

# Arizona State Board of Nursing

Janet Napolitano  
Governor

Joey Ridenour  
Executive Director



## ADVANCED PRACTICE COMMITTEE MEETING MINUTES

September 30, 2005

<b>MEMBERS PRESENT:</b>	<b>MEMBERS ABSENT:</b>
Theresa Crawley, Co-Chair Martha Carey-Lee Nancy Denke Regina Deringer Debra Duarte-Anderson Elizabeth Gilbert Linda Herrmann Judy Hileman Jane Lacovara Denise Link Anita Martinez Marianne McCarthy Claretta Munger Donald Pierce Linda Pierce Sally Reel (telephonic) Lori Rubarth	Judith Rich, Co-Chair Jennifer Brodie Nancy Cisar Anges Oblas Mel Stradling
<b>BOARD STAFF PRESENT:</b>	<b>GUESTS PRESENT</b>
Karen Grady Pamela Randolph Joey Ridenour	Eleanor Hollingsworth Helen Hess Ester Ruiz Dana Rosdahl Tina Dobson Frances Hauermarth Dale Flewelling

### 1. Call to Order

Theresa Crawley, Co-Chair, called the meeting to order at 9:32 a.m.

### 2. Orientation of New Members

Committee members and staff made introductions. Crawley discussed the purpose and goals of the Committee, and meeting guidelines.

### 3. Approval of Minutes

Crawley called for a motion to approve the Advanced Practice (AP) Committee Minutes of April 15, 2005. Lacovara moved, Martinez seconded. Motion carried.

### 4. Old Business

#### a. Update on Specialty Areas

Grady discussed the background on the specialty area subject. Examples were given of a new graduate FNP who wanted to work as a Psychiatric NP and another recent graduate FNP who wanted to work as a Pediatric NP in a pediatric ICU doing pediatric intensive care. Discussed apparent disconnect between the NP's graduate program specialty preparation and the role in which the NPs wanted to practice on graduation. Discussed a certain portion of the NP community seemed to feel strongly that if you get some on-the-job training an NP can work in other specialty areas without having formal preparation or credentials.

Reel stated AP has become more complex and the theoretical knowledge and competencies come from formalized education. There needs to be a match between the theoretical preparation for AP and the application to patient care, whether through a Masters degree, a certificate program, National Certification Exam, or whether that becomes through sub specialties and ways of validating the knowledge. Assuring competency is very important, and competency usually does have some kind of formal educational preparation.

Link supported Reel's statement and further clarified the differentiation of practice between RN and AP, and that while certainly you have to be an RN before you are accepted into an AP nursing program, AP is a different role, requiring advanced education and credentialing.

Hileman expressed concern about limiting potential practice for NPs and how NPs can be allowed to expand within their roles if there is no certification in the area in which the NP wants to practice.

D. Pierce stated he didn't feel there is limitation of NP's ability to work in specialty areas, and that all the areas have come through formalized education of some type. Formalized education enables standardized practice across all settings. The discussion needs to be focused on how to get the appropriate education in place rather than allowing NPs to "piece-meal" their preparation.

Grady clarified there is no intent to limit NP practice but rather the regulations are in place to ensure that NPs entering practice are qualified.

The group discussed an example of a new graduate FNP who was asked to take a role in a radiology department performing "simple" diagnostic procedures, e.g., thoracentesis, paracentesis, that the physicians did not want to do anymore or did not have time to do. The facility wanted to hire an NP to fill the gap. The radiologist was going to "show him what to do." Discussion

was held that physicians do not determine an NP's scope of practice and that the NP has to rely on their own qualifications.

Carey-Lee stated she does legal nurse consulting and in cases that are naming NPs the NP usually has to prove that they have the appropriate education. It is important that education is from an accredited body or is acceptable within the standards of practice.

McCarthy stated most FNP, ANP, GNP programs are educating their graduates to become primary care providers, not specific to setting. The scope of practice of an NP in an acute care setting is different from an intensivist. McCarthy opined that the doctors may not want to do the procedures anymore due to liability. NPs may think they are being given an opportunity to expand their practice, however procedural skills do not expand nursing practice. NPs are primary care providers, not "doers of procedures". NPs are advanced practice nurses regardless of setting. If an NP wants to practice in an acute care setting they should do so as an advanced practice nurse, not as a pseudo physician.

