



Arkansas State Board of Nursing

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BOARD MEETING MINUTES

TIME AND PLACE:

January 10, 2018
ASBN Boardroom

MEMBERS PRESENT:

Ramonda Housh, MNSc, APRN, CNP, C-PNP; Rachel Sims, BSN, RN; Yolanda Green, LPN; Neldia Dycus, BS, MHSM, MHRD, RN; Stacie Hipp, MSN, APRN; Pamela Leal, RN, Representative of the Older Population; Michael Burdine, RN; Renee Mihalko-Corbitt, DNP, APRN, ACNS-BC; Melanie Garner, LPN, CLC; Janice Ivers, MSN, RN, CNE; Kaci Bohn, PhD, Consumer Representative; Lance Lindow, RN

MEMBERS ABSENT:

Haley Strunk, LPN

STAFF ATTENDING

AT VARIOUS TIMES:

Sue A. Tedford, MNSc, APRN, Executive Director
Fred Knight, JD, General Counsel
Mary Trentham, JD, MNSc, MBA, APRN, CNP, Attorney Specialist
Deborah Jones, RN, MNSc, Assistant Director
Karen McCumpsey, RN, MNSc, Assistant Director
Darla Erickson, CPA, Administrative Services Manager
Susan Lester, Executive Assistant to the Director
Tammy Claussen, MSN, RN, CNE, Program Coordinator
Debra Garrett, DNP, APRN, Program Coordinator
Lisa Wooten, MPH, BSN, RN, Program Coordinator
LouAnn Walker, Public Information Coordinator
Jim Potter, Regulatory Board Chief Investigator
Albert Williams, Information Systems Coordinator

President Ramonda Housh called the meeting to order at 8:38 a.m. A flexible agenda was declared.

Sue Tedford welcomed and introduced the two (2) new Board Members, Neldia Dycus and Rachel Sims.

Mary Trentham, the Board's attorney, presented Consent Agreements that had been entered into since the last meeting. Following discussion of each individual agreement, the following motion was passed:

MOTION 1: I MOVE that the Arkansas State Board of Nursing ratify the following Consent Agreements:

- Barrow, Debra Denise, R033690, L017944 (expired)** (Bryant, AR)
Violation – Terms and Conditions of Probation
Probation – 2 years
Course – Anger Management
Civil Penalty - \$1,500.00
- Baser, Karen Rebecca, R088182, L045461 (expired)** (Maumelle, AR)
Violation – Terms and Conditions of Probation
Probation – 2 years
Course – Ethics of Nursing Practice
Civil Penalty - \$750.00
- Chaloupka, Sharon Denise Alford, L025080** (Beebe, AR)
Violation – ACA § 17-87-309 (a)(6)
Probation – 1 year
Courses - Prescription Drug Abuse: Scope, Prevention, and Management
Considerations for Nurses; Sharpening Critical Thinking Skills
- Desonie, Nancy Susan Isch, R044280** (Conway, AR)
Violation – ACA § 17-87-309 (a)(6) (a)(8), and (a)(9)
Probation – 1 year
Course – Documentation for Nurses; The Arkansas Nurse Practice Act
Civil Penalty - \$875.00
- Doty, Brandon Kyle, R090965 (expired)** (Jonesboro, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Probation – 4 years
Courses – Documentation For Nurses; Disciplinary Actions: What Every Nurse
Should Know; Prescription Drug Abuse: Scope, Prevention, and
Management Considerations for Nurses
Civil Penalty - \$3,500.00
- Farmer, Alexis Suzanne, R092246** (Harrison, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Probation – 2 years
Course – The Arkansas Nurse Practice Act; Prescription Drug Abuse: Scope,
Prevention, and Management Considerations for Nurses
Civil Penalty - \$1,500.00
- Hale, Meredith Ann, R090080** (Benton, AR)
Violation – Terms and Conditions of Probation
Suspension – 3 months to be followed by
Probation – 2 years
Courses – Sharpening Critical Thinking Skills; Prescription Drug Abuse: Scope,
Prevention, and Management Considerations for Nurses
Civil Penalty - \$1,000.00

Hazelwood, Brittany Nicole Hazelwood McCoy, R092239 (expired), L047936 (expired) (El Dorado, AR)
Violation – Terms and Conditions of Probation
Probation – 2 years
Course – Maintaining Professional Boundaries in Nursing
Civil Penalty - \$1,500.00

Higgins, Jewel Janice, L057818 (Hot Springs, AR)
Violation – ACA § 17-87-309 (a)(6)
Probation – 2 years
Course – Documentation for Nurses
Civil Penalty - \$1,500.00

Hobbs, Chaundell Renae Montague, R074536 (Benton, AR)
Violation – Terms and Conditions of Probation
Probation – 2 years
Courses – Documentation for Nurses; Disciplinary Actions: What Every Nurse Should Know
Civil Penalty - \$750.00

Hopson, Christa M., R097318 (North Little Rock, AR)
Violation – ACA § 17-87-309 (a)(6)
Probation – 1 year
Course – The Arkansas Nurse Practice Act
Civil Penalty - \$1,250.00

Howard, Rachel Ann Kilgore Arnold, R095426, L052177 (expired) (Amity, AR)
Violation – Terms and Conditions of Probation and (a)(4)
Probation – 2 years

Jones, Alicia Dawn Holliday, R093203 (Batesville, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Suspension – 3 months to be followed by
Probation – 2 years
Course – Disciplinary Actions: What Every Nurse Should Know

Jordan, Jeremy Edward, R082939 (Omaha, AR)
Violation – ACA § 17-87-309 (a)(2), (a)(4) and (a)(6)
Probation – 3 years
Courses – Sharpening Critical Thinking Skills; Anger Management; The Arkansas Nurse Practice Act

Loetscher, Kandace Lyn Scobey, R085389 (Rison, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Suspension – 6 months to be followed by
Probation – 2 years
Course – Disciplinary Actions: What Every Nurse Should Know
Civil Penalty - \$1,500.00

Love, Ann Karen Tenhaken Flanders, R045029, L020898 (expired) (Little Rock, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Probation – 2 years
Courses - Prescription Drug Abuse: Scope, Prevention, and Management
Considerations for Nurses; Ethics of Nursing Practice

McCarty, Harry Douglas, R035359 (expired) (Benton, AR)
Violation – Terms and Conditions of Probation
Suspension – 6 months to be followed by
Probation – 2 years
Course - Prescription Drug Abuse: Scope, Prevention, and Management
Considerations for Nurses
Civil Penalty - \$750.00

McCurdy, Kim Ann Jalbert, R028823 (Fordyce, AR)
Violation – ACA § 17-87-309 (a)(6)
Probation – 1 year
Course – Sharpening Critical Thinking Skills
Civil Penalty - \$750.00

McClanahan, Michael, R091597 (expired) (Alexander, AR)
Violation – Terms and Conditions of Probation
Suspension – 3 months to be followed by
Probation – 3 years
Courses – Ethics of Nursing Practice, Disciplinary Actions: What Every Nurse
Should Know
Civil Penalty - \$2,200.00

Naucke, Sally Houston, P000827, R030516 (Little Rock, AR)
Violation – Terms and Conditions of Probation
Probation – 2 years
Course - Prescription Drug Abuse: Scope, Prevention, and Management
Considerations for Nurses
Civil Penalty - \$750.00

Page, Melissa Lee, L047800 (expired) (Springdale, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Probation – 3 years
Courses – Documentation for Nurses; Prescription Drug Abuse: Scope,
Prevention, and Management Considerations for Nurses; Ethics of
Nursing Practice
Civil Penalty - \$2,000.00

Perry, Vallyn Nicole, R082820 (Little Rock, AR)
Violation – ACA § 17-87-309 (a)(6) and (a)(9)
Probation – 2 years
Courses – Disciplinary Actions: What Every Nurse Should Know; Anger
Management
Civil Penalty - \$750.00

- Pool, Julie Renee Thompson, R065274 (expired)** (Benton, AR)
Violation – ACA § 17-87-309 (a)(4) and (a)(6)
Probation – 2 years
- Power, Denitia Lynn Lumsden, R080641(expired)** (Rison, AR)
Violation – ACA § 17-87-309 (a)(6)
Probation – 2 years
Civil Penalty - \$1,500.00
- Russell, Amber, RN Applicant** (Russellville, AR)
Violation – ACA § 17-87-309 (a)(4)
Probation – 1 year
- Tabbe, Tammy Sue, L050364** (Hot Springs, AR)
Violation – Terms and Conditions of Probation
Probation – 3 years
Courses – Maintaining Professional Boundaries in Nursing; Ethics of Nursing Practice
Civil Penalty - \$750.00
- Waldrup, James Derrick, L049993** (Warren, AR)
Violation – Terms and Conditions of Probation
Probation – 1 year
Courses – Sharpening Critical Thinking Skills; The Arkansas Nurse Practice Act
PASSED.

Sue Tedford presented information regarding the disbursement of funds for scholarships. After discussion the following motion was passed:

MOTION 2: I MOVE that the Arkansas State Board of Nursing continue the disbursement of funds from the Faith A. Fields Nursing Loan Program for the 2018 Spring Semester, as follows:

Educator Applicants:

- 1) \$1,500.00 payable to the American Sentinel University on behalf of Ashley Murdock;
- 2) \$1,500.00 payable to the Arkansas Technical University on behalf of Ashley Ball;
- 3) \$1,500.00 payable to the American Sentinel on behalf of Elizabeth Riley;

Practice Applicants:

- 1) \$1,200.00 payable to Northwest Tech on behalf of Amanda Burton;
- 2) \$1,200.00 payable to University of Central Arkansas on behalf of Emily Luck;
- 3) \$600.00 payable to University of Arkansas in Little Rock on behalf of Amanda Harwell;

The recipients for the Jill S. Hasley Scholarship Loan and are listed as follows:

Educator Applicant:

- 1) \$3,000.00 payable to the University of Arkansas in Fayetteville on behalf of Susan Ferguson;

Practice Applicant:

- 1) \$600.00 payable to University of Arkansas in Little Rock on behalf of Wesley Smith.

PASSED

Mary Trentham presented an additional Consent Agreement for the Board's consideration. Following discussion of the agreement, the following motion was passed:

MOTION 3: I MOVE that the Arkansas State Board of Nursing ratify the following Consent Agreement:

Strack, Kelli Michel, R088945

(Conway, AR)

Violation – ACA § 17-87-309 (a)(6)

Probation – 1 year

Courses – Documentation for Nurses; Critical Thinking Skills

Civil Penalty – \$750.00

PASSED

DISCIPLINARY HEARINGS

General Counsel, Fred Knight represented the Board. Motions reflect the decisions of the Board reached in deliberation following the hearing of each case.

TERRI DIANE BAILEY RICHARDSON, APRN LICENSE NO. A005341, RN LICENSE NO. R033103 and LPN LICENSE NO. L018415 (EXPIRED)

Respondent was present for the proceedings before the Board and was not represented by counsel. Deborah Garrett, DNP, APRN, provided testimony on behalf of the Board. Respondent has requested a hearing before the Board to request a Prescriptive Authority Certificate. After a hearing before the Board on August 13, 1986, Respondent's nursing license was suspended for two (2) years with conditions. The Board found that the respondent was guilty of violating Ark. Code Ann. §17-87-309(a)(2), (a)(4), and (a)(6). On August 7, 1991, after a hearing before the Board, Respondent's license was placed on probation for two (2) years with conditions. The Board found that the Respondent had violated Ark. Code Ann. §17-87-309(a)(4) and (a)(6). On October 11, 2002, after a hearing before the Board the Respondent was found to have violated Ark. Code Ann. §17-87-309(a)(4), (a)(6), and (a)(9), and her license was placed on probation for two (2) years with conditions. On or about October 25, 2001, the Respondent voluntarily surrendered her nursing license. On January 14, 2004, after a hearing before the Board, the Respondent was found to have violated the terms and conditions of her probation. Respondent's nursing license was placed on probation for ten (10) years with conditions. Respondent's license was cleared of probationary status on January 13, 2014. Respondent was issued an APRN license on or about August 23, 2017. Respondent now request her Certificate for Prescriptive Authority.

MOTION 4: I MOVE that based on the evidence presented and the allegations contained in the Order and Notice of Hearing, the Arkansas State Board of Nursing finds that **TERRI DIANE BAILEY RICHARDSON, APRN LICENSE NO. A005341, RN LICENSE NO. R033103 and LPN LICENSE NO. L018415 (EXPIRED)**, not violated Arkansas Code Annotated § 17-87-309 and that Respondent's Prescriptive Authority be Issued.

Lance Lindow has recused himself from this case.
Brought by Janice Ivers and seconded by Melanie Garner.
PASSED

ELISA CATHERINE COLLIE FELTNER, RN LICENSE NO. R089254

Respondent was not present for the proceedings before the Board and was not represented by counsel. Deborah Jones, MN Sc, RN, and Penny Summers, RN, Investigator, Pharmacy Services, provided testimony on behalf of the Board. Respondent is licensed as a Registered Nurse and holds License No. R089254. On or about April 7, 2017, Carol Gore, MBS, BSN, RN, Chief Nursing Office and Alan Reams, PD, Director of Pharmacy, Saint Mary's Regional Medical Center, Russellville, Arkansas, reported Respondent's mismanagement of controlled substances and activity consistent with drug diversion. Respondent was hired at St. Mary's on September 22, 2015. Respondent received a written warning for excessive absences on January 19, 2017. During an audit of patient narcotic transactions for the months of December 2016, January 2017, and February 2017, it was discovered that Respondent's administration of hydromorphone was substantially greater than her co-workers. The audit revealed that on at least fourteen (14) occasions Respondent failed to document the administration or wastage of controlled substances. On March 14, 2017, Respondent was asked to submit a reasonable cause urine drug screen (UDS). After four (4) attempts of not being able to provide an acceptable specimen, Respondent left the facility and did not return. Respondent's employment was terminated. During an investigation and review by Pharmacy Services, Arkansas Department of Health, of seven (7) of Respondent's patient's records the following was discovered: between December 4, 2016, and March 6, 2017, a total of 1.25 mg of lorazepam was unaccounted for, 0.25 mg of alprazolam was unaccounted for, 7.5 mg of hydrocodone was unaccounted for, 2 mg of hydromorphone was unaccounted for, and there were multiple occasions where Respondent did not document the administration of controlled substances in patient records until two (2) or three (3) days after she had allegedly administered the drugs. Respondent's pharmacy records indicate that between July 11, 2015, and June 30, 2017, she received multiple prescriptions for controlled substances including codeine, Adderall, hydrocodone, and tramadol. While employed at Washington Regional Medical Center, Respondent received verbal and written warnings for excessive absences, lethargic behavior, slurred speech, untimely wasting of narcotics, not documenting shift assessments, and inappropriate medication administration. On March 30, 2015, Respondent received a written warning due to improper medication administration, giving twice the amount of oxycodone/Percocet as other nurses during a ten week period, and giving multiple narcotics to the same patient within minutes of each other. On or about October 4, 2017, Respondent submitted to a psychological evaluation by Dr. George M. DeRoeck, Psy. D. Dr. DeRoeck concluded that the Respondent was not capable of practicing nursing at the time. Staff have attempted to contact and work with the Respondent.

