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April 12, 2017

Ohio Attorney General Mike DeWine
c/o Opinions Section
30 East Broad Street, 15th Floor
Columbus, OH 43215

Re: Ohio Board of Nursing Legal Opinion Request of March 8, 2017

Dear Attorney General DeWine:

I am writing on behalf of our client, the Ohio Association of Advanced Practice Nurses ("OAAPN"), and its certified nurse practitioner ("CNP") members in response to the Ohio Board of Nursing ("BON") request for a legal opinion as to whether CNPs who are not nationally certified in acute care "may engage in acute care practice, based on clinical experience obtained post-graduate through the course of employment/ workplace training."[1] OAAPN's position is that the Ohio Nurse Practice Act and national standards for nursing care under various national certifications do not categorically exclude CNPs who do not have an acute care certification from providing services that may be considered acute care or practicing in an acute care setting.

Under the Ohio Nurse Practice Act, a CNP's scope of practice is defined as follows: A "certified nurse practitioner may provide to individuals and groups nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. . . . A nurse authorized to practice as a certified nurse practitioner, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, **provide services for acute illnesses**, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the board."[2] The Nurse Practice Act specifically authorizes CNPs to provide services for acute illnesses.

Further, the Board of Nursing regulations governing CNP scope of practice state that "An advanced practice registered nurse shall provide to patients nursing care that requires knowledge and skill obtained from advanced formal education, which includes a clinical practicum, **and clinical experience** as specified in sections 4723.41 and 4723.43 of the Revised Code and this chapter. Except as otherwise precluded by law or rule, each advanced practice registered nurse shall practice in accordance with the following: (1) The advanced practice registered nurse's education **and clinical experience**; (2) The advanced practice registered nurse's national certification as provided in section 4723.41 of the Revised Code; and (3) Chapter 4723. of the

[1] BON Request for Legal Opinion from the Ohio Attorney General Mike DeWine, March 8, 2017.
[2] ORC 4723.43(C) (emphasis added).

Revised Code and rules adopted under that chapter."[3] The Board's own regulations clearly specify that a CNP may practice in accordance with his or her clinical experience in addition to his or her education and national certification.

In practice, many CNPs work in hospitals and other institutional settings where acute care is rendered. In each setting, the hospital grants CNPs privileges to perform certain services after completion of an application and thorough credentialing process, whereby the hospital requires each CNP to provide evidence of his or her skills and abilities. The hospitals review the CNPs' applications, background, and experiences—both educational and clinical—to determine what services the CNP is competent to provide. This credentialing process focuses on patient safety and ensures that no CNP is authorized or permitted to perform services in the hospital that he or she is not fully capable of providing in a competent manner based on his or her educational and clinical background, including the CNP's national certification.

The hospital credentialing process provides thorough protection and vetting against CNPs providing services that he or she is not able to properly perform. Additionally, most hospitals re-credential their FNPs on a regular basis, typically every one to two years. Each hospital has substantial processes and mechanisms in place to regularly ensure that their CNPs are not performing tasks or providing care that the CNP is not able to safely provide.

While a CNP's national certification is important to determining what skills and abilities a CNP has, CNPs should not be limited to providing only those specific services encompassed within their certification if a CNP has sufficient clinical and post-graduate experience to make them competent to perform other procedures, as determined by the hospital credentialing processes. If the Attorney General provides a stricter interpretation of a CNP's scope of practice, then virtually every hospital in the State of Ohio will be unable to provide proper access to care for its patients under their current staffing models because of the restrictions that will be placed on the CNPs that they employ, some of whom have been practicing for years in acute care settings, safely and competently, without an acute care certification.

