I have no financial or commercial relationships to disclose
OBJECTIVES

▸ Describe federal issues of interest to Nurse Practitioners

▸ Identify state regulatory issues of interest to Nurse Practitioners

▸ Discuss scope of practice considerations for Nurse Practitioners
"The first commandment is: Thou shalt not shoot the messenger."
FEDERAL LEGISLATION
WHAT’S HAPPENING IN WASHINGTON?

2017 Was a Busy Year in Health Care

Key Milestones in 2017 Health Care Agenda

January 20th
President Trump sworn in; signs, health care executive order

May 4th
After multiple false starts, House passes AHCA

July 25th-28th
Senate votes down BCRA, ORRA, HCFA

December 22nd
President Trump signs tax bill into law; repeals ACA’s individual mandate penalty

1) American Health Care Act.
2) Better Care Reconciliation Act.
3) Obamacare Repeal Reconciliation Act.
4) Health Care Freedom Act.

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Source: Health Care Advisory Board interviews and analysis.
OPIOID CRISIS

- 91 deaths in the US each day
- 418 drug-induced deaths in Maine in 2017 (an increase of 11% from the previous year)
- The majority of overdose deaths were caused by at least one opioid
- 26% of deaths in Maine were in Cumberland Co., 20% in York Co. and 16% in Penobscot Co.
- Average age of overdose victims was 41 years of age

Total Drug Deaths, Comparing the Totals for Deaths Caused by Pharmaceutical and Non-Pharmaceutical (Illicit) Drugs

Figure 1. Number of drug-induced deaths in Maine, with subtotals for deaths caused by any pharmaceutical drugs and for deaths caused by any illicit (non-pharmaceutical) drugs. Most deaths are caused by more than one drug. Pharmaceutical and illicit drugs may be combined to cause death.

COMPREHENSIVE ADDICTION & RECOVERY ACT OF 2016 (CARA)

- Signed into law by President Obama on July 22nd, 2016
- “Expands access to substance use treatment services and overdose reversal medications - including medication assisted treatment (MAT) by extending the privilege of prescribing buprenorphine in office-based settings to qualifying nurse practitioners (NPs) and physician assistants (PAs) until Oct. 1, 2021”¹
- NPs and PAs who have completed the required training and obtain the X waiver from the DEA can treat up to 30 patients

¹ Source - SAMS.org
X-WAIVER REQUIREMENTS

- Be licensed under state law to prescribe schedule III, IV, or V medications
- Complete 24 hours of education through a qualified provider (AANP members offers this education for free through the AANP CE Center)
- Through other training or experience, demonstrate the ability to treat and manage opioid use disorder
- The MSBON has no input on this federal issue other than to prescribe in the state you must hold a DEA license
NP’s Holding X Waivers

- Maine - 114
- New Hampshire - 82
- Vermont - 40
- Massachusetts - 285

Nationally more than 5000 Nurse Practitioners have obtained X waivers

Source: SAMSA
WHAT ELSE NEEDS TO BE DONE?

- The ability of NP’s and PA’s to prescribe MAT per the CARA act is set to expire October 1, 2021

- AANP is actively lobbying to make this act permanent AND to add CRNAs, CNMs and CNS to the bill

- Please visit the AANP Advocacy Center at aanp.org and support an NP’s ability to prescribe medicated assisted therapies permanent AND urge legislators to increase the number of patients we can treat to be the same as that of physicians (100-275)

- This process is quick, easy and goes directly to your US senators and representatives. You could also call or visit them.
DIABETIC SHOES


- On 3/24/17 referred to the subcommittee on Health

- This bill amends title XVIII (Medicare) of the Social Security Act to allow a nurse practitioner to fulfill documentation requirements for coverage, under Medicare, of special shoes for diabetic individuals. Under current law, such requirements may be satisfied only by a physician.

Source: AANP
DIABETIC SHOES

- Coverage for extra-depth or custom-molded therapeutic shoes and inserts for individuals with diabetes became a Medicare benefit on May 1, 1993.