MOTION 5: I MOVE that based on the evidence presented and the allegations contained in the Order and Notice of Hearing, the Arkansas State Board of Nursing finds that **ELISA CATHERINE COLLIE FELTNER, RN LICENSE NO. R089254**, has been charged with a violation of Arkansas Code Annotated § 17-87-309(a)(5), (a)(6); and that Respondent's license and privilege to practice as a nurse be suspended two (2) years with the following terms and conditions:

- Pursuant to A.C.A. §17-87-104(b)(1), Respondent must pay a civil penalty of \$4,400.00 plus any outstanding balance associated with previous disciplinary action.
- Respondent shall immediately notify the Board in writing of any change, even a temporary one, in name or address.
- Respondent shall attend AA/NA, or other Board approved treatment program/support group meetings and shall submit quarterly reports to the Board. Respondent shall provide acceptable evidence of attendance. Acceptable evidence shall consist of completion of the disciplinary form, *Aftercare Meetings Report*. Respondent shall attend at least three (3) AA/NA or other Board approved support group meetings a week during the period of supervision or follow the evaluator's recommendations if the Evaluator's recommendations are greater.

- Respondent shall obtain or continue counseling with a psychiatrist, psychologist, or other recognized mental health practitioner and shall submit the practitioner's progress report every two (2) months until discharged by the practitioner. Treatment shall begin within thirty (30) days of receipt of this order.
- Respondent shall submit to observed, random drug screens. The observed drug screens shall meet the criteria established by the Board and be conducted through a Board-approved drug screen monitoring program, laboratory, and collection site. Respondent shall contact a Board-approved drug screen-monitoring program within five (5) business days of receipt of this Order. Respondent shall not submit specimens at Respondent's place of employment or practice site. Respondent shall not collect any drug screen ordered by the Board of Nursing. Respondent shall contact the drug screening company daily. If selected for testing, Respondent shall present for a drug screen the same day of the notification and shall have two (2) hours to submit a specimen. Dilute specimens will be considered an attempt to alter test results.
- Respondent shall abstain at all times from the use of controlled or abuse potential substances, including alcohol and products that contain alcohol. Respondent shall not consume hemp, poppy seeds, or any product or by-product containing the same. Short-term treatment may be allowed for an acute illness or acute condition. Short-term treatment is a course of treatment that is limited in duration. Respondent shall notify board staff in writing immediately of any acute illness or condition treated with abuse potential substances. Respondent shall ensure that the prescribing practitioner submits a written report to Board staff within ten (10) days of prescribing a controlled or abuse potential substance.
- Respondent shall be re-evaluated for safe-to-practice by a practitioner, who meets the Board approved criteria and specializes in addiction disorders prior to reinstatement. Respondent shall supply a copy of the Board's Order to the evaluator and practitioner must be provided the psychological evaluation from Dr. DeRoeck, dated October 16, 2017.
- Respondent shall provide evidence of successful completion of a continuing education course approved by the Board staff in the following: *The Nurse and Professional Behaviors, Substance Abuse and Documentation for Nurses*.
- Respondent shall request license reinstatement in a registered letter to the Board once compliance with the Board's Order is met.
- Respondent shall submit a personal report to accompany required data to the Board on a quarterly basis.
- Respondent shall ensure that all required reports are submitted to the Board on a quarterly basis.
- Respondent shall obey all federal, state, and local laws, and all rules governing the practice of nursing in this state.
- Respondent shall be responsible for all costs involved in complying with the Board's Order.
- Pursuant to Ark. Code Ann. §17-87-309, failure to comply with this Order may result in additional disciplinary action on the Respondent's licensure and /or privilege, including but not limited to, additional probation, suspension, or revocation of licensure and/or privilege to practice nursing in this state.
- A probation period of three (3) years shall follow the suspension period. All conditions of the suspension period regarding treatment programs, random drug screens, and abstinence shall continue through the probation period.
- While on probation, if working as a nurse Respondent shall notify each employer of the Board's Order and shall practice under an employer monitored nurse contract. The employer shall submit to the Board a copy of the employer-monitored nurse contract and bi-monthly Performance Evaluation Reports.
- Respondent shall work under direct supervision in any setting. Direct supervision requires another nurse to be working in the same setting as Respondent and readily available to provide assistance and intervention.
- Respondent shall be limited to eight (8) to ten (10) hour shifts with a maximum of forty (40) hours per week.

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- Respondent shall not be employed in critical care, hospice or home health settings.
- Respondent shall not work outside the State of Arkansas in another compact licensure state.
- Respondent shall request verification of termination of the probationary period in a registered letter to the Board.

Brought by Mike Burdine and seconded by Neldia Dycus.

PASSED

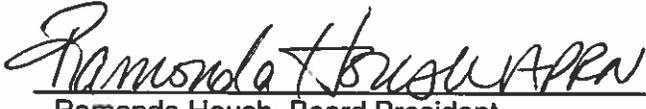
STAFF REPORTS

Sue Tedford along with Kaci Bohn and Ramonda Housh shared information regarding their trip to the North Carolina Board of Nursing where they learned about their alternative to discipline program. The program in North Carolina works with participants of the program on a case-by-case basis. Nurses are assessed by a counselor and a doctor using the culture of health philosophy. Discipline is only used when a program participant is non-compliant. While in the program, the nurse provides admission of addiction. All nurses meeting admission criteria are offered entry into the North Carolina alternative to discipline program. After an eligible nurse declines entry into the program twice, an investigation ensues. The nurse must submit to at least one year of drug screening and their employer is made aware of their participation in the program. Alternative to discipline program participants have one shot in the non-disciplinary tract. While in the program, the nurse's license is kept active but the nurse agrees not to practice.

Board Members expressed their concerns about some of the processes involved in the North Carolina alternative to discipline program but agreed there were many positive aspects of the program. Sue Tedford informed the Board Members two consultants have been hired to assist with the drafting of policies for the Arkansas State Board of Nursing's alternative to discipline program which currently remains unnamed. Ms. Tedford shared the attached flowchart and rough draft version of policies (Attachment #1). After much discussion about the policies and details regarding the ASBN alternative to discipline program, an ad hoc committee was created to work out further specifics of the program. The ad hoc committee members include the following Board Members: Kaci Bohn, Mike Burdine, Yolanda Green, Ramonda Housh, and Pam Leal.

Debbie Garrett shared information regarding an APRN's scope of practice. She provided every Board Member with a copy of the attached Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, *July 7, 2008*, (Attachment #2) and Nurse Practitioner Core Competencies Content, *2017*, (Attachment #3). Ms. Garrett explained the requirements of the consensus model and how they affect Arkansas APRNs. After discussion, it was determined ASBN should hold nurses to the standards as set out in the consensus model. It was also decided ASBN should educate the public and employers about those standards. The Board Members directed Ms. Garrett to ensure APRNs practice within their education certifications and not to approve collaborative practice agreements unless APRNs are practicing within their scopes. The Board Members suggested sending reminder letters to renewing APRNs telling them not to forget that collaborative practice agreements must be within their scope of practice and nurses who practice outside their scopes are subject to discipline.

There being no further business, the meeting adjourned at 4:50 p.m.



Ramonda Housh, Board President

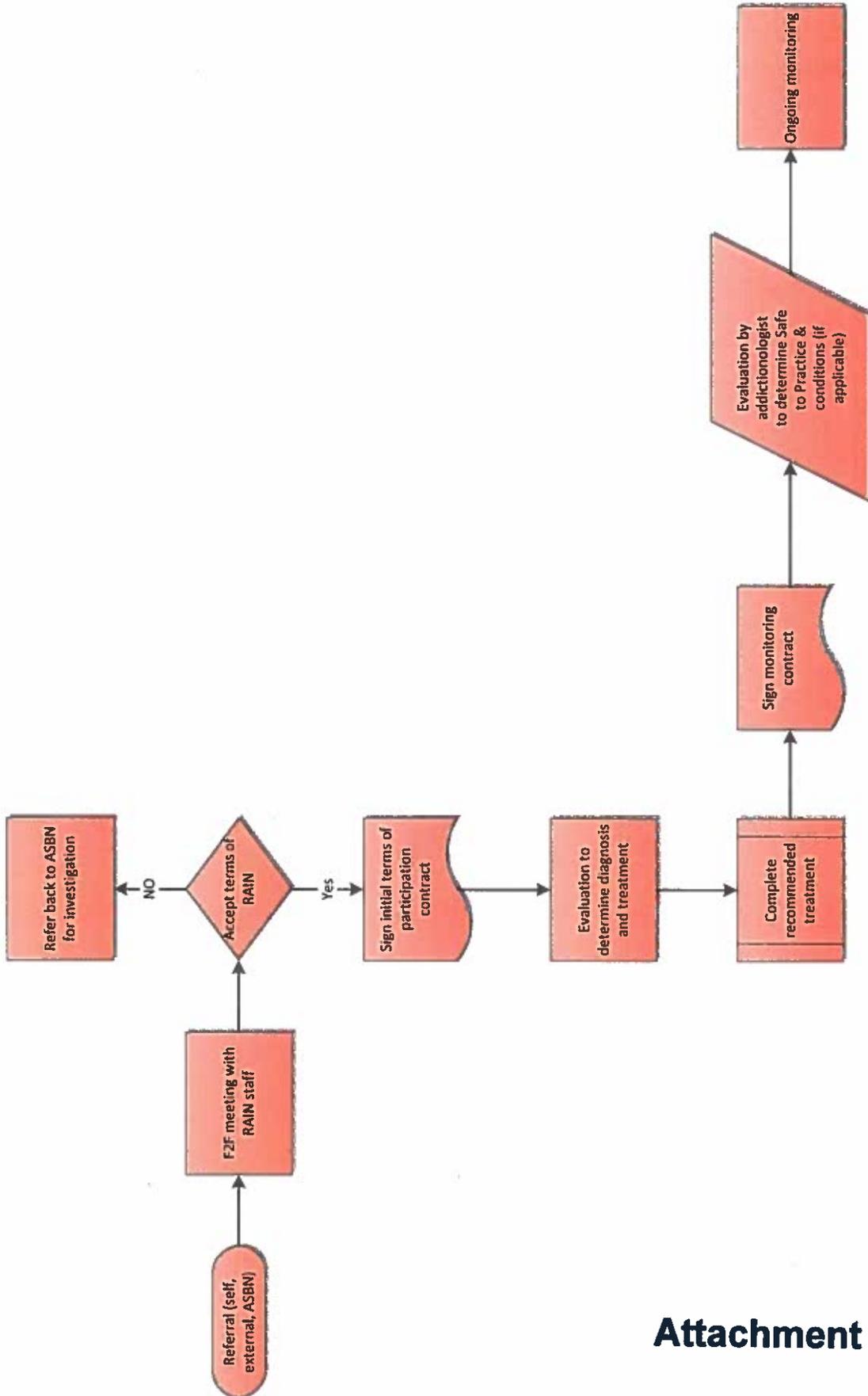


Susan Lester, Recording Secretary



Date Approved

RAIN Program Process



Attachment #1

At any point in the RAIN program the participant is not cooperative or compliant, the case will be referred to the ASBN for review by the disciplinary process.

Assessment and Evaluation Requirements

POLICY: Individuals referred to RAIN shall be provided guidelines for enrollement and participation in the RAIN program.

PROCEDURE:

- I. Upon contact from an individual seeking admission into the RAIN program, information about the agency, referral process and monitoring process will be provided.
- II. At the time of acceptance of RAIN services the participant shall:
 - a. Complete and submit a release of information for:
 - i. Employer (current or most recent)
 - ii. ASBN
 - iii. Evaluator and/or treatment provider
 - b. Sign a participant contract; and
 - c. Place all Arkansas nursing licenses on inactive status and agree to not practice as a nurse in any setting.
- III. The individual will be required to either:
 - a. Undergo a treatment evaluation with an ASBN approved licensed practitioner who is familiar with RAIN, substance use disorders and ASBN requirements; or
 - b. Admit directly to an ASBN approved substance use disorder treatment facility.
- IV. Initial Treatment Evaluation
 - a. To be acceptable, the evaluation appointment and interview should occur after the individual has officially requested RAIN services and from a healthcare provider licensed by the state of Arkansas and approved by the ASBN. Exceptions are considered on a case-by-case basis.
 - b. The focus of the evaluation is to determine if the individual has a substance use disorder that would interfere with his/her ability to practice nursing.
 - c. The purpose of the evaluation is to gather information regarding the evaluator's diagnostic impression and to recommend treatment and/or monitoring parameters.
 - d. All evaluations shall be conducted through an in-person assessment.
 - e. The evaluation does not establish a patient/provider relationship.
 - f. The evaluator will provide RAIN with a written report providing recommendations, if any, and a determination of the individual's fitness to practice safely.
 1. Upon receipt, the evaluation report will be reviewed by the RAIN staff.
 2. RAIN staff member will contact the participant and provide the recommendations, if any, to the individual. An evaluation recommendation letter will be mailed (certified and regular) to the individual. The letter will establish a timeline for compliance with the recommendations.
 3. If there are no recommendations the file will be closed and when appropriate notify the ASBN.
 4. The individual is expected to comply with all treatment and monitoring recommendations.

Policy I

- V. Treatment
 - a. An individual who recognizes that (s)he needs treatment may bypass the RAIN evaluation and report directly to a treatment facility approved by the ASBN.
 - b. The treatment facility shall conduct an assessment to determine if the individual will benefit from treatment and if so, the appropriate level of treatment.
 - c. When the treatment facility staff have determined the level of treatment, the individual may seek treatment at that facility or another as long as the treatment is consistent with the recommendation and the facility is approved by the ASBN.
 - d. If already admitted to an inpatient treatment facility at the time of referral, the individual shall sign a release allowing the treatment facility and RAIN to correspond about the admission evaluation and ongoing treatment to ensure the care is comparable to those facilities approved by the ASBN. There is no assurance that RAIN will accept non Board approved treatment facilities.
- VI. Addictive evaluation
 - a. Prior to return to practice as a nurse, the participant shall complete an addictive evaluation by a Board approved addiction specialist.
- VII. Declined Service
 - a. The file will be closed and the ASBN notified when an individual who has requested participation in RAIN does not complete the enrollment/intake process.
- VIII. Public Safety
 - a. The ASBN is immediately notified when the RAIN staff has concern for an individual's immediate safety or the safety of others.
 - b. RAIN may continue with its offer of services to the individual unless otherwise directed by the ASBN.
- IX. Demographic information, including, but may not be limited to the following will be collected from the request for services form and entered into RAIN's database:
 - a. Name
 - b. Address
 - c. Telephone number(s)
 - d. License number
 - e. Referral source (employer, self, ASBN, treatment, legal, etc.)
 - f. Details of why services are being requested (who, what, when, where, and why)
 - g. Education
 - h. Employment History

Admission Criteria

POLICY: Participation in the RAIN program is limited to those individuals who are health care providers licensed or are seeking licensure by the Arkansas State Board of Nursing (ASBN).