Attached to its request, the BON provided the Attorney General's office with a copy of its Fall 2016 Momentum Magazine Article titled "Certified Nurse Practitioners (CNPs) in Primary and Acute Care" (the "Article"). In the Article, the BON states that "CNPs are only authorized to provide the care and treatment of patients/conditions for which they are prepared based on their formal graduate education and national certification. Section 4723.43, Ohio Revised Code (ORC)."[4] The BON further reasons that, "the national certifications for Adult-Gerontology Primary Care, Pediatric Primary Care, or Family, are not certifications that are designed for the management and treatment of critically ill, and/or unstable patients. CNPs with these national certifications should not be routinely managing and treating critically ill or unstable patients in their daily practices. It is not legally permissible for a CNP with national certification in Adult-Gerontology Primary Care, Pediatric Primary Care, or Family to engage in Acute Care practice as discussed above without obtaining formal graduate education and subsequent national certification in Acute Care."[5] This interpretation of the scope of practice of a

[3] OAC 4723-8-02(B)-(B), emphasis added.
[4] Ohio Board of Nursing, Certified Nurse Practitioner (CNPs) in Primary or Acute Care, 16 Momentum (Fall 2016).
[5] *Id.*, at 16–17.

CNP is not only inconsistent with the Ohio Nurse Practice Act and the BON's own regulations, it is also contradictory to the BON APRN Decision Making Model and the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, published by the National Council of State Boards of Nursing.

The Article contains an overly restrictive interpretation of the scope of practice of a CNP, which, if enforced, will have a dramatic effect on not only CNPs themselves but also the many health care providers and patients for which these CNPs already provide acute care services.

Ohio law does not define a specific scope of practice for CNPs based on their different certifications or even mention the possible different certifications that a CNP may obtain. As mentioned above, the Nurse Practice Act states that CNPs "may provide preventive and primary care services, *provide services for acute illnesses*, and evaluate and promote patient wellness within the nurse's nursing specialty, *consistent with the nurse's education and certification*."[6] This statutory language expressly states that all CNPs may provide services for acute illnesses, so long as the services are *consistent* with the CNP's education and certification. "Consistent" generally means "marked by harmony, regularity, or steady continuity; free from variation or contradiction."[7] Consistency is a matter of compatibility, not a ceiling. Providing care that was not necessarily discussed in nursing school or on a specific certification exam is not "inconsistent" with the nurse's education and certification so long as the care that the nurse provides does not contradict his or her education and certification.

Neither the Nurse Practice Act nor the BON regulations make any delineations or restrictions based on different certifications, and the laws do not state that a CNP without an acute care certification cannot maintain an acute care practice, as the BON has interpreted the language. The law merely states that the CNP's practice must be *consistent* with his or her education and experience—not that his or her practice is limited to the things that the CNP learned in nursing school or studied for before taking a certification licensure exam as a new graduate. Accordingly, there is no basis in Ohio law for the strict interpretation that it is illegal for a CNP without an acute-care certification to provide acute care services. Conversely, the requirements of Ohio law allow a CNP with any type of specialty certification to perform any nursing task that is not "inconsistent" with their education and certification, so long as the CNP can otherwise show that he or she has the requisite "knowledge and skill" to provide such services.

Additionally, as quoted above, the Article cites Ohio Revised Code ("ORC") § 4723.43 to support the assertion that CNPs can only treat patients and conditions "for which they are prepared based on their *formal graduate education* and national certification." This is a vast mischaracterization of the plain language of Ohio law as well as the BON's own APRN Decision Making Model. The Nurse Practice Act and BON regulations do state that a CNP's scope of practice is based on his or her "advanced formal education and clinical experience" and that a CNP's practice must be "consistent with the nurse's education and certification." However, Ohio law does not limit the CNP's "advanced formal education" for purposes of determining the scope of practice to his or her "formal *graduate* education." This is an important distinction because the

[6] ORC 4723.43.
[7] Merriam Webster Dictionary, "consistent".

medical field changes rapidly and there are many medical advances that may not have been included in the material that a CNP studies in his or her graduate program because the information simply did not exist yet. Similarly, there are many tasks that may not have been addressed when the CNP took his or her specialty certification exam because, again, the information did not yet exist.