- Podiatrists, NP’s, PA’s, and CNS (in some states) can write prescriptions for therapeutic footwear but certifying physicians must provide documentation that they personally examined a patient’s feet or otherwise verify the exam performed by one of these other care providers.

DIABETIC SHOES

- In the House there are currently 29 co-sponsors
- Per Senator Collins office, this legislation will be introduced in the Senate in May
- The National PA Association (AAPA) and the American Podiatric Medicine Association (APMA) have joined forces with AANP to support the ability to certify the need for diabetic shoes
- Please visit the AANP Advocacy Center at aanp.org to support this initiative and to encourage introduction of the bill in the Senate
FOOTWEAR MATTERS

Foot problems associated with diabetes are a significant portion of the health risk and cost.

<table>
<thead>
<tr>
<th>IMPAIRED SENSATION OR FOOT PAIN</th>
<th>RISK OF AMPUTATIONS</th>
<th>HIGH COSTS FOR FOOT ULCER CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% - 70% of diabetes patients have mild to severe forms of nervous system damage</td>
<td>80% of these amputations were preceded by a foot ulcer</td>
<td>Costs 5.4 times higher first year</td>
</tr>
<tr>
<td>CAN CAUSE impaired sensation or pain in the feet</td>
<td>67%</td>
<td>Costs 2.8 times higher second year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AFTER FIRST FOOT ULCER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compared with diabetic patients without foot ulcer</td>
</tr>
</tbody>
</table>

Studies have shown therapeutic footwear can decrease ulcers and amputations in diabetic patients.

For many diabetes patients, not wearing therapeutic footwear isn’t worth the risk.

<table>
<thead>
<tr>
<th>FOOT CARE PROGRAMS</th>
<th>THERAPEUTIC FOOTWEAR</th>
<th>CUSTOM ORTHOTIC INSOLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPUTATIONS</td>
<td>FOOT ULCERS</td>
<td>FOOT REULCERATIONS</td>
</tr>
<tr>
<td>LOWERED BY 45% TO 85%</td>
<td>LOWERED 12%</td>
<td>LOWERED TO 15%</td>
</tr>
<tr>
<td>AFTER 2 YEARS</td>
<td>LOWERED 18%</td>
<td>LOWERED TO 6%</td>
</tr>
<tr>
<td>Foot care programs may include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot care education and preventive therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of foot problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to specialists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Study examined the impact of therapeutic footwear on diabetic complications (foot ulcers and amputations)
- Patients with Type 2 Diabetes mellitus (T2DM)
- Simple size = 26,417 people
- Followed patients for 1 year before and 2 years after receiving therapeutic shoes

- 79% reulceration rate before treatment
- 54% amputation rate before treatment


HOME HEALTH

- Some form of this legislation has been introduced every session over the last decade, most recently by Senator Collins on 2/27/17

- *Home Health Care Planning Improvement Act (S. 445/H.R. 1825)*

- There are currently 170 supporters in the House, 42 in the Senate

- This bill allows Medicare payment for home health services ordered by a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant
ACO ASSIGNMENT

- HR 1160 - ACO Assignment Improvement Act
- Introduced 2/16/17 in the House by Rep. Derek Kilmer
- Referred to the subcommittee on Health on 3/2/17
- There are 20 bill co-sponsors - none from Maine
- This bill would allow the assignment of nurse practitioner (NP) patients to Medicare Shared Savings ACOs
- Again, please visit the AANP advocacy center
OTHER FEDERAL ISSUES STILL NEEDING TO BE ADDRESSED . . .