PROCEDURE:

- I. Eligibility
 - a. Individual shall hold a current, active license issued by the ASBN; or
 - b. Be an applicant for initial licensure or for reinstatement by the ASBN; and
 - c. If applicable, must voluntarily place license(s) on inactive status until approved for reactivation by RAIN staff.
- II. Enrollment. The individual shall request services in writing by submitting all appropriate forms including release of information and providing a copy of all requested legal documents.
- III. Referral to RAIN requires one or more of the following:
 - a. A finding by an ASBN board approved mental health service provider or treatment facility that an individual has a substance use disorder and can benefit from monitoring during the early stage of recovery.
 - b. A finding or belief that ability to practice of a licensee or an applicant for licensure is impaired or potentially impaired due to the use of alcohol and/or other drugs.
 - c. The individual has requested to participate in the RAIN program.
 - d. The individual is requested to participate in RAIN by his/her employer
 - e. The individual has successfully completed treatment for substance use disorder and a reasonable expectation exists that the impairment or potential impairment will be alleviated.
- IV. Enrollment in RAIN is voluntary regardless of the referral source. Although the final decision to accept or decline services is solely the individual's, not doing so may impact his/her status with the ASBN.
- V. Enrollment or participation in RAIN may be denied if the individual:
 - a. Is not eligible for licensure in the state of Arkansas.
 - b. Does not have a condition identified for which treatment is available and can reasonably expect to alleviate or significantly reduce the practice issues for which the individual was referred or seeking services.
 - c. Is unwilling or unable to abstain from potentially addicting drugs (legal or illegal), including alcohol.
 - d. Is unable to abstain from abuse potential medications unless approval for the medication is recommended and documented by a Board approved addiction evaluator.
 - e. Insists that RAIN communication, either written or verbal, be filtered through an attorney.
 - f. After undergoing an evaluation wherein substance use disorder treatment is recommended the participant is unable or unwilling to adhere to the evaluation recommendation, (s)he may be temporarily excluded from enrollment until (s)he provides documentation of completion of the recommended level of treatment at a Board approved treatment facility.
 - g. After requesting RAIN services, the participant abandoned the enrollment or declined to complete the enrollment process.

Referral for Participation

POLICY: Referrals will be accepted from any external source, the ASBN or by the individual requesting participation.

PROCEDURE:

I. Referral Source

a. Self-referrals may result from:

1. A licensee experiencing issues related to substance use disorder (e.g. a positive drug screen, workplace issues, diversion for self-administration, transferring from a similar program in another state, etc.).
2. A licensee who has been charged or convicted of a drug related crime.

b. External referrals may come from any source such as:

1. The employer;
2. Co-worker;
3. Family member;
4. Anonymous source; or
5. Local, state or national agency, etc.

c. ASBN referrals may come from:

1. The review of a complaint filed against the licensee if the complaint appears to be related to a substance use disorder.
2. Determination that it is appropriate for the individual to undergo a RAIN evaluation prior to issuance of an initial license or the reinstatement of an expired license based on the individual's substance use history.
3. An investigation being conducted by the ASBN.

II. The referring source will provide, at a minimum:

1. Name of referring source, company/agency if applicable, address and telephone number.
2. Demographic information for the individual being referred (name, address and telephone number, profession and license number.
3. Detailed reason for referral and date incident(s) occurred or observed, name and contact information for others who may be aware or observed the behavior/incident.

III. Referral reasons may include, but not limited to:

- i. Criminal misdemeanor or felony conviction other than minor traffic offense
- ii. Diversion of narcotics or suspicion of diversion from the workplace for self-use.
Note: If a determination is made that an individual is diverting medications for the sole purpose of selling the medications or to provide to someone else, the individual is not eligible for RAIN.
- iii. Fitness-for-practice concern
- iv. Prescription forgery, over-prescribing or "doctor shopping"
- v. Workplace behavioral changes
- vi. Toxicology result other than "negative"
- vii. Documentation issues
- viii. Diagnosis of substance use disorder

IV. RAIN does not release the information regarding the referring source except to the ASBN.

V. Upon receipt of a referral, a RAIN staff member will contact the individual by sending a referral notification letter via the USPS certified and regular mail.

Policy III

- VI. An individual who is referred to RAIN and does not respond to RAIN's letter of notification by the deadline date, declines services, does not timely undergo an evaluation, or does not timely adhere to any/all RAIN recommendations shall be reported to the ASBN.
- VII. Individuals will not be admitted into the program if they:
 - 1. Diverted controlled substances for reasons other than self-administration;
 - 2. Engaged in behaviors resulting in patient harm;
 - 3. Have prior discipline by any board of nursing for substance abuse or diversion; or
 - 4. Demonstrated unsuccessful participation resulting in termination from the Arkansas ATD program or similar program offered in another jurisdiction.

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Monitoring Components

POLICY: The RAIN program is a five (5) year non-disciplinary monitoring program for individuals diagnosed with substance abuse disorder.

PROCEDURE:

- I. RAIN staff will immediately and accurately document, in writing, all contacts that are made with a participant, family member, employer, ASBN, or other professionals regarding an individual seeking RAIN services or who is enrolled in the program.
- II. At a minimum, each progress note will include, date of contact, purpose of contact, the name of the staff member entering the note, and issues discussed (who, what, when, why). Full names, titles, and telephone number of individuals referred to within note shall be entered when available.
- III. Each staff member will document all attempts to contact an individual, including, but not limited to, messages left on answering machines, voice mail and phone not being answered or no longer working.
- IV. RAIN staff is responsible for ensuring that appropriate release of information forms have been obtained for each participant assigned to his/her caseload.
- V. RAIN staff is responsible for ensuring that the information maintained in the database is current, correct and that all demographic (e.g., name, address, telephone number, date of birth, referral source, date, reason for referral, etc.), professional experience, evaluation, treatment, employment, education and monitoring agreement fields are entered.
- VI. RAIN staff is responsible for monitoring all aspects of the RAIN contract and ensuring that any reports required by the monitoring contract are received in a timely manner. This includes, but may not be limited to:
 - a. Progress Evaluation
 - b. Employer Performance Evaluation
 - c. Self-reports
 - d. Meeting Attendance Record
 - e. Verification of Prescription Medication
 - f. Drug Screen results
- VII. RAIN staff will speak with a participant when controlled medications are prescribed and review safe handling procedures and possible alternatives, reviewing closely all medication reports and requesting addictionologist consultation when indicated.
- VIII. RAIN staff will communicate at least once monthly with each assigned participant. More frequent contact may be necessary with participants who are early in their recovery or who may be noncompliant with the monitoring agreement. More frequent contact is intended to support those early in the program and to encourage the noncompliant individual to regain compliance.
- IX. If RAIN staff increase or decrease the number of default random selections for screening, the information shall be entered in the testing agency note field along with a detailed explanation for the change.
- X. RAIN staff will prepare a quarterly report and submit to the ASBN.
- XI. A fitness for duty evaluation may be necessary whenever a participant is consistently noncompliant, receives negative performance evaluation from employer or seemingly not progressing satisfactorily in the recovery process.

Compliance Requirements

POLICY: Participants are expected to follow all compliance requirements as specified in the evaluation recommendations, treatment plan and the program contract. Failure to comply may result in termination from the program.

PROCEDURE:

- I. The participant is responsible for following the evaluation recommendations, treatment plan, if any and monitoring agreement stipulations at all times while participating in the RAIN program.
- II. The participant is responsible for remaining free of all controlled or potentially addictive substances, including alcohol, over-the-counter and prescriptive drugs while enrolled in RAIN. If there is a need for the use of controlled or potentially addictive substances, the participant is required to consult with RAIN staff prior to ingesting these drugs, or within 48 hours.
- III. The participant is responsible for ensuring that all components of the monitoring agreement are followed and appropriate documentation is provided to RAIN according to policy. This may include, but is not limited to the following work-related items:
 - a. In the workplace environment, a RAIN participant must not accept any position which may be responsible for providing patient care to any other RAIN participant.
 - b. The participant will not accept any position where (s)he may be required to supervise another participant of RAIN while enrolled in the program.
 - c. The participant shall not work in any licensed health care field until approval to do so has been obtained from RAIN in writing. The participant must contact RAIN to receive approval for each specific position accepted and may not work in any unsupervised position. Whenever a change in professional employment is being considered, the participant must consult with RAIN and shall sign an authorization to release information for the prospective employer. The participant shall not begin working in any nursing related position or changing positions before receiving written authorization from RAIN.
- IV. Participants shall notify RAIN of any change of name, address, phone numbers, or employment within 24 hours of this change occurring. Participants who fail to communicate these changes may be discharged from the program and the ASBN notified.
- V. Participants are responsible for responding within one business day to call back requests from RAIN.
- VI. Participants enrolled in RAIN are responsible for assuring that the financial obligations of their evaluation and treatment are fulfilled as promptly as possible.
- VII. Additional Rules – participants in RAIN must adhere to the following:
 - a. Participants shall refrain from practice of nursing until authorized by RAIN staff, in writing, to a specific professional position.
 - b. Participants shall follow all treatment recommendations.
 - c. Participants must be actively involved in continuing care during participation in the RAIN program.
 - d. Participants must agree to and adhere to all aspects of the monitoring contract and/or amendments, including providing written reports as specified.
 - e. Participants must follow all specific participation procedures as outlined in the RAIN monitoring contract.

Policy V

- f. Any time a participant violates the monitoring contract, or a RAIN staff member believes that (s)he pose a threat to public safety, and/or have violated the *Nurse Practice Act*, the RAIN staff may notify the ASBN.
 - g. RAIN staff will explain to each participant seeking enrollment or enrolled in the program his/her rights, responsibilities and rules in non-technical language and make available a written copy.
- VIII. The participant shall sign the participant form acknowledging that (s)he has been informed of his/her rights.

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Employment Conditions and Parameters

POLICY: Specific conditions and parameters for employment locations, areas of practice and limitations on practice while participants are enrolled in the program are outlined in the participant's contract. Approval by RAIN staff is required prior to returning to practice, before accepting a new position or returning to previous employment.

PROCEDURE:

- I. A participant may request return to employment in a nursing position when the following conditions are met:
 - a. Completion of initial three (3) months of treatment recommendations;
 - b. Completion of an evaluation by a Board approved addictionologist, conducted within 30 days of submission of petition, which includes a statement the participant is ready to return to practice as a nurse and under what conditions this practice shall occur; and
 - c. Three months of 100% compliance with drug screening requirements.
- II. General requirements for seeking employment while participating in RAIN:
 - a. The participant shall submit a petition for reinstatement to the RAIN staff with all required documents.
 - b. Upon receipt of complete reinstatement petition the Reinstatement Committee shall review the petition and make a recommendation for return to practice.
 - c. Upon approval of return to work, the participant may seek employment.
 - d. Participants are to inform the prospective employer of RAIN participation prior to accepting any position. A job description is to be submitted to RAIN staff.
 - e. Participants will submit in writing, the name, address including zip code, phone number for the current employment and the name, telephone number, and email address of immediate supervisor to RAIN. If there is a change in supervisors the participant is to notify the new supervisor of RAIN enrollment and notify RAIN staff in a timely manner.
 - f. The RAIN staff will conduct a joint conference call with the employer and participant to discuss RAIN work requirements and restrictions prior to participant beginning employment.
 - g. Participants are required to provide employers with a copy of their RAIN contract.
 - h. Approved positions must include direct supervision. Supervisors must be aware of RAIN participation and be readily accessible.
 - i. Participants are required to practice a minimum of 64 hours per month for one year to meet completion criteria.
- III. Supervision Requirements
 - a. All RAIN participants must be supervised by another licensed healthcare professional working on the same shift, who must see the participant periodically throughout the shift and must be aware of the participant's RAIN participation.
 - b. Supervisors must hold the same level of licensure or greater. APRNs may be supervised by a physician.
 - i. Supervisors must be on premises and cannot be on-call, or on a pager.
 - ii. Supervisors shall have an active unencumbered license.
 - iii. Approval of supervisors with past discipline will be considered on a case-by-case basis by RAIN staff.

Policy VI

- c. The following work restrictions apply while employed as a nurse:
 - i. May not be self-employed or work for multiple employers in the healthcare field.
 - ii. Work more than 40 hours per week and/or more than 84 hours biweekly, if working 12-hour shifts.
 - iii. Work more than 12 hours in a 24 hour period.
 - iv. Float to areas not supervised by the participant's approved immediate supervisor.
 - v. Work in a substance abuse treatment center, home health setting, hospice, a staffing agency or areas of limited ability for supervision such as Critical Care, Emergency Department, Labor & Delivery, Cath lab or similar labs.
- d. Restrictions may be modified after 1 year of successful practice and documented compliance with RAIN participation if requested by participant or employer and approved by RAIN staff.

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Toxicology Testing

Policy: Participants in the RAIN program are required to submit periodic, random and on-demand toxicology testing. This testing may include urine, nails, blood and/or hair samples. Drug screens required by the RAIN program shall be accepted only through Board approved programs. Participants who are required to perform toxicology testing shall be referred to a Board approved drug screen-monitoring program.

Procedure:

- I. Accuracy and consistency are provided through a properly completed chain of custody at the collection site¹. Both the collector and the licensee who is providing the specimen for testing complete the chain of custody document.
- II. All urine drug screens shall be directly observed by the collector.
- III. Confirmation of results is provided through the process of confirmation cutoffs as outlined in the medical professional panel² (GC/MS – Gas Chromatography/Mass Spectrometry and LC/MS - Liquid Chromatography/Mass Spectrometry) by a Board approved drug screen monitoring program³.
- IV. Results of the random drug screens and verification of compliance with screening are available with online access by the Board approved drug screen-monitoring program. The RAIN staff is notified of any positive screen by the Board approved drug screen monitoring program. Chain of custody must be provided for the positive drug screen and is sent to the RAIN staff by the Board approved drug screen-monitoring program.
- V. Participants are required to check in with a Board approved drug screen monitoring program daily to determine if they have been selected for a random screening. Participants shall report to an approved testing site within two (2) hours of notification for testing.
- VI. RAIN staff reserved the right to require additional testing at any time during program participation.
- VII. Hair testing guidelines:
 - a. Not routinely employed unless there are concerns with other testing.
 - b. May be used if the participant has a history of a substance use disorder with fentanyl in which case a 14 panel hair test is required 3 times per year.
 - c. May be routinely required for CRNAs providing anesthesia.
- VIII. Dilute and abnormal urines.
 - a. The participant will be provided the dilute and abnormal specimen policy.
 - b. Dilute and abnormal urine results will follow the Progressive Action Policy.
- IX. Travel guidelines
 - a. Participants must notify RAIN staff one (1) week prior to traveling within the U.S. RAIN staff will advise participant of alternate collection sites.
 - b. Travel outside the U.S. requires approval at least two (2) weeks prior to traveling. Participants are required to submit and gain approval for documentation of travel plans and a recovery maintenance plan to RAIN prior to travel.
- X. Other forms of toxicology testing may be required including blood, nails, and hair at the discretion of the treatment team based on the unique situation of the participant.

¹ Chain of custody criteria

² Confirmation Cutoffs

³ Laboratory Criteria

APRN Specific Requirements

POLICY:

OVERVIEW: APRNs have additional issues concerning controlled substances, variable work schedules, and practice autonomy. APRNs often work in private practice without a supervisor. In addition, many hold prescriptive authority and may have an additional risk for use of controlled medications. To enroll in the RAIN program, APRNs must be in a practice with a supervisor (APRN or physician) that can meet the stipulation of the Employment Conditions and Parameters Policy. If employed as an RN and not performing as an APRN, supervisor may be another RN.

