KANSAS APRN TASK FORCE

Transforming Healthcare for Kansas

Access Quality Value

Highlights of the Statute:

The recommended statute changes provide uniformity and expectations on licensure, accreditation, certification, and education standards developed by a national collaborative (National Council of State Boards of Nursing –NCSBN, 2008). **These changes were made to improve access to safe, quality APRN care and establish a set of standards that continue to protect the public.**

The proposed changes in the Kansas APRN Statutes will address six main areas.

1. **Provide a current and updated definition of an Advanced Practice Registered Nurse (APRN)**

The definition of APRN is needed to identify those elements of practice that are designated as advanced practice nursing functions and is consistent with national expectations. Also included is a statement in the LPN and RN definitions to clarify that nurses could follow orders from APRNs.

2. **The APRN will be required to have malpractice coverage.**

The proposed bill will require an APRN to maintain and provide proof of malpractice insurance at the time of licensure and renewal. This is similar to the requirement for other healthcare professionals in the state.

3. **The APRN will be required to have national certification.**

The requirement of national certification is a standard of competency that helps protect the public (similar to physicians that are board certified in their area of specialty). Currently, Kansas is one of only three states that do not require national certification.

4. **Removal of the written protocol language.**

Studies of states that do not have laws that include "responsible physician language" have not found any differences in the degree of safety to the public. This allows APRNs to practice to the full extent of their education and training. The Board of Nursing will continue to authorize prescribing authority to the APRN. If the APRN needs to prescribe controlled substances, the APRN will go through the proper federal channels to obtain a DEA license to prescribe controlled drugs.

5. **Added language for a "Transition to Practice plan" for the new APRN Graduate or any APRN requesting a license that has less than 2000 hours of practice as a licensed APRN.**

For APRNs with less than 2,000 hours of experience as an APRN they must complete a "Transition to Practice" requirement. This professional obligation focuses only on the new APRN graduate. The "Transition to Practice" language mandates the new graduate APRN have a structured collaborative practice relationship with a licensed physician or APRN; and that they must include evidence of 2000 hours of practice in this collaborative relationship. This transition to practice serves to help the APRN transition into their new role after graduation. Please note that not all states require a transition to practice program for new APRN graduates. The Board of Nursing will adopt the specific guidelines in Rules and Regulations for the "Transition to Practice" language.

6. **The addition of a provision that recognizes the ability of the APRN to fulfill the requirement of a signature on forms that only have the word physician on them, as long as it is within the scope of practice of the APRN.**

It is a duplication of services and a hardship for patients to find a physician to sign a form when the patient has not seen the physician before. The language was taken from the Maine Nurse Practice Act.

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Advanced Practice Registered Nurse (APRN) Statute Legislation

Information for our Physician Colleagues

What this bill DOES NOT CHANGE:

- APRNs will continue to function within their Scope of Professional Practice as overseen by the KS Board of Nursing (This means *APRN Practice is Limited* by their area of education and training).
- Many APRNs will continue to work as employees in physician and other health care practices.
- Professional Collaboration will continue (just not "legal/mandated" collaboration). APRNs will continue to collaborate, work with and refer to physicians and other health care providers (This is a professional expectation).

Rational for change:

- **Institute of Medicine (IOM) report based on evidence found** APRNS should practice to the full extent of their education and training, by modifying laws (including KS law) that prevent this. IOM committee authors include:
  - T. A. BRENNAN, Executive Vice President, Chief Medical Officer, CVS Caremark, Woonsocket, RI
  - R. E. CAMPBELL, Vice Chairman (retired), Johnson & Johnson, New Brunswick, NJ
  - L. DEVLIN, Professor of the Practice, University of North Carolina at Chapel Hill School of Public Health
  - D. C. GOODMAN, Professor of Pediatrics and of Health Policy, and Director, Center for Health Policy Research, The Dartmouth Institute for Health Policy and Clinical Practice, Hanover, NH
  - J.C. HANSEN, Chief Executive Officer, American Geriatrics Society, New York
  - C. M. HARRIS, Chief Information Officer, Cleveland Clinic, OH

Physician support:

- H. V. Fineberg MD, President, Institute of Medicine & R. Lavizzo-Mourey, MD, MBA, president and CEO of the Robert Wood Johnson Foundation, recommend removing "barriers that prevent nurses from fully utilizing their skills to meet health care needs in their communities." (2013 IOM commentary).
- B. Healy, MD, "We simply lack sufficient primary-care doctors...nurses are moving into a gap rather than pushing out existing physicians...As in the past, nurses are recasting their profession to meet pressing needs, *not by morphing into M.D.'s but by being nurses plus*. (U.S. News & World/ 2010, April 10)
- D. Gorski, MD (Evidenced Based Medicine – managing editor) Comments Jan. 6, 2014 titled *Correcting the scope of practice of advanced practice nurses will not endanger patients:*
  - Nurse practitioners are different from physicians in that, first of all, they are nurses. However, they are nurses who have undergone advanced training such that they are qualified to manage common medical problems within their scope of practice.
  - I support increasing the scope of practice of APRNs/NPs commensurate with their education and training. Existing science and my own personal experience that began when I first started working with NPs in 1999 lead me to that conclusion. If there were strong arguments against this from a patient safety standpoint, believe me, I would have grave doubts. (After all, I am a physician, and I recognize that my inherent bias would almost certainly be that physicians provide better care, making me more inclined to take such arguments seriously if they were evidence based.) There aren't, at least none that are scientifically supported by outcomes data, which is why the reaction of my fellow physicians to such measures, which occurs in every state where such bills are introduced, saddens me.

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- J. Hasselle, MD, DLFAPA (Kansas physician)
    - Many physicians, their employers or their malpractice policy providers report erroneous concern that being a collaborative physician holds the physician liable for the APRN's practice. They are therefore unwilling to enter into any agreement. This liability is redundant, as the APRNs carry their own malpractice insurance. Also of note, the rate of malpractice suits against APRNs is far below that of physicians.
    - I have both worked with and been protocol psychiatrist for APRNs and always felt comfortable with their competency, ethics, and willingness to seek appropriate collaboration. I believe it is time that APRNs in the state of Kansas be given more independence and not have a relatively ineffectual law obstructing their ability to practice in their field of expertise.

Impact on Physician Practice and removal of APRN practice barriers

- *Do NOT impact MD earnings: variation in earnings between the states with and without APRN practice is not statistically significant. "For family and general physicians, wages rose by 5.73% per year in full SOP (i.e. not restrictive APRN laws) states and 5.11% per year in restrictive SOP states." (Pittman & Williams, 2011).*

Differences in APRN Education: by D. Gorski, MD:

A physician, once licensed in a state, can practice virtually any kind of medicine legally. It is the professional societies, not state laws, that determine the specialization of physicians.

APRNs on the other hand, go into training with a specific scope of practice. There are Family NPs, Adult NPs, Geriatric NPs, Women's Health Care NPs, Neonatal NPs, Acute Care NPs, Pediatric NPs, Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. AANP describes the NP role:

> NP students determine their patient populations at the time of entry to an NP program. Population focus from the beginning of educational preparation allows NP education to match the knowledge and skills to the needs of patients and to concentrate the program of academic and clinical education study on the patients for whom the NP will be caring. For example, consider a primary care Pediatric NP. The entire time in didactic and clinical education is dedicated to the issues related to the development and health care needs of the pediatric client. While medical students and residents spend time learning how to manage adult clients and complete surgery rotations, a primary care pediatric nurse practitioner student's educational time is 100 percent concentrated on the clinical area where the NP clinician will actually be practicing.

Most state laws are specific about APRN scope of practice. APRNs who practice outside of their scope of practice will find their license in jeopardy.

Maintain Quality – the evidence:

- The ability of APRNs to provide safe, cost-effective, high-quality care is well documented in many studies over the past 30 years.
- APRNs have low rates of malpractice and adverse actions (National Practitioner Data Bank; ratio APRNs 1:166 compared to 1:4 for physicians-Pearson, 2011).
- One third of the nation's states have adopted laws that allow APRNs to practice to the full extent of their education and training, with no changes documented in quality of care.