACNPs have been educated to provide acute care for their patients. This educational difference is what defines each of the nurse practitioner (NP) roles.

The SOP for APRNs is based on state statutes. There is no consistency across all states. The American Association of Nurse Practitioners notes that 22 states and the District of Columbia have full practice authority and can practice autonomously, 16 states require a collaborative agreement with a physician, and 12 states require physician supervision.⁵ Each state statute then controls the boundaries in which the APRN may practice.

According to the Consensus Model, the primary care NP (the FNP) is prepared to provide “. . . comprehensive, chronic continuous care characterized by a long term relationship between the patient and the primary care NP.”^{2,3} The National Organization of Nurse Practitioner Faculties White Paper further notes that “. . . primary care is not limited to preventive maintenance care of the well person but includes continuous care for patients with stable acute/or chronic conditions.”³ On the other hand, the acute care NP (ie, AG/ACNP) “. . . provides care for patients with unstable, chronic, complex acute, and critical conditions.”⁴ However, it is important to note that the role of the primary care and the acute care provider will sometimes overlap. For example, if a patient shows up at a clinic in a hypertensive crisis, the FNP has a legal duty to immediately stabilize the patient and then arrange immediate transport to a hospital where an AG/ACNP (or other acute care provider) would then treat the unstable hypertensive patient until he or she was stabilized and ready for discharge. The AG/ACNP could then refer the patient back to the FNP for care of his or her chronic hypertension. Both providers would then be working within their respective SOPs. The key point in this scenario is something that is emphasized in the Consensus Model, namely

“Scope of practice of the primary care or acute care Certified Nurse Practitioner (CNP) is **not setting specific** but is based on patient care needs.”²⁻⁴

Patient care needs define who is the most appropriate provider clinically, educationally, and legally to care for primary or acute care patients. The problem arises when neither the graduate APRN nor the employer fully understands the role of the APRN. The issue is bimodal. Some newly graduated NPs may believe that if they have been working as a registered nurse (RN) in a specific specialty that when they finish their NP program they can return to that specialty.⁶ For example, M.B. has spent the past 7 years working as an intensive care nurse in an intensive care unit (ICU). During her FNP master’s program, she continued to work in the ICU part-time. Upon graduation, she said she is planning on returning to the same ICU as an NP. It is this type of scenario that has profound legal implications for both the NP as well as the hospital. If the hospital credentials the NP, they leave themselves open to malpractice litigation for approving a nonqualified NP to work outside her SOP should an untoward event occur to an unstable, complex acute, and critically ill patient. The FNP in this same situation could not only become the primary defendant in a malpractice lawsuit but could also be disciplined by the Board of Nursing and potentially lose her certification as well as her RN license for practicing outside her SOP. In short, RN experience is not equivalent to the graduate education and certification that APRNs must achieve to be considered legally competent providers.⁶

The second part of this bimodal problem rests with the employing entity. Hospital credentialing committees rarely have an APRN as a member. The members of such committees are typically physicians who do not understand the limitations imposed by the different APRN SOPs. The differences are in the educational roles. FNPs should not be asked to care for critical, unstable, complex patients in an ICU unless they are dual certified as AG/ACNPs. Yet, there has been an uptick in malpractice suits related to this very scenario as noted in the Nursing Services Organization’s Nurse Practitioner Claim Report (4th edition).⁷ This lack of understanding has the potential to subject the hospital, the credentialing committee, the collaborating or supervisory physician, and the APRN to legal liability if an untoward outcome adversely affects the patient, as noted previously in the case of M.B. Additionally, any malpractice carrier that issued a policy to the APRN would probably not provide a defense for such a situation.^{6,7} So, what is the solution?