PROCEDURE:

- I. APRNs are required to participate in a 5-year monitoring. Any change to the 5-year monitoring plan requires approval by the ASBN.
- II. Readiness to return to practice must be thoroughly assessed by RAIN, the treatment team and the CRNA prior to re-entry. CRNA's must have a minimum of 1-year of documented recovery prior to re-entering the practice of anesthesia and this may be in a RN role but not as a CRNA. Changes to this requirement are only considered based on the specific treatment recommendations from the RAIN approved treatment program and the final authorization of the RAIN executive director in discussion with the RAIN team.
 - a. CRNAs may be evaluated by RAIN approved evaluators or treatment providers for Naltrexone or Vivitrol therapy prior to return to CRNA Practice.
 - b. CRNAs who receive less intensive treatment either in-patient or out-patient, may be required to refrain from anesthesia practice for a minimum of 18 months and with documented recovery, required meeting attendance and negative screenings. Alterations to the time limitation will be determined for the individual considering the type of treatment completed, severity of illness and treatment team recommendations. The time prior to re-entry to practice may be reduced (in rare circumstances) or extended.
 - i. A fitness for duty evaluation will be required prior to return to work.
 - ii. The CRNA will submit a CRNA Re-entry Contract when satisfactory progress has been made in monitoring and all treatment team recommendation have been met.
 - iii. A CRNA Re-entry Contract must be approved by RAIN and all conditions must be adhered to by the practicing CRNA.
- III. RAIN requires the submission and approval of a new CRNA Re-entry Contract completed by the CRNA and the new employer prior to any change in employment and/or supervisor.

Termination from Program

Policy: Participation in RAIN may be terminated and reported to the ASBN when a participant fails to comply with the treatment or monitoring requirements.

Procedure:

- I. Termination may occur for the following reasons:
 - a. Non-compliance of the RAIN Contract
 - b. Working or attempting to work in nursing when suspended by RAIN
 - c. Relocation outside the State of Arkansas without prior approval by RAIN
 - d. Participant requests termination
 - e. Any circumstance that presents an imminent danger to the public
 - f. Participant is unable or unwilling to abstain controlled drugs (legal or illegal), including alcohol.
 - g. Insists that RAIN communication, either written or verbal, be filtered through an attorney
 - h. Suspension of drug screening without reactivation
 - i. Failure to register for drug screening within 72 hours of signing the RAIN contract
 - j. Failure to check-in for screening for more than 3 consecutive days
 - k. Falsification of patient records
 - l. Providing any false records or reports required by the RAIN contract
 - m. Prescription seeking behaviors to obtain controlled or drugs of abuse
 - n. Unreported prescriptions for controlled or drugs of abuse
 - o. Refusal to screen at the request of an employer
 - p. Taking controlled/abusable medications not prescribed for participant
 - q. Submission of a substituted or adulterated specimen
 - r. Failure to report a misdemeanor or felony charge or conviction
 - s. Failure to respond to requests from RAIN staff
 - t. Level 2 violation
- II. The participant, employer, treatment providers and support group (when applicable) shall be notified of the termination by verbal or written communication. Notification will be documented in the participant's file.
- III. Participants may be suspended from the program for financial reasons and may be re-evaluated for re-entry. If after a reasonable amount of time, participants are unable to pay for participation in RAIN, the participant contract will be terminated and reported to the ASBN.

Successful Completion

POLICY: RAIN is a five (5) year non-disciplinary monitoring program. The participant will be released from the RAIN program upon successful completion of the monitoring agreement. The participant may be released from the contract after 36 months of continuous employment as a nurse (requires a minimum of 64 hours/month).

PROCEDURE:

- I. Participants are to complete the monitoring agreement within the timeframe stated in the agreement.
- II. Participants are expected to demonstrate consistent compliance with the stipulations within the agreement.
- III. All criteria must be met to successfully complete the program.
- IV. Noncompliance with any component of the agreement will result in a delay in the timeframe for completion.
- V. Criteria:
 - a. A minimum of twenty-four (24) consecutive months of negative/normal toxicology screens preceding established completion date (no missed/ dilute/abnormal/or positive screens).
 - b. Practice successfully as a licensed nurse as demonstrated by a minimum of four consecutive quarterly work place monitoring reports (employer evaluation) that reflect competent and safe practice in meeting established practice standards. Each month shall have a minimum of 64 hours of supervised practice.
 - c. Treatment provider(s) documented favorable reports.
 - d. Timely submission of all reports for a period of 12 months preceding established completion date, including, if applicable: Self reports, Employer reports, Verification of Prescribed Medication, Medication Management, counselor and/or therapy reports.
 - e. Demonstrate sustained knowledge of the conditions outlined in the agreement, use of basic skills and attitudes necessary for maintaining consistent compliance with the agreement.
 - f. Any participant who has not successfully completed the criteria by the end date of the monitoring period will be required to continue monitoring until all criteria are satisfactorily completed.

Short-Term Use of Controlled or Potentially Addictive Medications

POLICY: Participants may not practice in a clinical setting while taking controlled or potentially addictive substances.

PROCEDURE:

- I. The RAIN program staff recognize that a participant may require the use of controlled or potentially addictive medications for a short-term based on medical procedures, surgeries, and/or other medical conditions. When this is necessary the following guidelines shall apply:
 - a. Participants will not be authorized to practice in a clinical setting while taking controlled or potentially addictive medications.
 - b. For planned medical or dental procedures requiring controlled or potentially addictive medications, a RAIN prescription medication form shall be completed by the prescribing practitioner and submitted to the RAIN program staff prior to the date of the procedure. In the event of an emergency procedure, the participant or a designee shall notify RAIN staff within 48 hours of the emergency.
 - c. Participants are to discuss their recovery and participation in the RAIN program with medical providers who prescribe controlled or potentially addictive medications. The participant and provider should discuss the least amount of anticipated medication needed for planned procedures.
 - d. A negative urine drug screen and documentation of the prescription disposition will be required prior to return to any form of clinical practice.
 - e. Any exception to this policy will require the approval by RAIN staff.
 - f. Frequent or extended use of controlled or potentially addictive medications by a participant may require a full review of the case by RAIN and possibly an addiction specialist. RAIN defines extended use of controlled or potentially addictive substances as more than three (3) weeks.
- II. The RAIN contract may be extended during the use of any controlled or potentially addictive medication.

Long Term or Chronic Use of Controlled or Potentially Addictive Medications

POLICY: The RAIN program does not support the use of controlled or potentially addictive substances for the treatment of chronic medical conditions in participants who have a substance use disorder diagnosis. The RAIN program staff recognize in rare circumstances, acutely painful conditions and procedures occur. Participants are required to inform RAIN staff about the need for the controlled or potentially addictive medications and complete all associated forms and to not engage in nursing practice until approval has been obtained from RAIN staff.

PROCEDURE:

- I. In the rare case than an individual who has chronic and/or extensive medical conditions treated with controlled or potentially addictive medications on a long-term or chronic basis (defined as greater than 3 weeks) and a substance use disorder diagnosis, s/he may request evaluation for consideration for enrollment or continuation in the RAIN program. The goal of treatment should be abstinence or to reduce medication as required for the medical condition to ensure that the practitioner can practice with reasonable skill and safety with no harm to the public. The following are required for consideration:
 - a. The treating Arkansas healthcare provider will send their medical evaluation, testing, and clinical documentation for prescribing the medication to the RAIN program staff. Documentation must include information on whether the participant has ever had substance use disorder issues, and if so, what treatment was received in the past.
 - b. The participant must be evaluated by a RAIN approved evaluator for the appropriateness of the treatment plan and medication choices.
 - c. The participant may be required to undergo neuropsychological testing to determine a baseline of cognitive function while on the medication.
 - d. After all requested information is obtained, the RAIN staff will review the information and make a recommendation to the ASBN for conditions of participation in the RAIN program.
 - e. The ASBN will review all documentation and determine if the participant can enroll/continue in the RAIN program.
 - f. Quarterly updates from the treating healthcare provider documenting ongoing care and assessment of the medical condition shall be sent to the RAIN program staff.
 - g. The participant shall notify RAIN within 48 hours of receiving a prescription for a controlled or potentially addictive substance not previously approved.
 - h. A copy of all new prescription medications shall be sent to RAIN staff within ten (10) days of prescribing.
 - i. The RAIN staff may request any of the following:
 - i. Additional information from the treating health care provider
 - ii. A re-evaluation from an independent RAIN approved evaluator
 - iii. Additional psychological and/or neuropsychological testing
 - iv. Any other type of information or testing that will help determine the participant's ability to practice with reasonable skill and safety while taking the medication
 - j. The RAIN monitoring contract may be extended during the use of any controlled potentially addictive substance.

Policy XII

- k. If the RAIN program staff determines that the participant cannot practice with reasonable skill and safety while taking the medications(s), the participant will be suspended from practice until a new determination of fitness for duty. The participant may remain in monitoring until final disposition is determined.
- l. Approved prescribers for long-term medication use of more than 3 weeks include:
 - i. ASBN approved substance use disorder evaluator
 - ii. American Board of Addiction Medicine (ABAM) certified physician
 - iii. A psychiatrist with a Certificate of Added Qualifications in Addiction Medicine and an active American Society of Addiction Medicine (ASAM) member

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Progressive Action Policy

Policy: Noncompliance with the terms of the RAIN contract will be handled according to the Progressive Action Policy. Increasingly severe actions shall be applied when a participant violates the terms of the contract which may include termination from the program. Termination from the RAIN program will be reported to the ASBN.

Procedure:

- I. A sequence of documented written warnings may be initiated which identify problems and steps required to correct the problem(s).
 - a. Level 1 violation = written warning letter
 - b. Level 2 violation = termination from the program
- II. Depending on the severity of the violation/problem, Level 1 may be skipped.
- III. The following items are grouped into two categories (not intended to be all inclusive) of violations of the terms set forth in the participant's contract with the RAIN program. Violations may result in corrective action up to and including termination.
 - a. Level 1 violation may be implemented for the following:
 - i. Pattern of failure to check-in for drug screens (≥8 in 12 months)
 - ii. Dilute specimen (> 1 in 12 months)
 - iii. Pattern of failure to submit documentation (e.g. personal reports, AA/NA reports, etc.) as required by deadline.
 - iv. Pattern of failure to attend required AA/NA meetings
 - v. Pattern of failure to attend treatment or aftercare
 - vi. Marking the wrong option for screening (>2 in 12 months)
 - vii. Failure to follow the recommendations of the treatment facility
 - viii. Failure to disclose pertinent information (e.g. hospitalizations, employment status changes, etc.)
 - ix. Pattern of two consecutive missed screening check-ins occurring within 12 months
 - x. Failure to drug screen when selected
 - xi. Submission of drug screen when not requested
 - b. Level 2 violation (termination from the program) may be implemented for the following:
 - i. Beginning employment prior to approval by RAIN staff
 - ii. Suspension without reactivation of drug screening
 - iii. Failure to register for drug screening within 72 hours of signing the RAIN contract
 - iv. Failure to check-in for screening for greater than 3 consecutive days
 - v. Falsification of documentation in patient records
 - vi. Falsification of records/reports submitted to RAIN (e.g. reference letters, sponsor letters, employer performance reports, AA/NA reports, prescription ID forms, etc.)
 - vii. Failure to report within specified timeframe the prescription for controlled or potentially addictive medications
 - viii. Refusal to drug screen at the request of an employer

Policy XIII

- ix. Consuming controlled or potentially addictive medications not prescribed for the participant
 - x. Evidence of prescription seeking behavior to obtain controlled or potentially addictive medications
 - xi. Submission of a specimen deemed to have been substituted or adulterated
 - xii. Failure to report misdemeanor or felony charges (other than minor traffic violations)
 - xiii. Failure to report misdemeanor or felony conviction that occurs while in the program
 - xiv. Any information or event deemed by RAIN program staff to endanger the public
 - xv. Failure to respond to requests from RAIN program staff
 - xvi. Failure to comply with other conditions of the Contract
 - xvii. More than 3 warning letters occurring within 12 months.
- IV. Violations are "active" for twelve (12) rolling months. For example a participant receives a written warning for a violation June 4, 2017. Any subsequent violation between the written warning and June 4, 2018 will be considered "active" and progressive action will be applied. If a subsequent violation occurs after June 4, 2018, the process re-sets.

Criteria for Evaluators and Treatment Providers

POLICY: All evaluation and treatment providers will be approved by the Arkansas State Board of Nursing.

PROCEDURE: The following criteria will be used to determine approval of evaluators and treatment providers.

- I. An evaluator shall:
 - a. Be a physician, psychiatrist, psychologist, or mental health certified Advanced Practice Registered Nurse who is engaged in the treatment of substance use disorder, including alcohol;
 - b. Demonstrate the ability to perform an examination to include a detailed history with the appropriate testing i.e. drug screens and other psychological testing as indicated;
 - c. Identify a diagnosis and treatment required, if any;
 - d. Agree to state whether the nurse is safe to practice and under what conditions the practice must be restricted if any;
 - e. Cooperate and communicate with the ATD program director; and
 - f. Submit evaluation reports according to Board approved criteria.
- II. A treatment provider shall:
 - a. Provide outpatient and/or inpatient treatment;
 - b. Cooperate and communicate with the ATD program director;
 - c. Submit individualized written plan of care to include, but not limited to, assessment, diagnosis, treatment goals, discharge criteria, and recommendations for continuing recovery; and
 - d. Meet all regulatory requirements in their respective state.
- III. All evaluators and treatment providers shall submit documentation requested by the RAIN staff for review and approval by the ASBN.
- IV. Approved evaluators and treatment providers will be re-reviewed on an annual basis to determine continuation as a Board approved evaluator or treatment provider.
- V. ASBN may withdraw approval at any time they determine the evaluator or provider does not meet the required guidelines for approval.

**Consensus Model for APRN Regulation:
Licensure, Accreditation, Certification & Education**

July 7, 2008

**Completed through the work of the APRN Consensus Work Group & the
National Council of State Boards of Nursing APRN Advisory Committee**

Attachment #2

The APRN Consensus Work Group and the APRN Joint Dialogue Group members would like to recognize the significant contribution to the development of this report made by Jean Johnson, PhD, RN-C, FAAN, Senior Associate Dean, Health Sciences, George Washington School of Medicine and Health Sciences. Consensus could not have been reached without her experienced and dedicated facilitation of these two national, multi-organizational groups.

LIST OF ENDORSING ORGANIZATIONS

This Final Report of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee has been disseminated to participating organizations. The names of endorsing organizations will be added periodically.

The following organizations have endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (July 2008).