- Hospice -NPs are still unable to provide the initial certification of patients for hospice care

  - In 2003, Congress changed some of the physician-only language of the Social Security Act to allow nurse practitioners (NPs) to be "attending physicians" for hospice patients, if the patient designates an NP as the attending physician

  - An NP may not act as an attending physician for the certification process, but once a physician certifies that the patient is terminally ill, an NP may act as the attending physician

- Marijuana and the federal government
APRN PRACTICE & REGULATION
THE NUMBERS

- 248,000 NPs in the US
- NP’s provided 1.02 billion patient visits in 2017
- APRNs in Maine
  - 1717 Nurse Practitioners
  - 79 Clinical Nurse Specialists
  - 96 Certified Nurse Midwives
  - 452 Certified Registered Nurse Anesthetists
2018 Nurse Practitioner State Practice Environment

Source: AANP.org
In 2004 nurse leaders representing 23 national organizations began working together over a 4-year period to develop new national standards for Advanced Practice Registered Nurses (APRNs). These standards ensure that education, accreditation, certification, licensure and practice requirements for APRNs are the same throughout the country. The model is now 10 years old!
WHAT DROVE THE DEVELOPMENT OF THE MODEL?

- Lack of common definitions related to APRN roles - role, regulation, population foci
- Lack of standardization in programs leading to APRN preparation
- Proliferation of specialties and subspecialties - for example “Palliative Care NP”, “Cardiovascular CNS”
- Lack of common legal recognition across jurisdictions - for example, not all states have recognition for CNS
PROLIFERATION OF NURSE PRACTITIONER SPECIALITIES

- Adult NP
- Palliative NP
- School NP
- Acute Care NP
- Oncology NP
- Gerontology NP
- Homeland Security NP
- Occupational Health NP
- Child Psychiatric-Mental Health NP
- Adult Psychiatric-Mental Health NP
WHY IS IT NEEDED?

- To fully protect the public, it is important that APRNs across all states meet the same requirements.
- Significant variations exist in state laws regarding the requirements for Advanced Practice Registered Nurse (APRN) licensure, education, certification and practice.
- These variations limit mobility in practice and decrease patient access to quality health care.
APRN REGULATION & LACE

APRN regulation includes:

- **Licensure** - The granting of authority to practice
- **Accreditation** - Formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing related programs
- **Certification** - The formal recognition of knowledge, skills and experience demonstrated by the achievement of standards identified by the profession
- **Education** - The formal preparation of APRNs in graduate or postgraduate programs
The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.
APRN CORE EDUCATION – all education programs are accredited and follow a common preparation to all roles

Registered Nursing Base
- Masters or Doctoral Essentials Curriculum
- Common advanced courses in: Pharmacology (preparing to prescribe)
- Advanced assessment, and physiology (preparing to diagnose and treat)

Role Preparation – specific role preparation and clinical hours
- Nurse Practitioner
  - Acute care
  - Primary Care
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist

Populations – specific preparation in one or more populations
- Family Across the Lifespan
- Women’s Health and Gender Specific
- Pediatric
- Neonatal
- Psychiatric Mental Health
- Adult and Gerontology
CURRENT IMPLEMENTATION STATUS OF THE APRN CONSENSUS MODEL

Image: NCSBN

Refer to the [scoring grid](#) which is the basis for the map above for additional details.
A common question... is the APRN Consensus Model and the APRN Compact the same thing?

No, but they do build off one another.
HOW ABOUT THE APRN COMPACT?

- The APRN compact is not enacted at this time
- The compact will be implemented when 10 states enact the legislation
- Maine has not been successful with legislation to align us with the APRN Consensus Model and thus we cannot be a part of the APRN Compact
- Our last attempt was in 2015 - “An Act Regarding Advanced Practice Registered Nurse Requirements”
WHAT WOULD MAINE NEED TO DO TO JOIN THE COMPACT?

- We would have to be fully aligned with APRN Consensus -
  - For NPs we would need to remove the 2 year transition to practice (TTP) requirement
  - CNS would need prescribing privileges
  - CRNAs would need full prescribing and independent practice
  - CNMs - All set!
- Then APRN Compact legislation would need to be submitted and passed
The APRN Compact, approved May 4, 2015, allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other compact states. The APRN Compact will be implemented when 10 states have enacted the legislation.