The solution to this problem of misunderstanding one’s SOP is multifaceted and is going to require change at all levels of APRN education and practice. First, nursing school admission committees should ascertain whether their applicants are clear on the role and population they wish to work with before they are admitted to the program. Knowing this will better help the student to make a reasoned career choice. Second, graduate APRN programs should incorporate state statutes and the APRN regulations into their curriculum so students understand what this APRN role requires. Third, faculty and experienced APRNs should educate hospitals and other health care providers about the SOP for the various APRN roles. Fourth, APRNs in hospital settings need to advocate for inclusion on credentialing committees so they can help correct any misunderstandings or misconceptions that physicians have about placing APRNs in inappropriate roles. Fifth, graduate APRN

programs need to include lectures on the legal aspects of practice as well as how to avoid litigation in their curriculum that address malpractice suits and how to avoid the same.^{7,8} Finally, didactic courses should incorporate decision-making frameworks, such as the scope of nursing practice decision-making framework developed by the Tri-Council (American Association of Colleges of Nursing, American Nurses Association, American Organization of Nurse Executives, and National League for Nursing), for all nurses to determine whether the skill was within their role and SOP.⁹

It is projected that by 2020 the NP workforce will grow by 20%.¹⁰ In order to ensure that APRNs are practicing within their SOP as dictated by their state statutes and nursing practice act implementation of the previously mentioned recommendations should provide a safer environment for all primary and acute care patients. It is also incumbent on APRNs to review their state SOP on an annual basis and to continue to lobby for inclusion on credentialing committees as equal partners. As partners in this journey, academicians need to verify that newly admitted graduate students are clear on which role and which population they wish to serve. Following these few simple changes should not only ensure patient safety but also will help other health care providers to understand the role of the APRN. Finally, litigation cases related to APRNs working outside their SOP should be minimized.⁷

References

1. Report of the Pew Health Professions Commission’s Task Force on Healthcare Workforce Regulation. Reforming healthcare workforce regulation: policy considerations for the 21st century. San Francisco, CA: Healthcare Center at UCSF; December 1, 1995.
2. National Council of State Boards of Nursing. APRN Consensus Work Group and NCSBN APRN Advisory Committee. Consensus Model for APRN Licensure, Accreditation, Certification and Education. http://cdn.ymaws.com/www.nonpf.org/resource/resmgr/consensus_model/aprnconsensusmodelfinal09.pdf 2008. Accessed December 1, 2018.
3. Primary care and acute care certified nurse practitioners. http://cymcdn.com/sites/www.nonpf.org/resource/resmgr/consensus_model/acpcnpstatementfinal2013.pdf 2013. Accessed December 2, 2018.
4. National Organization of Nurse Practitioner Faculties. Statement on acute care and primary care certified nurse practitioner practice 2012. http://cymcdn.com/sites/www.nonpf.org/resource/resmgr/consensus_model/acpcstatementfinaljune2012.pdf. Accessed December 2, 2018.
5. American Association of Nurse Practitioners. State practice environment. <https://www.aanp.org/advocacy/state/state-practice-environment>. Accessed December 1, 2018.
6. Hartigan C. Scope of practice. *Crit Care Nurse*. 2016;36:70-72.
7. Nurses Service Organization. Nurse Practitioner Claim Report: 4th Edition Executive Summary. <https://www.nso.com/Learning/Artifacts/Claim-Reports/Nurse-Practitioner-Claim-Report-4th-Edition-A-Guide-to-Identifying-and-Addressing-Professional-Liability-Exposures>. Accessed December 2, 2018.
8. Sweeney CF, LeMahieu A, Fryer GE. Nurse practitioner malpractice data: informing nursing education. *J Prof Nurs*. 2017;23:271-275.
9. Ballard K, Haagensohn D, Christiansen L, et al. Scope of nursing practice decision-making framework. *J Nurs Regul*. 2016;7(3):19-21.
10. US Department of Health and Human Resources, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Rockville, MD: US Department of Health and Human Services; 2013.

Kenneth Miller, PhD, MJ, C-FNP, FAANP, FAAN, is a professor at the University of Texas Health Science Center in San Antonio. He can be contacted at millerkp@uthscsa.edu.

In compliance with national ethical guidelines, the author reports no relationships with business or industry that would pose a conflict of interest.



Ohio Board of Nursing

www.nursing.ohio.gov

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

MEMORANDUM

To: Board Members, Ohio Board of Nursing

From: Tom Dilling, Public and Governmental Affairs Officer/Liaison
Betsy Houchen, Executive Director

Subject: Legislation, 133rd General Assembly Update

Date: September 16, 2019

HB 177, Standard Care Arrangements

HB 177 was introduced April 9, 2019, proposing to eliminate the standard care arrangements entered into by advanced practice registered nurses and collaborating physicians or podiatrists; prohibit physician prescribing of schedule II controlled substances in convenience care clinics; and would remove physician oversight of an APRN granting clearance for a concussed student to return to play or practice in a sport, consistent with other parts of the bill. The bill has had four hearings in the House Health Committee.