Posted January 2009

Academy of Medical-Surgical Nurses (AMSN)
American Academy of Nurse Practitioners (AANP)
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing (AACN)
American Association of Critical-Care Nurses (AACN)
American Association of Critical-Care Nurses Certification Corporation
American Association of Legal Nurse Consultants (AALNC)
American Board of Nursing Specialties (ABNS)
American College of Nurse-Midwives (ACNM)
American College of Nurse Practitioners (ACNP)
American Holistic Nurses Association (AHNA)
American Nurses Association (ANA)
American Nurses Credentialing Center (ANCC)
American Psychiatric Nurses Association (APNA)
Arkansas State Board of Nursing
Association of Faculties of Pediatric Nurse Practitioners (AFPNP)
Commission on Collegiate Nursing Education (CCNE)
Dermatology Nurses Association (DNA)
Dermatology Nursing Certification Board (DNCB)
Emergency Nurses Association (ENA)
Gerontological Advanced Practice Nurses Association (GAPNA)
Hospice and Palliative Nurses Association (HPNA)
National Association of Clinical Nurse Specialists (NACNS)
National Association of Orthopedic Nurses (NAON)
National Association of Pediatric Nurse Practitioners (NAPNAP)
National Board for Certification of Hospice and Palliative Nurses (NBCHPN)
National Certification Corporation (NCC)
National Council of State Boards of Nursing (NCSBN)
National Gerontological Nursing Association (NGNA)
National League for Nursing (NLN)
National League for Nursing Accrediting Commission, Inc. (NLNAC)
National Organization of Nurse Practitioner Faculties (NONPF)
Nurse Practitioners in Women's Health (NPWH)
Nurses Organization of Veterans Affairs (NOVA)
Oncology Nursing Certification Corporation (ONCC)
Oncology Nursing Society (ONS)
Orthopedic Nurses Certification Board (ONCB)

APRN Joint Dialogue Group Report, July 7, 2008

Pediatric Nursing Certification Board (PNCB)

Wound, Ostomy and Continence Nurses Society (WOCN)

Wound, Ostomy and Continence Nursing Certification Board (WOCNCB)

INTRODUCTION

Advanced Practice Registered Nurses (APRNs) have expanded in numbers and capabilities over the past several decades with APRNs being highly valued and an integral part of the health care system. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs need to be effectively aligned in order to continue to ensure patient safety while expanding patient access to APRNs.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but shares the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards-governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

Many nurses with advanced graduate nursing preparation practice in roles and specialties e.g., informatics, public health, education, or administration) that are essential to advance the health of the public but do not focus on direct care to individuals and, therefore, their practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the four current APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education. Although extremely important to the nursing profession and to the delivery of safe, high quality patient care, these other advanced, graduate nursing roles, which do not focus on direct patient care, are not roles for Advanced Practice Registered Nurses (APRN) and are not the subject or focus of the Regulatory Model presented in this paper.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations included in this document. In a few instances, when agreement was not unanimous a 66% majority was used to determine the final recommendation. However, extensive dialogue and transparency in the decision-making process is reflected in each recommendation. The background of each group can be found on pages 13-16 and individual and organizational participants in each group in Appendices C-H.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Overview of APRN Model of Regulation

The APRN Model of Regulation described will be the model of the future. It is recognized that current regulation of APRNs does not reflect all of the components described in this paper and will evolve incrementally over time. A proposed timeline for implementation is presented at the end of the paper.

In this APRN model of regulation there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs¹, are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a pre-approval, pre-accreditation, or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited² and their graduates must be eligible for national certification used for state licensure.

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes. APRN certification programs will be accredited by a national certification accrediting body³. APRN certification programs will require a continued competency mechanism.

Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they cannot be licensed solely within a specialty area. *In addition, specialties can provide depth in one's practice within the established population foci.* Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e., nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations.

¹ Degree granting programs include master's and doctoral programs. Post-graduate programs include both post-master's and post-doctoral certificate education programs.

² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

³ The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

In addition, a mechanism that enhances the communication and transparency among APRN licensure, accreditation, certification and education bodies (LACE) will be developed and supported.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;
4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**

7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

The Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and

system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

Titling

The title Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.⁴ This title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles. An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

⁴ Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term *advanced public health nursing* however, may be used to identify nurses practicing in this advanced specialty area of nursing.

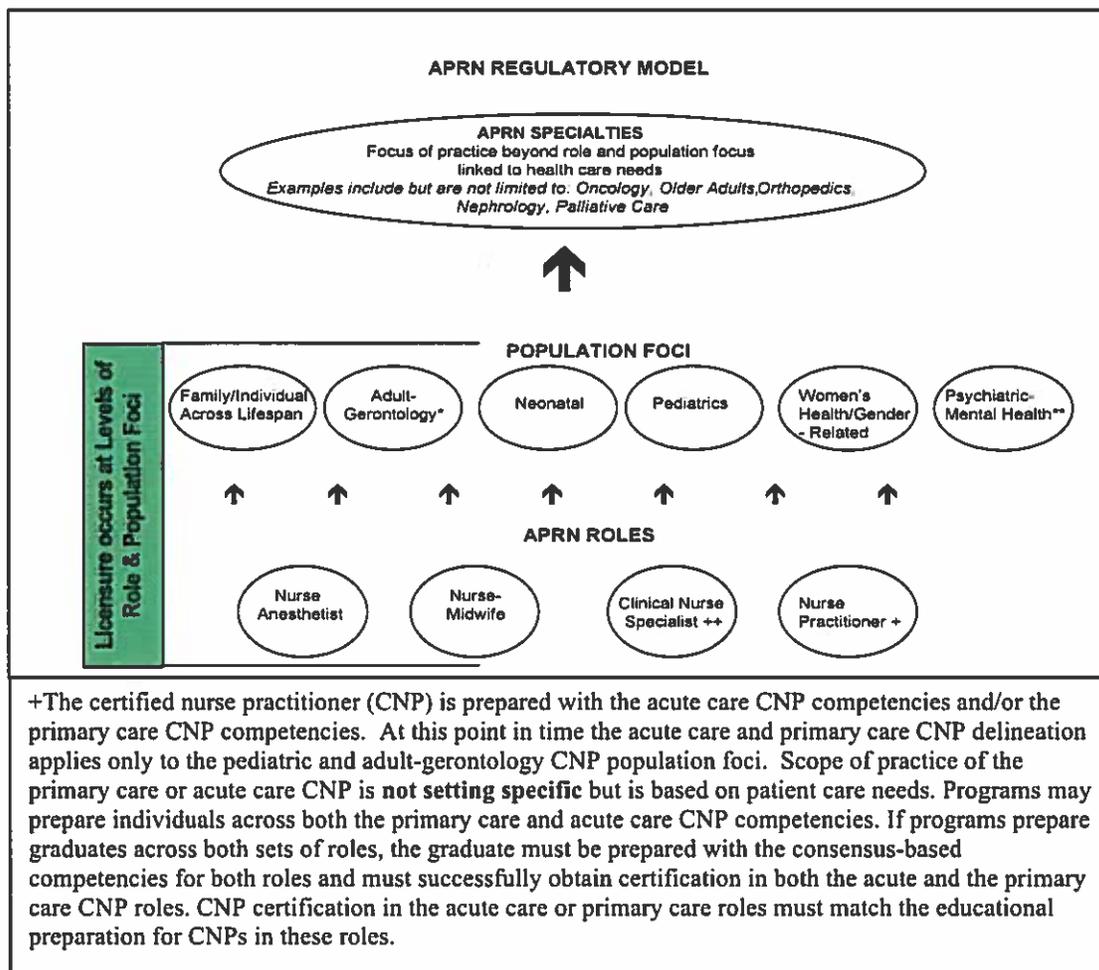


Diagram 1: APRN Regulatory Model

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

+ + The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation, or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- include at a minimum, three separate comprehensive *graduate-level* courses (the APRN Core) in:
 - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
 - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
 - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre-approval, pre-accreditation, or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to ensure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse, or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.

An APRN specialty

- preparation cannot replace educational preparation in the role or one of the six population foci;
- preparation can not expand one's scope of practice beyond the role or population focus
- addresses a subset of the population-focus;
- title may not be used in lieu of the licensing title, which includes the role or role/population; and
- is developed, recognized, and monitored by the profession.

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the role practice as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations, etc.).

Education programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN education programs, including preparation in the APRN core, role, and population core competencies. In addition, for licensure purposes, one exam must assess the APRN core, role, and population-focused competencies. For example, a nurse anesthetist would write one certification examination, which tests the APRN core, CRNA role, and population-focused competencies, administered by the Council on Certification for Nurse Anesthetist; or a primary care family nurse practitioner would write one certification examination, which tests the APRN core, CNP role, and family population-focused competencies, administered by ANCC or AANP. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty, *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the four nationally recognized APRN roles and in one of the six population foci. Individuals must be

recognized and credentialed in one of the four APRN roles within at least one population foci. APRNs are licensed at the role/population focus level and **not** at the specialty level. However, if not intended for entry-level preparation in one of the four roles/population foci and not for regulatory purposes, education programs, using a variety of formats and methodologies, may provide licensed APRNs with the additional knowledge, skills, and abilities, to become professionally certified in the specialty area of APRN practice.

Emergence of New APRN Roles and Population-Foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. In addition, the scope of practice within the role or population focus is not entirely subsumed within one of the other roles. Careful consideration of new APRN roles or population-foci is in the best interest of the profession.

For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus. A new role or population focus should be discussed and vetted through the national licensure, accreditation, certification, education communication structure: LACE. An essential part of being recognized as a role or population-focus is that educational standards and practice competencies must exist, be consistent, and must be nationally recognized by the profession. Characteristics of the process to be used to develop nationally recognized core competencies, and education and practice standards for a newly emerging role or population-focus are:

1. national in scope
2. inclusive
3. transparent
4. accountable
5. initiated by nursing
6. consistent with national standards for licensure, accreditation, certification and education
7. evidence-based
8. consistent with regulatory principles.

To be recognized, an APRN role must meet the following criteria:

- nationally recognized education standards and core competencies for programs preparing individuals in the role;
- education programs, including graduate degree granting (master's, doctoral) and post-graduate certificate programs, are accredited by a nursing or nursing-related accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA); and
- professional nursing certification program that is psychometrically sound, legally defensible, and which meets nationally recognized accreditation standards for certification programs.⁵

⁵ The professional certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

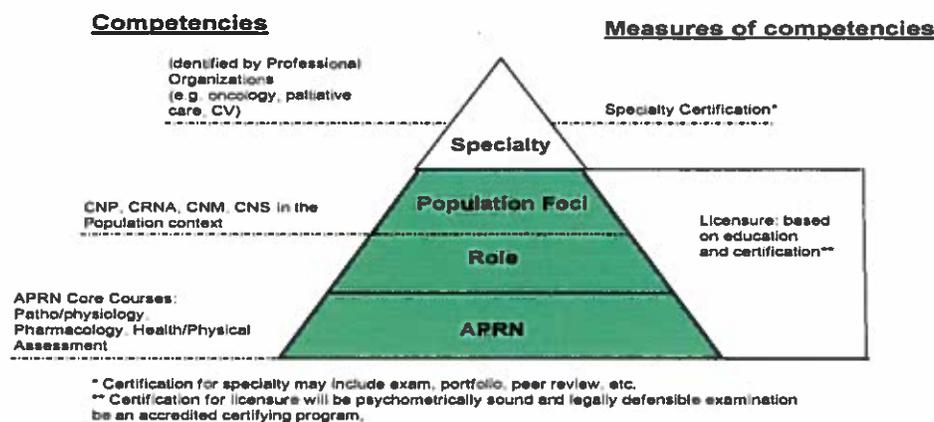


Diagram 2: Relationship Among Educational Competencies, Licensure, & Certification in the Role/Population Foci and Education and Credentialing in a Specialty

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification, and education (LACE) must work together. Expectations for licensure, accreditation, certification, and education are listed below:

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses⁶;
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;
8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact;

⁶ Except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse-midwives and midwives jointly.

9. have at least one APRN representative position on the board and utilize an APRN advisory committee that includes representatives of all four APRN roles; and,
10. institute a grandfathering⁷ clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

Foundational Requirements for Accreditation of Education Programs

Accreditors will:

1. be responsible for evaluating APRN education programs including graduate degree-granting and post-graduate certificate programs.⁸
2. through their established accreditation standards and process, assess APRN education programs in light of the APRN core, role core, and population core competencies;
3. assess developing APRN education programs and tracks by reviewing them using established accreditation standards and granting pre-approval, pre-accreditation, or accreditation prior to student enrollment;
4. include an APRN on the visiting team when an APRN program/track is being reviewed; and
5. monitor APRN educational programs throughout the accreditation period by reviewing them using established accreditation standards and processes.

Foundational Requirements for Certification

Certification programs providing APRN certification used for licensure will:

1. follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure (see appendix A for the NCSBN Criteria for APRN Certification Programs);
2. assess the APRN core and role competencies across at least one population focus of practice;
3. assess specialty competencies, if appropriate, separately from the APRN core, role and population-focused competencies;
4. be accredited by a national certification accreditation body;⁹

⁷ Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure.

However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- current, active practice in the advanced role and population focus area,
- current active, national certification or recertification, as applicable, in the advanced role and population focus area,
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and
- compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure).

Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) all new graduates applying for APRN licensure must meet the requirements outlined in this regulatory model

⁸ Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs.

⁹ The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

5. enforce congruence (role and population focus) between the education program and the type of certification examination;
6. provide a mechanism to ensure ongoing competence and maintenance of certification;
7. participate in ongoing relationships which make their processes transparent to boards of nursing;
8. participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Foundational Requirements for Education

APRN education programs/tracks leading to APRN licensure, including graduate degree-granting and post-graduate certificate programs will:

1. follow established educational standards and ensure attainment of the APRN core, role core and population core competencies^{10,11}
2. be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA).¹²
3. be pre-approved, pre-accredited, or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. ensure that graduates of the program are eligible for national certification and state licensure; and
5. ensure that official documentation (e.g., transcript) specifies the role and population focus of the graduate.

Communication Strategies

A formal communication mechanism, LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities would be created. The purpose of LACE would be to provide a formal, ongoing communication mechanism that provides for transparent and aligned communication among the identified entities. The collaborative efforts between the APRN Consensus Group and the NCSBN APRN Advisory Panel, through the APRN Joint Dialogue Group have illustrated the ongoing level of communication necessary among these groups to ensure that all APRN stakeholders are involved. Several strategies including equal representation on an integrated board with

¹⁰ The APRN core competencies for all APRN nursing education programs located in schools of nursing are delineated in the American Association of Colleges of Nursing (1996) *The Essentials of Master's Education for Advanced Practice Nursing Education* or the AACN (2006) *The Essentials of Doctoral Education for Advanced Nursing Practice*. The APRN core competencies for nurse anesthesia and nurse-midwifery education programs located outside of a school of nursing are delineated by the accrediting organizations for their respective roles i.e., Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME).

¹¹ APRN programs outside of schools of nursing must prepare graduates with the APRN core which includes three separate graduate-level courses in pathophysiology/physiology, health assessment, and pharmacology.

¹² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

face-to-face meetings, audio and teleconferencing, pass-protected access to agency web sites, and regular reporting mechanisms have been recommended. These strategies will build trust and enhance information sharing. Examples of issues to be addressed by the group would be: guaranteeing appropriate representation of APRN roles among accreditation site visitors, documentation of program completion by education institutions, notification of examination outcomes to educators and regulators, notification of disciplinary action toward licensees by boards of nursing.

Creating the LACE Structure and Processes

Several principles should guide the formulation of a structure including: 1) all four entities of LACE should have representation; 2) the total should allow effective discussion of and response to issues and ; 3) the structure should not be duplicative of existing structures such as the Alliance for APRN Credentialing. Consideration should be given to evolving the existing Alliance structure to meet the needs of LACE. Guidance from an organizational consultant will be useful in forming a permanent structure that will endure and support the work that needs to continue. The new structure will support fair decision-making among all relevant stakeholders. In addition, the new structure will be in place as soon as possible.

The LACE organizational structure should include representation of:

- State licensing boards, including at least one compact and one non-compact state;
- Accrediting bodies that accredit education programs of the four APRN roles;
- Certifying bodies that offer APRN certification used for regulatory purposes; and,
- Education organizations that set standards for APRN education.