Grady stated that the procedures that an NP adds to their practice should be within the scope of practice of their specialty area, whatever that might be. Grady referred to the article by Tracy Klein, Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution. Klein responded to the question: "I would like to set up a practice reading x-rays. Does my license permit this?" Klein wrote: "the answer is no, unless you have additional licensure and training that qualifies you as a specialist." The NP scope of practice generally provides for ordering and evaluation of laboratory results. Again, however, this in the context of provision of care for that patient in the specialty in which you are trained and licensed. Specific functions, such as reading x-rays to screen for gross abnormalities, are different from the level of expertise required to read x-rays for a diagnostic outcome on a focused and ongoing basis. This would demand additional training and validation of competency. Currently, the standard of practice in this field is established by the training and competencies of the radiologist."

There was discussion about the shortage of care providers to meet the demands of certain types of healthcare services. An analogy was given that just because there is a 3 month wait to see a dentist doesn't make an NP qualified to go out and practice dentistry. NPs do not have to fill any service gap by stepping in and holding themselves out to be qualified to perform those procedures.

Reel stated that if an NP is considering doing procedures such as thoracentesis to investigate the role of acute care NP because those are some procedures that ACNP's may be doing. It is not typically a primary care procedure. There was discussion that ACNP programs have been available in Arizona for the last 10 years, and another program just opened at U of A.

Crawley stated the Board can't approve something just because it is taught in a hospital. Education should be done in a formalized educational setting, not just on-site or on the job training.

Surgical first assisting was discussed as an example. Historically nurses used to stand in with the physicians to assist when they couldn't get an assistant. But at this point if a nurse wants to act as a surgical first assist they have to complete a specific program and be certified to do that. It may be difficult but it also assures that those who go through the program have a certain level of expertise.

Link stated NPs have spent a lot of time and energy to become an autonomous and distinct discipline separate from other disciplines. To argue that "if the physician says it's okay, then it's okay," a legislator or a person from another discipline could argue, "these people are not autonomous and independent, they need someone else to back them up". We want to remain autonomous and therefore, is there a way that we can do this within our own discipline, rather than using apprenticeship models and on-the-job-training and getting a nod-and-a-wink from a CEO of a hospital.

Duarte-Anderson discussed going through a dual certification process to become an FNP after having been a Psych NP for 10 years because her patients had become much more medically complicated. It was not something that she could have just learned "on the job." Duarte-Anderson stated it was important for her own safety and the safety of her patients that she expanded her knowledge base through a formalized program.

Hileman stated she also has a dual certification as an FNP for over 15 yrs and decided that if she was going to work psych in more depth than primary care, she had to go back and get her Psych NP. If there is a verified specialty program available, that's what needs to be done. Her question was as the NP role expands, how do we grow in areas in which there is no defined specialty to get a degree? Hileman opined that NP's started going into those areas such as psych and then the education program seemed to follow. She expressed concerns about what people who are FNP or ANP who work in cardiology would do.

McCarthy stated there is no problem with ANPs or GNPs working in the area of cardiology if they are practicing as AP nurses; they are not practicing as cardiologists. McCarthy stated some students think they're going to graduate and work as "intensivists", or "hospitalists" but they are not being prepared to work as hospitalists or intensivists, they are being prepared to be an AP nurse. Scope of practice is still scope of practice, there is no need to go beyond that.

McCarthy commented for clarification that the first CNSs were in Psych and they were able to do psychotherapy but could not prescribe medications. Many Psych CNSs returned to school and obtained FNPs, ANPs or GNPs. The history at ASU is that the Psych NP program was developed because Psych CNSs wanted to expand their practice; it was not because FNPs were out there practicing as Psych NPs.

Herrmann stated she is a GNP and works with a neurosurgeon as a geriatric specialist, a nurse, not a neurosurgery specialist. As a preceptor, she cautions students to be very realistic about their goals. Students often think they're going to practice as "intensivists" or in a procedure oriented practice. There are medical residents and Acute Care NPs to do procedures in the ICU. Students should be cautioned not to go to an FNP program when you have a trauma background and expect that you're going to be able to function in a trauma role in a hospital.

Reel stated they've encountered students along the way who have come into a primary care program and want to do acute care procedures. They have consistently said to their students that they ultimately have to be able to manage and take the full responsibility of the consequences of the actions, treatment and protocols that they implement with their patients. Learning a procedure without theoretical content means they aren't prepared to manage the entire scope of consequences. They don't have the theoretical acute care background for it.