HB 224, Nurse Anesthetists

HB 224 was introduced on April 29, 2019 and has had four hearings in the House Health Committee. At the fourth hearing on June 18, 2019, a substitute version of the bill was accepted by the committee. Attached, please find an LSC comparative synopsis document summarizing the substitute version changes from the "As Introduced" version of the bill.

HB 133, Military-Temporary Licensure

HB 133, as introduced, would require state occupational licensing agencies, under certain circumstances, to issue temporary licenses or certificates that are valid for six years to members of the military and spouses who are licensed in another jurisdiction and have moved to Ohio for active duty. The House version creating this special temporary license was passed by the House unanimously on June 19, 2019. The bill was referred to Senate Transportation, Commerce and Workforce Committee on September 11, 2019.

SB 7, Temporary Licensing-Military

SB 7 requires state occupational licensing agencies, under certain circumstances, to issue six-year temporary licenses or certificates to members of the military and spouses who are licensed in another jurisdiction and have moved to Ohio for active duty. The bill was amended in the Senate Transportation, Commerce and Workforce Committee on March 27, 2019. The amendments included an increase in the duration of the temporary licenses from three to six years, an allowance for the Ohio State Medical Board to provide expedited licenses instead of temporary licenses for certain health professions, and an amendment to change temporary license denial and revocation language from

1.3.2

“shall” to “may” to allow agencies additional discretion in choosing whether or not to award a license.

The bill passed out of committee and was voted out of the Senate unanimously on March 27, 2019. The Senate version of the military temporary licensing bill was included in the Senate version of the budget bill, HB 166, but was removed in the Conference Committee version of that bill. Sub. SB 7 was referred to the House Armed Services and Veterans Affairs Committee on May 22, 2019, where it was heard for the first time.

Current law provides for expedited processing of applications of members of the military and their spouses (see Rule 4723-2-02, OAC). The Board has promoted expedited licensing of the military through rules, processes and approval of certain military nursing programs which were added to statute. The duration of the temporary license, questions related to grounds for voiding the temporary, and the need to require completion of the licensure process such as criminal background checks are issues for further consideration. In addition, cost of implementation, consistency with other licensing and public safety checks, and requirements in the Ohio eLicense platform should also be explored.

Additional information and details related to the content and status of any state bill mentioned in the legislative report may be found at <https://www.legislature.ohio.gov/legislation/searchlegislation;jsessionid=17223f7a114e6ed96192eff21785?0>.



www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
and DraftingLegislative Budget
Office

Substitute Bill Comparative Synopsis

Sub. H.B. 224

133rd General Assembly

House Health

Elizabeth Molnar, Attorney

This table summarizes how the latest substitute version of the bill differs from the immediately preceding version. It addresses only the topics on which the two versions differ substantively. It does not list topics on which the two bills are substantively the same.

Previous Version (As Introduced)	Latest Version (L_133_1055-2)
Clinical support functions	
<p>Authorizes a certified registered nurse anesthetist (CRNA) to perform <i>clinical functions</i>, rather than <i>clinical support functions</i> as under current law, if the functions are either of the following:</p> <ol style="list-style-type: none"> 1. Completed pursuant to a physician consultation; 2. Specified in the clinical experience standards established for nurse anesthetist education programs (R.C. 4723.43(B)(1)(j)). 	<p>Restores the phrase <i>clinical support functions</i> and instead provides that a CRNA may perform them in consultation with a physician (R.C. 4723.43(B)(1)(j)).</p>
Timeline	
No provision.	<p>Specifies that the actions a CRNA is authorized to perform under the bill may occur only during the time period that begins on the patient's admission to the facility or setting where the CRNA practices and ends with the patient's discharge from recovery (R.C. 4723.43(B)(2)).</p> <p>Also provides that clinical support functions may be performed at any time (R.C. 4723.43(B)(2)).</p>
Credentials and clinical privileges	
No provision.	Requires a CRNA to have been granted credentials