Timeline for Implementation of Regulatory Model

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification, and education, certain recommendations will be implemented sequentially. However, recognizing that this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform decisions made by each of these entities as the APRN community moves to fully implement the APRN Regulatory Model. A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

HISTORICAL BACKGROUND

NCSBN APRN Committee (previously APRN Advisory Panel)

NCSBN became involved with advanced practice nursing when boards of nursing began using the results of APRN certification examinations as one of the requirements for APRN licensure. During the 1993 NCSBN annual meeting, delegates adopted a position paper on the licensure of advanced nursing practice which included model legislation language and model administrative rules for advanced nursing practice. NCSBN core competencies for certified nurse practitioners were adopted the following year.

In 1995, NCSBN was directed by the Delegate Assembly to work with APRN certifiers to make certification examinations suitable for regulatory purposes. Since then, much effort has been made toward that purpose. During the mid and late 90's, the APRN certifiers agreed to undergo accreditation and provide additional information to boards of nursing to ensure that their examinations were psychometrically sound and legally defensible (NCSBN, 1998).

During the early 2000s, the APRN Advisory Panel developed criteria for APRN certification programs and for accreditations agencies. In January 2002, the board of directors approved the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to improve the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues such as with the establishment of the annual NCSBN APRN Roundtable in the mid 1990's. In 2002, the Advisory Panel also developed a position paper describing APRN regulatory issues of concern.

In 2003, the APRN Advisory Panel began a draft APRN vision paper in an attempt to resolve APRN regulatory concerns such as the proliferation of APRN subspecialty areas. The purpose of the APRN Vision Paper was to provide direction to boards of nursing regarding APRN regulation for the next 8-10 years by identifying an ideal future APRN regulatory model. Eight recommendations were made. The draft vision paper was completed in 2006. After reviewing the draft APRN vision paper at their February 2006 board meeting, the board of directors directed that the paper be disseminated to boards of nursing and APRN stakeholders for feedback. The Vision paper also was discussed during the 2006 APRN Roundtable. The large response from boards of nursing and APRN stakeholders was varied. The APRN Advisory Panel spent the remaining part of 2006, reviewing and discussing the feedback with APRN stakeholders. (See Appendix C for the list of APRN Advisory Panel members who worked on the draft APRN Vision Paper and Appendix D for the list of organizations represented at the 2006 APRN Roundtable where the draft vision paper was presented.)

APRN Consensus Group

In March 2004, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) submitted a proposal to the Alliance for Nursing Accreditation, now named Alliance for APRN Credentialing¹³ (hereafter referred to as *the APRN Alliance*) to establish a process to develop a consensus¹⁴ statement on the credentialing of advanced practice nurses (APNs).¹⁵ The APRN Alliance¹⁶, created in 1997,

¹³ At its March 2006 meeting, the Alliance for Nursing Accreditation voted to change its name to the Alliance for APRN Credentialing which more accurately reflects its membership.

¹⁴ The goal of the APRN Work Group was unanimous agreement on all issues and recommendations. However, this was recognized as an unrealistic expectation and may delay the process; therefore, consensus was defined as a two thirds majority agreement by those members of the Work Group present at the table as organizational representatives with each participating organization having one vote.

¹⁵ The term advanced practice nurse (APN) was initially used by the Work Group and is used in this section of the report to accurately reflect the background discussion. However, the Work group reached consensus that the term advanced practice registered nurse (APRN) should be adopted for use in subsequent discussions and documents.

was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. A number of differing views on how APN practice is defined, what constitutes specialization versus subspecialization, and the appropriate credentialing requirements that would authorize practice had emerged over the past several years.

An invitation to participate in a national APN consensus process was sent to 50 organizations that were identified as having an interest in advanced practice nursing (see Appendix F). Thirty-two organizations participated in the APN Consensus Conference in Washington, D.C. June 2004. The focus of the one-day meeting was to initiate an in-depth examination of issues related to APN definition, specialization, sub-specialization, and regulation, which includes accreditation, education, certification, and licensure¹⁷. Based on recommendations generated in the June 2004 APN Consensus Conference, the Alliance formed a smaller work group made up of designees from 23 organizations with broad representation of APN certification, licensure, education, accreditation, and practice. The charge to the work group was to develop a statement that addresses the issues, delineated during the APN Consensus Conference with the goal of envisioning a future model for APNs. The Alliance APN Consensus Work Group (hereafter referred to as *the Work Group*) convened for 16 days of intensive discussion between October 2004 and July 2007 (see Appendix H for a list of organizations represented on the APN Work Group).

In December 2004, the American Nurses Association (ANA) and AACN co-hosted an APN stakeholder meeting to address those issues identified at the June 2004 APN Consensus meeting. Attendees agreed to ask the APN Work Group to continue to craft a consensus statement that would include recommendations regarding APN regulation, specialization, and subspecialization. It also was agreed that organizations in attendance who had not participated in the June 2004 APN Consensus meeting would be included in the APN Consensus Group and that this larger group would reconvene at a future date to discuss the recommendations of the APN Work Group.

Following the December 2004 APN Consensus meeting, the Work Group continued to work diligently to reach consensus on the issues surrounding APRN education, practice, accreditation, certification, and licensure, and to create a future consensus-based model for APRN regulation. Subsequent APRN Consensus Group meetings were held in September 2005 and June 2006. All organizations who participated in the APRN Consensus Group are listed in Appendix G.

¹⁶ Organizational members of the Alliance for APRN Credentialing : American Academy of Nurse Practitioners Certification Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, National Organization of Nurse Practitioner Faculties

¹⁷ The term regulation refers to the four prongs of regulation: licensure, accreditation, certification and education.

APRN Joint Dialogue Group

In April, 2006, the APRN Advisory Panel met with the APRN Consensus Work Group to discuss APRN issues described in the NCSBN draft vision paper. The APRN Consensus Work Group requested and was provided with feedback from the APRN Advisory Panel regarding the APRN Consensus Group Report. Both groups agreed to continue to dialogue.

As the APRN Advisory Panel and APRN Consensus Work Group continued their work in parallel fashion, concerns regarding the need for each group's work not to conflict with the other were expressed. A subgroup of seven people from the APRN Consensus Work Group and seven individuals from the APRN Advisory Panel were convened in January, 2007. The group called itself the APRN Joint Dialogue Group (see Appendix E) and the agenda consisted of discussing areas of agreement and disagreement between the two groups. The goal of the subgroup meetings was anticipated to be two papers that did not conflict, but rather complemented each other. However, as the APRN Joint Dialogue Group continued to meet, much progress was made regarding areas of agreement; it was determined that rather than two papers being disseminated, one joint paper would be developed, which reflected the work of both groups. This document is the product of the work of the APRN Joint Dialogue Group and through the consensus-based work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification, and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

CONCLUSION

The recommendations offered in this paper present an APRN regulatory model as a collaborative effort among APRN educators, accreditors, certifiers, and licensure bodies. The essential elements of APRN regulation are identified as licensure, accreditation, certification, and education. The recommendations reflect a need and desire to collaborate among regulatory bodies to achieve a sound model and continued communication with the goal of increasing the clarity and uniformity of APRN regulation.

The goals of the consensus processes were to:

- strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- develop a vision for APRN regulation, including education, accreditation, certification, and licensure;

- establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and
- produce a written statement that reflects consensus on APRN regulatory issues.

In summary, this report includes: a definition of the APRN Regulatory Model, including a definition of the Advanced Practice Registered Nurse; a definition of broad-based APRN education; a model for regulation that ensures APRN education and certification as a valid and reliable process, that is based on nationally recognized and accepted standards; uniform recommendations for licensing bodies across states; a process and characteristics for recognizing a new APRN role; and a definition of an APRN specialty that allows for the profession to meet future patient and nursing needs.

The work of the Joint Dialogue Group in conjunction with all organizations representing APRN licensure, accreditation, certification, and education to advance a regulatory model is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge, the APRN Regulatory Model will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

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APPENDIX A
NCSBN CRITERIA FOR EVALUATING CERTIFICATION PROGRAMS

Criteria	Elaboration
<p>I. The program is national in the scope of its credentialing.</p>	<p>A. The advanced nursing practice category and standards of practice have been identified by national organizations.</p> <p>B. Credentialing services are available to nurses throughout the United States and its territories.</p> <p>C. There is a provision for public representation on the certification board.</p> <p>D. A nursing specialty organization that establishes standards for the nursing specialty exists.</p> <p>E. A tested body of knowledge related to the advanced practice nursing specialty exists.</p> <p>F. The certification board is an entity with organizational autonomy.</p>
<p>II. Conditions for taking the examination are consistent with acceptable standards of the testing community.</p>	<p>A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program.</p> <p>B. Eligibility criteria rationally related to competence to practice safely.</p> <p>C. Published criteria are enforced.</p> <p>D. In compliance with the American Disabilities Act.</p> <p>E. Sample application(s) are available.</p> <p>1) Certification requirements included</p> <p>2) Application procedures include:</p> <ul style="list-style-type: none"> • procedures for ensuring match between education and clinical experience, and APRN specialty being certified, • procedures for validating information provided by candidate, • procedures for handling omissions and discrepancies <p>3) Professional staff responsible for credential review and admission decisions.</p> <p>4) Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items.</p> <p>F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.</p>
<p>III. Educational requirements are consistent with the requirements of the advanced practice specialty.</p>	<p>A. Current U.S. registered nurse licensure is required.</p> <p>B. Graduation from a graduate advanced practice education program meets the following requirements:</p> <p>1) Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking</p> <p>2) If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1.</p> <p>3) Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing</p>

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<p>I. The program is national in the scope of its credentialing.</p>	<p>A. The advanced nursing practice category and standards of practice have been identified by national organizations.</p> <p>B. Credentialing services are available to nurses throughout the United States and its territories.</p> <p>C. There is a provision for public representation on the certification board.</p> <p>D. A nursing specialty organization that establishes standards for the nursing specialty exists.</p> <p>E. A tested body of knowledge related to the advanced practice nursing specialty exists.</p> <p>F. The certification board is an entity with organizational autonomy.</p>
<p>II. Conditions for taking the examination are consistent with acceptable standards of the testing community.</p>	<p>A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program.</p> <p>B. Eligibility criteria rationally related to competence to practice safely.</p> <p>C. Published criteria are enforced.</p> <p>D. In compliance with the American Disabilities Act.</p> <p>E. Sample application(s) are available.</p> <p>1) Certification requirements included</p> <p>2) Application procedures include:</p> <ul style="list-style-type: none"> • procedures for ensuring match between education and clinical experience, and APRN specialty being certified, • procedures for validating information provided by candidate, • procedures for handling omissions and discrepancies <p>3) Professional staff responsible for credential review and admission decisions.</p> <p>4) Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items.</p> <p>F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.</p>
<p>III. Educational requirements are consistent with the requirements of the advanced practice specialty.</p>	<p>A. Current U.S. registered nurse licensure is required.</p> <p>B. Graduation from a graduate advanced practice education program meets the following requirements:</p> <p>1) Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking</p> <p>2) If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1.</p> <p>3) Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing</p>

	<p>accreditation guidelines</p> <p>4) The curriculum includes, but is not limited to:</p> <ul style="list-style-type: none"> • biological, behavioral, medical, and nursing sciences relevant to practice as an APRN in the specified category; • legal, ethical, and professional responsibilities of the APRN; and • supervised clinical practice relevant to the specialty of APRN <p>5) The curriculum meets the following criteria:</p> <ul style="list-style-type: none"> • Curriculum is consistent with competencies of the specific areas of practice • Instructional track/major has a minimum of 500 supervised clinical hours overall • The supervised clinical experience is directly related to the knowledge and role of the specialty and category <p>C. All individuals, without exception, seeking a national certification must complete a formal didactic and clinical advanced practice program meeting the above criteria.</p>
<p>IV. The standard methodologies used are acceptable to the testing community such as incumbent job analysis study, logical job analysis studies.</p>	<p>A. Exam content based on a job/task analysis.</p> <p>B. Job analysis studies are conducted at least every five years.</p> <p>C. The results of the job analysis study are published and available to the public.</p> <p>D. There is evidence of the content validity of the job analysis study.</p>
<p>V. The examination represents entry-level practice in the advanced nursing practice category.</p>	<p>A. Entry-level practice in the advanced practice specialty is described including the following:</p> <ol style="list-style-type: none"> 1) Process 2) Frequency 3) Qualifications of the group making the determination 4) Geographic representation 5) Professional or regulatory organizations involved in the reviews
<p>VI. The examination represents the knowledge, skills, and abilities essential for the delivery of safe and effective advanced nursing care to the clients.</p>	<p>A. The job analysis includes activities representing knowledge, skills, and abilities necessary for competent performance.</p> <p>B. The examination reflects the results of the job analysis study.</p> <p>C. Knowledge, skills, and abilities, which are critical to public safety, are identified.</p> <p>D. The examination content is oriented to educational curriculum practice requirements and accepted standards of care.</p>
<p>VII. Examination items are reviewed for content validity, cultural bias, and correct scoring using an established mechanism, both before use and periodically.</p>	<p>A. Each item is associated with a single cell of the test plan.</p> <p>B. Items are reviewed for currency before each use at least every three years.</p> <p>C. Items are reviewed by members of under-represented gender and ethnicities who are active in the field being certified. Reviewers have been trained to distinguish irrelevant cultural dependencies from knowledge necessary to safe and effective practice. Process for identifying and processing flagged items is identified.</p>

	<p>D. A statistical bias analysis is performed on all items.</p> <p>E. All items are subjected to an “unscored” use for data collection purposes before their first use as a “scored” item.</p> <p>F. A process to detect and eliminate bias from the test is in place.</p> <p>G. Reuse guidelines for items on an exam form are identified.</p> <p>H. Item writing and review is done by qualified individuals who represent specialties, population subgroups, etc.</p>
VIII. Examinations are evaluated for psychometric performance.	A. Reference groups used for comparative analysis are defined.
IX. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically.	A. Passing standard is criterion-referenced.
X. Examination security is maintained through established procedures.	<p>A. Protocols are established to maintain security related to:</p> <ol style="list-style-type: none"> 1) Item development (e.g., item writers and confidentiality, how often items are re-used) 2) Maintenance of question pool 3) Printing and production process 4) Storage and transportation of examination is secure 5) Administration of examination (e.g., who administers, who checks administrators) 6) Ancillary materials (e.g., test keys, scrap materials) 7) Scoring of examination 8) Occurrence of a crisis (e.g., exam is compromised, etc)
XI. Certification is issued based upon passing the examination and meeting all other certification requirements.	<p>A. Certification process is described, including the following:</p> <ol style="list-style-type: none"> 1) Criteria for certification decisions are identified 2) The verification that passing exam results and all other requirements are met 3) Procedures are in place for appealing decisions <p>B. There is due process for situations such as nurses denied access to the examination or nurses who have had their certification revoked.</p> <p>C. A mechanism is in place for communicating with candidate.</p> <p>D. Confidentiality of nonpublic candidate data is maintained.</p>
XII. A retake policy is in place.	<p>A. Failing candidates permitted to be reexamined at a future date.</p> <p>B. Failing candidates informed of procedures for retakes.</p> <p>C. Test for repeating examinees should be equivalent to the test for first time candidates.</p> <p>D. Repeating examinees should be expected to meet the same test performance standards as first time examinees.</p> <p>E. Failing candidates are given information on content areas of deficiency.</p> <p>F. Repeating examinees are not exposed to the same items when taking the exam previously.</p>
XIII. Certification maintenance	A. Certification maintenance requirements are specified (e.g., continuing

<p>program, which includes review of qualifications and continued competence, is in place.</p>	<p>education, practice, examination, etc.).</p> <p>B. Certification maintenance procedures include:</p> <ol style="list-style-type: none"> 1) Procedures for ensuring match between continued competency measures and APRN specialty 2) Procedures for validating information provided by candidates 3) Procedures for issuing re-certification <p>C. Professional staff oversee credential review.</p> <p>D. Certification maintenance is required a minimum of every 5 years.</p>
<p>XIV. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.</p>	<p>A. Communication mechanisms address:</p> <ol style="list-style-type: none"> 1) Permission obtained from candidates to share information regarding the certification process 2) Procedures to provide verification of certification to Boards of Nursing 3) Procedures for notifying Boards of Nursing regarding changes of certification status 4) Procedures for notification of changes in certification programs (qualifications, test plan or scope of practice) to Boards of Nursing
<p>XV. An evaluation process is in place to provide quality assurance in its certification program.</p>	<p>A. Internal review panels are used to establish quality assurance procedures.</p> <ol style="list-style-type: none"> 1) Composition of these groups (by title or area of expertise) is described 2) Procedures are reviewed 3) Frequency of review <p>B. Procedures are in place to ensure adherence to established QA policy and procedures.</p>

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APPENDIX B
American Nurses Association
Congress on Nursing Practice and Economics
2004
Recognition as a Nursing Specialty

The process of recognizing an area of practice as a nursing specialty allows the profession to formally identify subset areas of focused practice. A clear description of that nursing practice assists the larger community of nurses, healthcare consumers, and others to gain familiarity and understanding of the nursing specialty. Therefore, the document requesting ANA recognition must clearly and fully address each of the fourteen specialty recognition criteria. The inclusion of additional materials to support the discussion and promote understanding of the criteria is acceptable. A scope of practice statement must accompany the submission requesting recognition as a nursing specialty.