Mitchell opined that no one knows what nurses do. The levels of education are very, very confusing. But, next week his boss has to hire a psychiatrist for their department. Mitchell guaranteed his boss will not hire an internist and say "they will pick up that psychiatry stuff, no problem." She will hire a psychiatrist. Mitchell opined we need to be very clear on what our scope of practice is and hire a person trained in that area, so that people know what we do.

Munger commented that there seems to be a need for additional advanced education, and questioned whether it needed to be a whole program or if it can be met with some guidelines that include specified validated post graduate education programs, as opposed to another certification.

Crawley stated when she first started out as an anesthetist they didn't even have monitors, so practice evolved. But the basic background was always there. She had to validate what she learned because the public and practice demanded it. "What is your education, how many have you done, how were you prepared to do this?" Crawley stated as a person who might need some of the NP's expertise in the future she needs to know that she's being taken care of by someone who is educated and qualified to do that. "I need to know, if anything goes wrong, that you can validate that you knew what you were doing." Where can you validate to the public that you were educated in that area?

The meeting recessed at 10:47 a.m. and reconvened at 11:03 a.m.

Suggestions from the committee were requested for direction.

Ridenour stated this is a partnership and we all need to be on the same page. Forty years ago this role started and it is now based on an integrated didactic and clinical experience not on "on the job training". The future of this role

needs to be shared by all of us. Our goal is to have the statutes and the rules reflect what we need to have in regulation and law. There is still a very large part of the NP community that has a very different viewpoint on how you prepare nurses for this role. So even though I'm very much encouraged by the debate and discussion we've had today, this certainly has to be taken beyond the Board of Nursing. To try to get the employers on board too because it's very revealing when we get calls from some of the very large acute care facilities in the state that they do have individuals that have had recent FNP preparation and exit from a program applying for positions to be a PNP. We had explored before, perhaps a day long conference and having some of the same information being presented: How has education evolved? What are the credentials that people have to have now vs. what they had to have before? What are they looking for to help that person get into the right role? All they take is a word from someone that this person should be hired. They would not hire a physician in that manner and they should not be hiring AP nurses in that manner. It should be based on credentials and the competencies that the individual has.

Pierce questioned the current way that certifications and specialty procedures such as first assist are approved now. It was discussed that practitioners are certified in their broad specialty area of practice. Verification of specific competencies/procedures/skills are done at a facility level through privileging/credentialing. The Board also recognizes certification by an accredited body.

McCarthy pointed out that facilities can't grant additional privileges to NPs beyond that which is allowed by regulation.

Carey Lee opined that if an NP is subspecializing within their specialty area, and it is not a situation clearly outside of scope such as the Psych NP and the FNP situation where they are clearly two basic AP specialty situations, then perhaps they could attain additional certification or credentials from another governing body as validation.

Rosdahl stated we do have generalists in Adult and Family and some of those individuals want to have a specialty. How does the Board provide some kind of approval that that individual has a level of competence to practice in a specialty area without narrowing those generalist roles.

Discussion was held that physicians have methods in place for further subspecialization but it does not currently exist in the same form for NPs.

Ridenour questioned how much regulation is desired in subspecialties and stated we're very happy if people really understand the specialty areas and that FNP is different than a Psych Mental Health NP. Ridenour cautioned not to feel that subspecialties need to be regulated. They need to be safe practitioners but we would have to have more evidence why we would need to do that. Those that hire the individual can focus on the competencies of the individual. Ridenour opined the group made a huge leap today and tried to

understand that today education and clinical experience drives what your specialty is, not other methods that worked 40, 30, or 20 years ago.

Hermann discussed there are some students ready to graduate from their programs and are being told by potential employers that they will not be able to be hired because of all this concern. Apparently it has been blown out of proportion. It is obvious that an FNP shouldn't be managing acute and complex psychiatric issues but the trickle down effect of that has been that there are hospitals in the area that are not going to hire ANPs for a hospital based practice.

Ridenour stated people have over responded or under responded, we have the two extremes. What came to the Board's attention had to do with extreme transgressions into other NP roles. An FNP wanted to be a PNP, working peds ICU covering independently 24 hrs a day. Another FNP wanted to be an NNP with on-the-job training. So if you can help people understand how extreme those attempts have been it will help people understand how this has evolved. We may need a day of dialogue to really reach different groups. We need to bring in education, clinicians, and perhaps other experts. When this started to be planned a short time ago, it started to evolve into a meeting that was going to be by invitation only, it was going to be a closed meeting, and that CANNOT happen. We will not reach the people we need to reach. So that's why it did not make much progress.