Previous Version (As Introduced)	Latest Version (L_133_1055-2)
	<p>and clinical privileges by the medical staff of the facility or setting where the CRNA practices before the CRNA may do any of the following:</p> <ol style="list-style-type: none"> 1. Perform and document evaluations and assessments, which may include ordering and evaluating diagnostic tests; 2. Establish anesthesia care plans; 3. Select, order, and administer fluids and treatments for conditions related to the administration of anesthesia; 4. Select, order, and administer pain relief therapies; 5. When performing clinical support functions, order fluids, treatments, drugs, and diagnostic tests and evaluate the results of those tests. <p>(R.C. 4723.43(B)(2)).</p>
Facility policy	
<p>No provision.</p>	<p>Requires the facility or setting where the CRNA practices to have in place a written policy establishing standards and procedures to be followed by the CRNA when doing any of the following:</p> <ol style="list-style-type: none"> 1. Ordering and evaluating diagnostic tests; 2. Establishing anesthesia care plans; 3. Selecting, ordering, and administering fluids, treatments, and drugs <p>(R.C. 4723.43(B)(2)).</p>



MEMORANDUM

TO: Members of the Advisory Committee on Advanced Practice Registered Nursing

FROM: Lisa Emrich, Program Manager

DATE: October 22, 2019

SUBJECT: Practice Unit: Sample/Summary of APRN Questions Received

The Board's Practice Unit responds to various questions received from licensees and the public. Below is a sample list of summarized questions received since June 17, 2019.

1. I have received notices from my credentialing manager that I need to renew my APRN license before October 31, 2019. I indeed notified the Board last year that my ANCC national certification was updated through 2020, so why does the Board website continue to reflect my license will expire October 31, 2019?
2. As a Women's Health NP, am I legally allowed to prescribe Expedited Partner Treatment to a male?
3. Our physicians have recently asked the APRN-CNPs in the department to learn medical tattooing. Training has been set up with a local tattoo artist to come teach the procedure. I'm curious if this is within my scope of practice as an APRN. Our doctors are not currently practicing this procedure.
4. I'm a certified Pediatric Nurse Practitioner working in a school-based health program. During flu vaccine season, teachers and school staff ask if I can order the flu shot for them. I have told them I cannot, since they are out of the age range of pediatrics. But am asking if I would be able to order flu vaccine for non-pediatric patients to help get school staff immunized?
5. I have had a Certificate to Prescribe for many years. This year when I tried to renew it, the website says I can't renew it because I no longer have one. This is not accurate information and I don't know what has happened. Can you please assist with this?

6. I am a newly certified and licensed adult Family Nurse Practitioner. I have interviewed for an Adult CNP position for an inpatient surgical trauma service that would include rounding on the inpatient floors, including ICU trauma patients, assisting the surgeon with cases, and performing bedside procedures. Is this type of position allowed within my scope of practice as a CNP with national certification in "Family?" Is Acute Care certification required for this position? I recently completed the Pediatric Acute care NP program and am readying for the Pediatric Acute Care national exam but do not have an adult acute care certification.
7. I am looking for clarification on when an APRN -CNP can begin practice. According to OAAPN, the SCA is required to be signed and available for the employer and the BON, however the question is "when" can the APRN begin practice once the SCA has been signed by both the APRN and collaborative physician?
8. I have been an APRN, since March 2019, and am still learning the law and rules. The facility's pharmacy is no longer located in the same building where I practice. Am I allowed to dispense any form of medication, such as samples, or medication that would usually be delivered by the pharmacy? I was told that giving the medication to the patient would be "dispensing." Please send me information on this or where to locate it.
9. I am seeking your assistance in understanding "incident to" billing. I do not want to bill incorrectly. With "incident to" billing we cannot treat "new" conditions, but What constitutes "new?" If a patient has a history of anxiety and they were treated for it in the past several months or years ago. This patient comes in for a head cold but while he would like to discuss resuming treatment. Can I do this? It is "new" in that they have not had to manage it in several years, but not "new" in that they have had the issue before. Also, say the patient has a history of recently diagnosed hypertension and placed on medication. I see them the following month and I need to change the medication. Can I do this and still bill "incident to?"
10. Can you please assist me with getting scheduled 2 medications added to my DEA?!
11. I was granted a temporary RN license. Can I use that to work as a CRNA, if so, how do I do this?
12. I would like to conduct Telemedicine from my home. Do I need to do anything with the Board of Nursing to accomplish this? Since my license is in Ohio, I would appreciate information on how I can provide this service within other states, and states' requirements such as practice there in time of disasters.