Criteria for Recognition as a Nursing Specialty

The following criteria are used by the Congress on Nursing Practice and Economics in the review and decision-making processes to recognize an area of practice as a nursing specialty:

A nursing specialty:

1. Defines itself as nursing.
2. Adheres to the overall licensure requirements of the profession.
3. Subscribes to the overall purposes and functions of nursing.
4. Is clearly defined.
5. Is practiced nationally or internationally.
6. Includes a substantial number of nurses who devote most of their practice to the specialty.
7. Can identify a need and demand for itself.
8. Has a well derived knowledge base particular to the practice of the nursing specialty.
9. Is concerned with phenomena of the discipline of nursing.
10. Defines competencies for the area of nursing specialty practice.
11. Has existing mechanisms for supporting, reviewing and disseminating research to support its knowledge base.
12. Has defined educational criteria for specialty preparation or graduate degree.
13. Has continuing education programs or continuing competence mechanisms for nurses in the specialty.
14. Is organized and represented by a national specialty association or branch of a parent organization.

APPENDIX C

NCBN APRN Committee Members 2003 -2008

2003

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Georgia Manning, Arkansas State Board of Nursing
- Deborah Bohannon-Johnson, Board President, North Dakota Board of Nursing
- Jane Garvin, Board President, Maryland Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Nancy Chornick, NCSBN

2004

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing
- Georgia Manning, Arkansas State Board of Nursing
- Jane Garvin RN, Board President, Maryland Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Nancy Chornick, NCSBN

2005

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing
- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- Kim Powell, Board President, Montana Board of Nursing
- Nancy Chornick, NCSBN

2006

- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Laura Poe, Member, Utah State Board of Nursing

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- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Ann Forbes, Board Staff, North Carolina Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Sheila N. Kaiser, Board Vice-Chair, Massachusetts Board of Registration in Nursing
- Nancy Chornick, NCSBN

2007

- Faith Fields, Board Liaison, Arkansas State Board of Nursing
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member, Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Marcia Hobbs, Board Member, Kentucky Board of Nursing
- Nancy Chornick, NCSBN

2008

- Doreen K. Begley, Board Member, Nevada State Board of Nursing
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member, Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Board Member, Idaho Board of Nursing
- Cristiana Rosa, Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont Board of Nursing
- Cathy Williamson, Board Member, Mississippi Board of Nursing
- Tracy Klein, Member Staff, Oregon State Board of Nursing
- Darlene Byrd, Board Member, Arkansas State Board of Nursing
- Nancy Chornick, NCSBN

Appendix D

2006 NCSBN APRN Roundtable Organization Attendance List

Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Psychiatric Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Holistic Nurses' Certification Corporation
American Midwifery Certification Board
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurses Executives
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Emergency Nurses Association
George Washington School of Medicine
Idaho Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing
Massachusetts Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Board for Certification of Hospice & Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National League for Nursing Accrediting Commission

North Carolina Board of Nursing
Oncology Nursing Certification Corporation
Pediatric Nursing Certification Board
Rhode Island Board of Nursing
Texas Board of Nurse Examiners
Utah Board of Nursing
Vermont Board of Nursing
Wound, Ostomy and Continence Nursing Certification Board

2007 APRN Roundtable Attendance List

American Association of Colleges of Nursing
ABNS Accreditation Council
Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American College of Nurse Practitioners
American Midwifery Certification Board
American Nurses Credentialing Center - Certification Services
American Organization of Nurse Executives
Arkansas State Board of Nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Colorado Board of Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Council on Certification of Nurse Anesthetists and Council on Recertification of Nurse Anesthetists
Emergency Nurses Association
Idaho Board of Nursing
Illinois State Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing

APRN Joint Dialogue Group Report, July 7, 2008

Loyola University Chicago Niehoff School of Nursing

Minnesota Board of Nursing

Mississippi Board of Nursing

National Association of Clinical Nurse Specialists

National Association of Pediatric Nurse Practitioners

National League for Nursing Accrediting Commission

National Organization of Nurse Practitioner Faculties

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties

Oncology Nursing Certification Corporation

Pennsylvania Board of Nursing

Pediatric Nursing Certification Board

Rhode Island Board of Nursing

Rush University College of Nursing

South Dakota Board of Nursing

Tennessee Board of Nursing

Texas Board of Nurse Examiners

Vermont Board of Nursing

APPENDIX E

APRN Joint Dialogue Group Organizations represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
Compact Administrators
National Association of Clinical Nurse Specialists
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Council of State Boards of Nursing
NCSBN APRN Advisory Committee Representatives (5)

Appendix F

ORGANIZATIONS INVITED TO APN CONSENSUS CONFERENCE JUNE, 2004

Accreditation Commission for Midwifery Education
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Academy of Nursing
American Association of Critical Care Nurses
American Association of Critical Care Nurses Certification Program
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
Association of Faculties of Pediatric Nurse Practitioners
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Certification Board Perioperative Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
Hospice and Palliative Nurses Association
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
NANDA International
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Board for Certification of Hospice and Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing
Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National Gerontological Nursing Association
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties

APRN Joint Dialogue Group Report, July 7, 2008

Nurse Licensure Compact Administrators/State of Utah Department of Commerce/Division
of Occupational & Professional Licensing
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Sigma Theta Tau, International
Society of Pediatric Nurses
Wound Ostomy & Continence Nurses Society
Wound Ostomy Continence Nursing Certification Board

APPENDIX G

ORGANIZATIONS PARTICIPATING IN APRN CONSENSUS PROCESS

Academy of Medical-Surgical Nurses
Accreditation Commission for Midwifery Education
American College of Nurse-midwives Division of Accreditation
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical Care Nurses Certification
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board for Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse-Midwives
American College of Nurse Practitioners
American Holistic Nurses Association
American Nephrology Nurses Association
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Faculties of Pediatric Nurse Practitioners
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools
District of Columbia Board of Nursing
Department of Health
Dermatology Nurses Association
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
George Washington University
Health Resources and Services Administration
Infusion Nurses Society
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
Kentucky Board of Nursing

National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School of Nurses
National Association of Orthopedic Nurses
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing
Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
Nephrology Nursing Certification Commission
North American Nursing Diagnosis Association International
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Pennsylvania State Board of Nursing
Public Health Nursing Section of the American Public Health Association.
Rehabilitation Nursing Certification Board
Society for Vascular Nursing
Texas Nurses Association
Texas State Board of Nursing
Utah State Board of Nursing
Women's Health, Obstetric & Neonatal Nurses
Wound, Ostomy, & Continence Nurses Society
Wound, Ostomy, & Continence Nursing Certification

APPENDIX H

APRN CONSENSUS PROCESS WORK GROUP

ORGANIZATIONS THAT WERE REPRESENTED AT THE WORK GROUP MEETINGS

Jan Towers, American Academy of Nurse Practitioners Certification Program
Joan Stanley, American Association of Colleges of Nursing
Carol Hartigan, American Association of Critical Care Nurses Certification Corporation
Leo LeBel, American Association of Nurse Anesthetists
Bonnie Niebuhr, American Board of Nursing Specialties
Peter Johnson & Elaine Germano, American College of Nurse-Midwives
Mary Jean Schumann, American Nurses Association
Mary Smolenski, American Nurses Credentialing Center
M.T. Meadows, American Organization of Nurse Executives
Edna Hamera & Sandra Talley, American Psychiatric Nurses Association
Elizabeth Hawkins-Walsh, Association of Faculties of Pediatric Nurse Practitioners
Jennifer Butlin, Commission on Collegiate Nursing Education
Laura Poe, APRN Compact Administrators
Betty Horton, Council on Accreditation of Nurse Anesthesia Educational Programs
Kelly Goudreau, National Association of Clinical Nurse Specialists
Fran Way, National Association of Nurse Practitioners in Women's Health, Council on Accreditation
Mimi Bennett, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
Kathy Apple, National Council of State Boards of Nursing
Grace Newsome & Sharon Tanner, National League for Nursing Accrediting Commission
Kitty Werner & Ann O'Sullivan, National Organization of Nurse Practitioner Faculties
Cyndi Miller-Murphy, Oncology Nursing Certification Corporation
Janet Wyatt, Pediatric Nursing Certification Board
Carol Calianno, Wound, Ostomy and Continence Nursing Certification Board
Irene Sandvold, DHHS, HRSA, Division of Nursing (*observer*)

ADDENDUM

Example of a National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies

The national consensus-based process described here was originally designed, with funding by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, to develop and validate national consensus-based primary care nurse practitioner competencies in five specialty areas. The process was developed with consultation from a nationally recognized expert in higher education assessment. The process subsequently has been used and validated for the development of similar sets of competencies for other areas of nursing practice, including competencies for mass casualty education for all nurses and competencies for acute care nurse practitioners and psych/mental health nurse practitioners.

This process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies is an iterative, step-wise process. The steps are:

Step 1: At the request of the organization(s) representing the role or specialty, a neutral group or groups convenes and facilitates a national panel of all stakeholder organizations as defined in step 2.

Step 2: To ensure broad representation, invitations to participate should be extended to one representative of each of the recognized nursing accrediting organizations, certifiers within the role and specialty, groups whose primary mission is graduate education and who have established educational criteria for the identified role and specialty, and groups with competencies and standards for education programs that prepare individuals in the role and specialty.

Step 3: Organizational representatives serving on the national consensus panel bring and share role delineation studies, competencies for practice and education, scopes and standards of practice, and standards for education programs.

Step 4: Agreement is reached among the panel members

Step 5: Panel members take the draft to their individual boards for feedback.

Step 6: That feedback is returned to the panel. This is an iterative process until agreement is reached.

Step 7: Validation is sought from a larger group of stakeholders including organizations and individuals. This is known as the Validation Panel.

Step 8: Feedback from the Validation Panel is returned to National Panel to prepare the final document.

Step 9: Final document is sent to boards represented on the National Panel and the Validation Panel for endorsement.

The final document demonstrates national consensus through consideration of broad input from key stakeholders. The document is then widely disseminated.



Nurse Practitioner Core Competencies Content

A delineation of suggested content specific to the NP core competencies

2017

NP Core Competencies Content Work Group

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* The 2017 Nurse Practitioner Core Competencies Content publication aligns the competencies with the 2016 Adult-Gerontology Acute Care And Primary Care NP Competencies.

Nurse Practitioner Core Competencies with Suggested Curriculum Content 2017

In the development of the nurse practitioner (NP) population-focused competencies, a task force had extensive discussions of competencies vs. content. The task force concluded that it would be beneficial to programs if some content could be included as exemplars of how to support curriculum development for addressing a competency. Within the 2013 edition of the NP population-focused competencies, the final column in each population's competency table presents the respective competency work group's ideas of relevant content.

NONPF convened a work group to identify the suggested curriculum content for the NP Core Competencies. This work group consisted of members of the task force that prepared the 2014 edition of the NP Core Competencies, as well as additional representation from the NONPF Board and Curricular Leadership Committee. A sub-group of the NONPF Curricular Leadership Committee completed a review of the draft content, and the work group incorporated the review feedback into the final document presented herein. Please see the cover page for a list of work group members and an acknowledgment of the reviewers.

The table that follows includes the NP Core Competencies and a list of suggested curriculum content. NONPF does not intend for the requirement of all of this content, nor is the content list comprehensive for all that a program would cover with population-focused competencies. The content column reflects only suggestions for content relative to the core competencies. This document should be used in combination with the population-focused competencies.