LaCovara stated in the extreme cases presented it is obvious to everyone here why those would not be allowable. What about NPs that work in cardiology clinics all over the state of Arizona, what are the educational requirements to work in those roles? People are having questions with the more gray areas.

Ridenour stated she is using the extremes is to help understand what we're hearing at the Board. The ones that are truly overlapped you do have to look at the individual, what their program provided them and what their focus was, and those are the ones we get calls on everyday. This is where the answer is a little bit harder to give because unless you really know more about that individual it's hard to give the right answer.

Grady stated it can be very individualized depending on the person's program. That is why we are more concerned with the overall understanding of broad scope of practice. Then it's incumbent upon the NP themselves to understand what their exact preparation was and to remain within that or else go out and attain some additional accredited, formalized education to support their practice.

Hess agreed and stated we don't want to limit practice and that part of being a professional is understanding what you can do and what you can't. Part of your scope of practice is appropriate referral to somebody else. If you don't understand what your role is and what your current scope is, you shouldn't be doing it. That person who is in a specialty area as a professional has to determine for themselves whether they are competent. They can determine that through whatever training they get in order to assure that competence.

The Board's role is about determining broad guidelines, and the role as professionals is to be professional and to refer when appropriate, and to be competent in what we do.

Crawley asked if there was a suggestion or recommendation the group would like to formalize, or for a meeting, or for an educational program, or discuss again.

**Pierce made a motion, seconded by Link, to hold a day of education in the 4<sup>th</sup> quarter of 2005, regarding Advanced Practice specialty areas, with information from that meeting to be brought back to the January 2006 Advanced Practice Committee Meeting for further recommendations. After discussion, Pierce amended the motion to extend the time for the meeting to the 1<sup>st</sup> quarter of 2006. Motion carried.**

**Lacovara made a motion, seconded by Pierce, to form a sub-committee from the APRN existing committee to formalize the Agenda and setting up a program for the Day of Education Meeting, and researching information from other states. Motion carried.**

**Volunteers for Sub-Committee:**

**Donald Pierce  
Linda Herrmann  
Nancy Denke  
Marianne McCarthy  
Denise Link  
Regina Deringer  
Linda Pierce  
Sally Reel  
Martha Carey-Lee**

- b. Update on Article 5 Rules  
Randolph reported that rulemaking was heard at GRRC (Governor's Regulatory Review Council) on September 13, 2005, and would go into effect on November 13, 2005, with few changes. Grady stated that the final rulemaking can be located on the ASBN website.

**5. New Business**

- a. Draft CNS portfolio guidelines  
Randolph reviewed the guidelines and explained that in lieu of completing a formal CNS program, there are several persons using the title "CNS" who have not completed a CNS program. They would like a way to show that they do have core CNS competencies. The core competencies from the National Assoc of Clinical Nurse Specialists guidelines were utilized to develop projects that would demonstrate those competencies. Although this appears extensive, this is in lieu of a Master's level program. These portfolio projects will be scored separately by 3 persons and then their scores will be averaged

and added to determine whether the individual has passed or failed the project guidelines. The scoring rubric would be used by all 3 persons. The three persons looking at the portfolio projects would be: a practicing CNS, a CNS educator, and the executive director of the Board or her designee.

Randolph clarified that the portfolio option is for Master's prepared nurses who have not completed a CNS program.

**McCarthy made a motion, seconded by Deringer, to approve the CNS portfolio guidelines for presentation to the Board for approval. Motion carried.**

- b. Draft Arizona Medical Board rules for Office-based surgery  
The proposed rules were reviewed page by page. Recommendations were made for language revisions.

**D. Pierce made a motion, seconded by Martinez, to forward the proposed rulemaking back to the Arizona Medical Board with the recommendations set forth. Motion carried.**

**6. Items for Agenda for Future Meetings**

Meeting dates for 2006 to be determined.

**7. Adjournment**

Motion was made by Link, seconded by Martinez to adjourn the meeting. Motion carried and Crawley adjourned the meeting at 12:04 p.m.

**Next meeting will be January 13, 2006, beginning at 9:30 a.m.**