NCSBN has developed a model for states to enact the Advanced Practice Nurse Compact. Below find model legislation and rules.

Is your state moving forward with the APRN Compact?

---

State with pending 2017 APRN Compact legislation  State with enacted APRN Compact legislation
RESOLVED, THAT OUR AMERICAN MEDICAL ASSOCIATION CONVENE AN IN-PERSON MEETING OF RELEVANT PHYSICIAN STAKEHOLDERS TO INITIATE CREATION OF A CONSISTENT NATIONAL STRATEGY PURPOSED TO 1) EFFECTIVELY OPPOSE THE CONTINUAL, NATIONWIDE EFFORTS TO GRANT INDEPENDENT PRACTICE (E.G., APRN CONSENSUS MODEL, APRN COMPACT) TO NON-PHYSICIAN PRACTITIONERS AND 2) EFFECTIVELY EDUCATE THE PUBLIC, LEGISLATORS, REGULATORS, AND HEALTHCARE ADMINISTRATORS AND 3) EFFECTIVELY OPPOSE STATE AND NATIONAL LEGISLATIVE EFFORTS AIMED AT INAPPROPRIATE SCOPE OF PRACTICE EXPANSION OF NON-PHYSICIAN HEALTHCARE PRACTITIONERS
NATIONAL COUNCIL OF STATE BOARDS OF NURSING

NCSBN RESPONDS

- A new national campaign to promote the APRN compact at nursingamerica.org
- National TV Ad
- Video
ENHANCED NURSE LICENSURE
COMPACT
ENLC
ENHANCED NURSE LICENSURE COMPACT (ENLC)

- Maine replaced the old nurse compact licensure compact with the new enhanced nurse licensure compact last July.
- The eNLC became effective January 19, 2018.
- All RNs who were licensed before this date were grandfathered in Maine.
- This relates to RN licensure only, the eNLC does not pertain to your APRN license.
- eNLC
WHAT ARE SOME OF THE CHANGES WITH THE ENLC?

- Requires fingerprinting and criminal background checks
- Bars individuals with felony convictions from holding a multistate license
- Bars individuals convicted of a misdemeanor related to the practice of nursing from holding a multistate license
What if I move out of state/change my permanent address?

- You will need to meet the requirements of the new state.
- If the move is to another eNLC compact state, that means fingerprints/CBC in order to receive your RN license.
- You will also need to apply for your APRN license in the new state.
Consider that your education prepares you to practice in a designated lane ...

Certification is your driving exam.

Your license is your permission to drive.

SCOPE OF PRACTICE

Source: NCSBN - M. Cahill
NP SCOPE OF PRACTICE (SOP)

- SOP is being increasingly scrutinized by boards of nursing and malpractice insurers.
- "The certified nurse practitioner shall provide only those health care services for which the certified nurse practitioner is educationally and clinically prepared, and for which competency has been maintained."\(^1\)
- The Maine BON does not actively seek out NP’s working outside of scope, it is inherent on the individual NP to work within their scope of practice.
- The BON may discipline RNs or APRNs working outside of their scope of practice.

1. Source: MSBON
SCOPE OF PRACTICE

- SOP of practice of any licensed health care professional is defined in the practice acts of each state’s laws.
- State legislatures have the authority to adopt of modify practice acts and therefore adopt or modify scope of practice.
- Employment should be consistent with the speciality for which you were educationally prepared, certified and licensed by the Board of Nursing.
ACUTE VS. PRIMARY CARE NP

- NP educational programs are either primary care or acute care focused
- Certification as both an acute care NP and primary care NP requires completion of both formal educational programs
- Patient safety is jeopardized when clinicians practice outside their scope of practice
- Regardless of the willingness of some employers to credential the NP to practice beyond his/her educational preparation and certification, the NP is obligated to adhere to his/her scope of practice

Source: Certified Nurse Practitioners - Primary & Acute Care Practice, Ohio Board of Nursing July 2017
“There are 2 broad categories of NP preparation: primary care with didactic and clinical education focused on health promotion, disease prevention and treatment of patients primarily in ambulatory and community settings; and acute care with didactic and clinical education focused on the management of patients with complex acute, critical and chronic health conditions primarily in acute care (hospital) settings”
“The nurse practitioner’s specified scope of practice is critical with respect to any theory of liability or potential allegations that may be asserted in malpractice litigation. It also forms the context within which a court will determine whether negligent conduct occurred and whether the nurse practitioner acted within the scope of practice.”