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
Scientific Foundation Competencies	<ol style="list-style-type: none"> 1. Critically analyzes data and evidence for improving advanced nursing practice. 2. Integrates knowledge from the humanities and sciences within the context of nursing science. 3. Translates research and other forms of knowledge to improve practice processes and outcomes. 4. Develops new practice approaches based on the integration of research, theory, and practice knowledge. 	<p>Comparison of patient data sets with evidence-based standards to improve care</p> <p>Scientific foundations to practice, including, but not limited to, knowledge of advanced pathophysiology, pharmacology, physiology, genetics, and communication skills</p> <p>Science from other disciplines relevant to health care</p>

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
		<p>Theories/conceptual frameworks/principles for practice:</p> <ul style="list-style-type: none"> • Translational research that guides practice • Critical evaluation of research findings • Mid-range nursing theories and concepts to guide nursing practice • Evidence-based care • Physiologic • Communication • Developmental • Genetic • Behavior change • Population health <p>Critical thinking development:</p> <ul style="list-style-type: none"> • Evidence appraisal • Formulating a practice problem • Use of science-based theories and concepts to assess, enhance, and ameliorate health care delivery phenomena • Use of PICO questions to initiate research and quality improvement projects <p>Qualitative and quantitative research and quality improvement methods</p> <p>Ethical and legal protection of human subjects</p> <p>Inquiry processes and practices related to health literacy, vulnerable populations, and culture</p> <p>Monitoring of health outcomes</p>
Leadership Competencies	<ol style="list-style-type: none"> 1. Assumes complex and advanced leadership roles to initiate and guide change. 2. Provides leadership to foster collaboration with multiple 	<p>Content related to:</p> <ul style="list-style-type: none"> • Crisis management and leadership • Stress management (for staff and patient/family) • Teams and teamwork, including team leadership, building

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
	<p>stakeholders (e.g. patients, community, integrated health care teams, and policy makers) to improve health care.</p> <ol style="list-style-type: none"> 3. Demonstrates leadership that uses critical and reflective thinking. 4. Advocates for improved access, quality and cost effective health care. 5. Advances practice through the development and implementation of innovations incorporating principles of change. 6. Communicates practice knowledge effectively, both orally and in writing. 7. Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus. 	<p>effective teams, and nurturing team</p> <p>Leadership, change, and management theories with application to practice</p> <p>Political processes, political decision making processes, and health care advocacy</p> <p>Problem solving:</p> <ul style="list-style-type: none"> • Influencing and negotiation • Conflict management • Strategic thinking • Managing change <p>Business development:</p> <ul style="list-style-type: none"> • High reliability organization principles • Building and maintaining effective teams • Project management concepts • Principles of effective decision making • Principles of change management • Civility • Principles of innovation <p>Communications:</p> <ul style="list-style-type: none"> • Scholarly writing, manuscript, and abstract preparation • Structuring and presenting persuasive arguments <p>Peer review:</p> <ul style="list-style-type: none"> • Publications • Presentations • Research • Practice. <p>Leadership development:</p>

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
		<ul style="list-style-type: none"> • Skills to influence decision-making bodies at the system, state, or national level • Interprofessional leadership • Assuming leadership positions in professional, political, or regulatory organizations • Structure and functions of editorial/board roles • Ethical and critical decision making, effective working relationships, and a systems-perspective <p>Concepts of strategic planning process</p> <p>Leadership styles</p> <p>How to lead change in practice, manage practice changes</p> <ul style="list-style-type: none"> • Monitoring implementation and fidelity • Adaptation of change to patients, providers and organizational needs and resources • Interim feedback on achievements and efficiencies • Interpretation of data and articulating evidence <p>Self-reflection of leadership style e.g., personal leadership strengths and weaknesses; working with diverse skills sets and diverse teams</p>
Quality Competencies	<ol style="list-style-type: none"> 1. Uses best available evidence to continuously improve quality of clinical practice. 2. Evaluates the relationships among access, cost, quality, and safety and their influence on health care. 3. Evaluates how organizational structure, care processes, financing, marketing, and policy decisions impact the quality of health care. 4. Applies skills in peer review to promote a culture of 	<p>Quality Safety Education in Nursing (QSEN) principles and content</p> <p>Evaluation of outcomes of care such as quality improvement projects with an evaluation component</p> <p>Reflective practice</p> <p>Culture of safety</p> <p>Quality improvement processes and practices</p> <p>Knowledge of quality improvement methods such as:</p> <ul style="list-style-type: none"> • Plan-Do-Study Act • Six Sigma

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
	<p>excellence.</p> <p>5. Anticipates variations in practice and is proactive in implementing interventions to ensure quality</p>	<p>Cost benefit analysis</p> <p>Peer review process</p> <ul style="list-style-type: none"> • Reviewer • Reviewee <p>Collaborative team processes and practices</p> <p>Leadership skills for leading change for quality clinical practice</p> <p>Methods and measures of quality assurance during transitions of care</p> <p>Laws and rules to enhance quality such as</p> <ul style="list-style-type: none"> • Meaningful use • Federal, state, and local quality data sources and indicators
Practice Inquiry Competencies	<ol style="list-style-type: none"> 1. Provides leadership in the translation of new knowledge into practice. 2. Generates knowledge from clinical practice to improve practice and patient outcomes. 3. Applies clinical investigative skills to improve health outcomes. 4. Leads practice inquiry, individually or in partnership with others. 5. Disseminates evidence from inquiry to diverse audiences using multiple modalities. 6. Analyzes clinical guidelines for individualized application into practice 	<p>Leadership for role in practice improvement</p> <p>Clinical investigation strategies:</p> <ul style="list-style-type: none"> • Identifying clinical practice problems • Appraising evidence for application to practice (e.g., design, methods, tools, analysis) • Literature search methods, including, but not limited to, the PICO Model to define a clinical questions and search for the best clinical evidence <p>Use of electronic databases, such as electronic health records:</p> <ul style="list-style-type: none"> • Assessing clinical practice • Reviewing patient technology • Exploring behaviors and risk factors • Using data to support evidence based changes in clinical management • Template development

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
		<p>Patient management, including, but not limited to, discerning gaps in care and barriers to care needing resolution during patient encounters</p> <p>Project development and management:</p> <ul style="list-style-type: none"> • Synthesis and translation/extrapolation of research to selected populations • Frameworks to guide projects • Quality improvement methods • Assessment of resources needed and available for projects • Competing priorities of patients, payers, providers, and suppliers • Data-based, needs assessment for project • Processes used in conducting projects based on current and best evidence, including evaluation of the application of evidence or inquiry to the population of concern • Evaluation of outcomes (for health status of patient and population as well as system outcomes) • Evaluation of why expected results were or were not attained and lessons learned • Making recommendations for further work • Addressing issues of sustainability of project findings <p>Dissemination of work and findings:</p> <ul style="list-style-type: none"> • Abstract and manuscript writing to support the dissemination of project/research outcomes • Discussion of clinically meaningful results that may or may not be statistically significant • Presentation skill development with modification for different audiences

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
		<p>Integration of findings:</p> <ul style="list-style-type: none"> • Results, methods, and tools, as appropriate, into care delivery • Identification of best practices • Opportunities for multidisciplinary team/inter-professional collaboration for patient care • Development and use of clinical guidelines • Use of clinical judgment to improve practice • Application of evidence to validate or change policy <p>Evaluation of alternative care delivery models and treatments, including costs, cost benefits, and return on investment</p> <p>Institutional review board policies and processes</p> <p>Interprofessional research and scholarship exemplars and opportunities</p>
Technology and Information Literacy Competencies	<ol style="list-style-type: none"> 1. Integrates appropriate technologies for knowledge management to improve health care. 2. Translates technical and scientific health information appropriate for various users' needs. <ol style="list-style-type: none"> 2.a Assesses the patient's and caregiver's educational needs to provide effective, personalized health care. 2.b Coaches the patient and caregiver for positive behavioral change. 3. Demonstrates information literacy skills in complex decision making. 4. Contributes to the design of clinical information systems 	<p>Technology available in clinical practice:</p> <ul style="list-style-type: none"> • Electronic resources that identify current evidenced-based care • Electronic resources that enhance patient safety • Technological care delivery systems • Telehealth • Information databases used by health care systems • Electronic communication with other professionals and patients • Encrypted and unencrypted technology • Electronic resources to support differential diagnosis, algorithmic thinking, and medical record review • Templates for documentation in nursing care • Use of electronic datasets to evaluate practice and improve quality, cost, and efficiency of care <p>Technology available to support education:</p> <ul style="list-style-type: none"> • Standardized patient encounters • Electronic/computer based learning modules based on characteristics such as cultural literacy, educational level,

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
	<p>that promote safe, quality and cost effective care.</p> <p>5. Uses technology systems that capture data on variables for the evaluation of nursing care.</p>	<ul style="list-style-type: none"> • and home assessment • Coaching/teaching resources adapted to population, health literacy, and age of patient learning styles, • Age-appropriate concepts and development of educational tools • Use of applications for references at point of care <p>Using telehealth to provide care for the adult population, considering benefits, methods, differences, and regulatory issues.</p> <p>IT resources such as:</p> <ul style="list-style-type: none"> • Informatics competencies from Technology Informatics Guiding Education Reform (TIGER) initiative • American Medical Informatics Association (AMIA) <p>Use of electronic communication methods, including social media, with healthcare professionals, patients, families, and caregivers</p> <p>Compliance issues related to patient privacy with use of technology</p> <p>Population-appropriate clinical indicators for incorporation into information systems, such as electronic health records</p> <p>Use of technologies to monitor and evaluate clinical problems, e.g.</p> <ul style="list-style-type: none"> • Blood pressure • Vital signs • Glucose • Weight
Policy Competencies	<ol style="list-style-type: none"> 1. Demonstrates an understanding of the interdependence of policy and practice. 2. Advocates for ethical policies that promote access, equity, quality, and cost. 3. Analyzes ethical, legal, and social factors influencing policy 	<p>Policy analysis process:</p> <ul style="list-style-type: none"> • Political environment • Political feasibility • Economic feasibility • Implementation strategy and planning • Outcomes evaluation at local, state, national, and international levels

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
	<p>development.</p> <ol style="list-style-type: none"> 4. Contributes in the development of health policy. 5. Analyzes the implications of health policy across disciplines. 6. Evaluates the impact of globalization on health care policy development. 7. Advocates for policies for safe and healthy practice environments. 	<ul style="list-style-type: none"> • Specific NP role for influencing health care agenda and patient advocacy <p>Health policy and health care reform:</p> <ul style="list-style-type: none"> • Federal budget • National health priorities • Methods for appropriation of funding • Vulnerable populations and needs • The relationship between the USPSTF guidelines and Affordable Care Act implementation <p>Legislative and regulatory processes:</p> <ul style="list-style-type: none"> • Origin of laws • Regulatory process • How to influence/impact passage of laws and their translation into regulation • Health care financing and third party reimbursement <p>Population health model and its impact on policy planning</p> <p>Introduction of global issues:</p> <ul style="list-style-type: none"> • Infections • Travel • Immigration • Disasters/terrorism • Access to health care <p>Ethical issues in health care planning:</p> <ul style="list-style-type: none"> • Fairness • Equity and health disparities • Access and resource allocation • Health behavior • Social determinants of health

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
Health Delivery System Competencies	<ol style="list-style-type: none"> 1. Applies knowledge of organizational practices and complex systems to improve health care delivery. 2. Effects health care change using broad based skills including negotiating, consensus-building, and partnering. 3. Minimizes risk to patients and providers at the individual and systems level. 4. Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders. 5. Evaluates the impact of health care delivery on patients, providers, other stakeholders, and the environment. 6. Analyzes organizational structure, functions and resources to improve the delivery of care. 7. Collaborates in planning for transitions across the continuum of care. 	<p>Organizational practices:</p> <ul style="list-style-type: none"> • Organizational structure, tables of organization • Organizational decision making • Organizational theory • Principles of management <p>Interprofessional collaborative partnerships</p> <p>Informatics/information systems:</p> <ul style="list-style-type: none"> • Interpreting variations in outcomes • Use of data to improve practice • Use of collateral information • Organizational delivery subsystems, (e.g. electronic prescription writing-pharmacy software) <p>Needs assessment of populations served:</p> <ul style="list-style-type: none"> • Socioeconomic and cultural factors • Unique population needs • System resources to meet population needs (e.g. use interpreters to facilitate communication) • Community resources/system outreach to community • Diversity among providers

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
		<p>Financial issues:</p> <ul style="list-style-type: none"> • Financial business principles • Health care system financing • Reimbursement systems • Resource management • Billing and coding principles <p>Interprofessional/team competencies:</p> <ul style="list-style-type: none"> • Communication (theory) • Collaboration • Conflict resolution • Consultations/referrals • Team building • Values and ethics • Roles and responsibilities <p>Safety and quality:</p> <ul style="list-style-type: none"> • Cost-effective care • Legal/ethical issues • Research and quality improvement • Continuous quality improvement • Quality and Safety Education in Nursing <p>Transitional care:</p> <ul style="list-style-type: none"> • Navigating transitions across health care settings • Coordination of services <p>Planning, delivering and/or evaluating models of care:</p> <ul style="list-style-type: none"> • Models of planned change • Process and evaluation design implementation • Evaluation models • Process of proposing changes in practice

Competency Area	NP Core Competencies	Curriculum Content to Support Competencies <i>Neither required nor comprehensive, this list reflects only suggested content specific to the core competencies</i>
Ethics Competencies	<ol style="list-style-type: none"> 1. Integrates ethical principles in decision making. 2. Evaluates the ethical consequences of decisions. 3. Applies ethically sound solutions to complex issues related to individuals, populations and systems of care. 	<p>Legislative and regulatory issues:</p> <ul style="list-style-type: none"> • Relevant and current issues (e.g., Accountable Care Act implementation) • Process of health care legislation • Scope and standards of practice • Cultural competence • Theories of vulnerability • Social determinants of health <p>Policy and advocacy:</p> <ul style="list-style-type: none"> • Reducing environmental health risks • Implications of health policy • Variations in policy <p>Ethics in decision making:</p> <ul style="list-style-type: none"> • Ethical considerations in decision making in clinical practice • Applications of ethical principles in policy making and in care delivery <ul style="list-style-type: none"> - theories of ethical decision making - ethics committee - genetic counseling - clinical research - legal statutes - cultural sensitivity - scope of practice <p>Evaluation of ethical decisions:</p> <ul style="list-style-type: none"> • Methods of evaluating outcomes (long-term and short-term) • Debriefing and assessment of outcomes • Ethical frameworks. <p>Population-specific complex ethical issues occurring in clinical practice</p>

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Independent Practice Competencies	<ol style="list-style-type: none"> 1. Functions as a licensed independent practitioner. 2. Demonstrates the highest level of accountability for professional practice. 3. Practices independently managing previously diagnosed and undiagnosed patients. <ol style="list-style-type: none"> 3.a. Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end-of-life care. 3.b. Uses advanced health assessment skills to differentiate between normal, variations of normal and abnormal findings. 3.c. Employs screening and diagnostic strategies in the development of diagnoses. 3.d. Prescribes medications within scope of practice. 3.e. Manages the health/fitness status of patients and families over time. 4. Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making. <ol style="list-style-type: none"> 4.a. Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration. 4.b. Creates a climate of patient- centered care to include 	<p>System-specific resources to implement ethical decisions (e.g. hospice care, palliative care)</p> <p>Spiritual resources for patients and families (e.g., on site and media based)</p> <p>Clinical decision making based on evidence and patient/provider partnership</p> <p>Current and emerging professional standards</p> <p>Novice to expert continuum of clinical practice</p> <p>Political, policy and regulatory issues regarding licensure, national certification, and scope of practice.</p> <p>Leadership approaches for employment contract negotiation, networking, and advancing professional standards and roles</p> <p>Application of select sciences to practice:</p> <ul style="list-style-type: none"> • Pharmacology • Physiology • Pathophysiology <p>Specific areas of assessment, including but not limited to:</p> <ul style="list-style-type: none"> • Physical • Psychosocial • Developmental • Family • Psychiatric mental health • Oral health <p>Screenings</p> <p>Diagnostics (tests, labs)</p> <p>Specific procedures</p>

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	<p>confidentiality, privacy, comfort, emotional support, mutual trust, and respect.</p> <p>4.c Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care.</p> <p>4.d Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care.</p> <p>4e. Develops strategies to prevent one's own personal biases from interfering with delivery of quality care.</p> <p>4f. Addresses cultural, spiritual, and ethnic influences that potentially create conflict among individuals, families, staff and caregivers.</p> <p>5. Educates professional and lay caregivers to provide culturally and spiritually sensitive, appropriate care</p> <p>6. Collaborates with both professional and other caregivers to achieve optimal care outcomes.</p> <p>7. Coordinates transitional care services in and across care settings.</p> <p>8. Participates in the development, use, and evaluation of professional standards and evidence-based care.</p>	<p>Health promotion, prevention, and disease management</p> <p>Pharmacology and complementary alternative therapies</p> <p>Provider-patient relationship:</p> <ul style="list-style-type: none"> • Role of culture in patient-centered care • Contracting a management plan with patient and/or family • Culture of trust in interpersonal relationship w/patient and/or families <p>Business of practice:</p> <ul style="list-style-type: none"> • Legal, business, and ethical issues • How to set up, finance and evaluate a practice , • Writing a business plan <p>Cultural issues</p> <p>Concepts of life-long learning</p>