~ Carolyn Buppert, NP, JD
What if I receive “on-the-job training”? - On-the-job training does not expand scope of practice. For example, a pediatric primary care NP cannot be trained on the job to care for critically ill or traumatically injured children in the hospital setting.

What if I get a speciality certification? APRNs may specialize beyond their role and population focus but are not licensed at the specialty level. APRN specialty preparation does not expand one’s scope of practice beyond their population focus, educational preparation or certification.

Does my specialization as an RN count? Pre-NP specialization at the RN level does not expand scope of practice at the NP level.
COMMON SOP QUESTIONS

- Is SOP setting specific? Scope of practice is not setting specific but based on patient needs

  - The acute care or primary care NP may evaluate an acutely ill patient but a patient's severity of symptoms determines which provider is most appropriate to care for that patient

  - It is recognized that there is overlap, particularly in regards to management of the simple acute patient

- What if I work under direct physician supervision?


DOCTOR OF NURSING PRACTICE

DNP
WHAT’S NEW WITH DNP?

- There are 303 DNP programs enrolling students at schools of nursing nationwide, and an additional 124 DNP programs are in the planning stages.
- DNP programs are now available in 50 states plus the District of Columbia.
- From 2015 to 2016, the number of students enrolled in DNP programs increased from 21,995 to 25,289.
- 50% of NP programs have transitioned to the DNP.
DNP

- The only APRN group who have called for the DNP as the entry level degree to practice are the Certified Registered Nurse Anesthetists (by 2025)

- Frequent questions I receive about the DNP...

  - Will I have to go back to school or will the BON require that I have a DNP degree? No - the AACN stresses that nurses with master’s degrees will continue to practice in their current capabilities

  - Does having the DNP expand my scope of practice? No

  - Will I be paid more? It depends
Use of the academic title “Doctor” - we should be using the term “physician”. Medicine believes they own this academic title and this has created difficulties for us.

As our numbers increase, the number of malpractice cases against NPs are increasing. The number one cause of closed malpractice claims (for all providers) is diagnostic error.

Maine is facing an RN shortage, an APRN shortage and a nurse faculty shortage.

We have a dire need for NP preceptors (please email me if you are willing to serve as a preceptor).

The international RN workforce is in enormous flux.
WHAT'S ON THE HORIZON

New Employer Coalition Takes Aim at Health Care Costs

Amazon
300K+ Employees

Berkshire Hathaway
360K+ Employees

JPMorgan Chase
240K+ Employees

"The ballooning costs of healthcare act as a hungry tapeworm on the American economy...we share the belief that putting our collective resources behind the country's best talent can, in time, check the rise in health costs while concurrently enhancing patient satisfaction and outcomes."

Warren Buffett
Berkshire Hathaway Chairman and CEO

Source and Credit - Advisory Board, advisoryboard.com
Freakonomics Podcast "Nurses to the Rescue"

Take a listen when you have the time

http://freakonomics.com/podcast/nurses-to-the-rescue/
THE END

ANY QUESTIONS?
VALERIE.FULLER@MAINE.EDU
REFERENCES AND RESOURCES


REFERENCES AND RESOURCES


- National Council of State Boards of Nursing - APRN Compact https://www.ncsbn.org/aprn-compact.htm


REFERENCES AND RESOURCES

- Maine State Board of Nursing - http://www.maine.gov/boardofnursing/