While the graduate nursing program and specialty certification of a CNP serve as the foundation for the CNP's practice abilities and competencies, it is entirely unrealistic to limit the CNP's practice to this education and the tasks covered on the CNP's initial certification exam because this would effectively prevent a CNP from providing any innovative service or treatment. Enforcing the Article's interpretation of a CNP's scope of practice would mean that nurses who attended nursing school even 10 years ago cannot perform some of the currently accepted best practices for nursing care because those practices had not yet been invented, and thus the nurse did not learn about them in school or prepare for them before taking a certification exam. It is detrimental to patient care to assert that a CNP's practice abilities are limited to the care that was covered in a nursing graduate program or on a certification exam because then CNPs would not be able to provide groundbreaking services to their patients.

Further, CNPs have historically evolved their scope of practice over the course of their career to meet the demands of medical advances based on various educational experiences—not just based on their nursing school graduate education and the certification exam that they took once they graduated. As a clear example that a CNP is not limited to providing services that he or she learned in nursing school or that fall under a certain certification category, the APRN Decision Making Model adopted by the BON in 2006 and most recently updated in March of 2015 ("Decision Making Model") does not limit a CNP's scope of practice to tasks that he or she learned in a formal graduate education program or require a service to traditionally fall under a certain specialty certification.

Instead, the Decision Making Model states that the CNP "must be able to provide documentation, upon request of the Board, to show evidence of your knowledge to perform the procedure/activity. Such knowledge is generally obtained through education emanating from a recognized body of knowledge relative to the care to be provided. Documentation could include:

- APRN educational programs;
- Preceptorship, fellowship, or internship; and/or
- Other formally organized educational experience"[8]

The Decision Making Model further provides that CNPs "must be able to provide documentation, upon request of the Board, to show evidence of your skills and abilities to perform the procedure/activity. Documentation could include:

- APRN educational programs;
- Formally organized educational experience; and/or
- Return demonstrations or skills check-off"[9]

[8] Ohio Board of Nursing, APRN Decision Making Model, 1 (March 2015).
[9] *Id.*, at 2.

The Decision Making Model expressly allows CNPs to gain knowledge to perform services through practical experience, such as an internship, and through other educational experiences—the CNP's formal graduate education and certification are only one source of knowledge for a CNP's practice. Further, the language of this document states that these sources of knowledge and abilities are mere examples that "could" be used to show proper documentation that a task is within a CNP's scope of practice, and not an exhaustive list. For example, it is possible that a CNP with a pediatric primary care certification has taken extensive continuing education courses in acute care and completed an internship treating critically ill patients. These experiences fall outside of the CNP's formal graduate education and certification but would certainly give the CNP the knowledge, skills, and abilities to treat critically ill or unstable patients.

The guidance of the Article would require CNPs who have been relying on the Decision Making Model since 2006 to suddenly stop performing any service that they did not learn in nursing school or study in preparation for their certification exam. This is not only a waste of the CNPs' talents and abilities that they have gained as they grew in their careers, but a dangerous limitation that may result in highly limited access to care for critically ill and unstable patients who are treated by CNPs with a variety of certifications on a daily basis. The BON is essentially saying that it would prefer that there be one less qualified provider helping patients with emergency conditions on a regular basis than having an experienced CNP who took a different certification exam as a new graduate assist in saving patients' lives.

It would be impractical to enforce the interpretation of a CNP's scope of practice described in the Article because it would limit the access to quality patient care that many CNPs are qualified to provide in an acute care setting based on their clinical experience and continuing education, with their graduate nursing education and certification serving as the foundation. Further, many CNPs have relied on the APRN Decision Making Model to determine whether tasks are within their scope of practice, and it would be an immense burden on the CNPs and the health care providers that they work with to suddenly restrict practices that are otherwise supported by the Decision Making Model.

Most notably, the Consensus Model for APRN Regulation published by the National Council of State Boards of Nursing and endorsed by 48 other nursing-related organizations (the "Consensus Model"), which the BON provides to nurses on its website and has incorporated into its regulations and guidance, does not support the strict interpretation of the scope of practice for CNPs. The Consensus Model provides that state licensing boards should not be regulating CNPs in the manner proposed in the Article, stating that "state licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model."[10] The Consensus Model expressly states that while all CNPs are "prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies *only* to the pediatric and adult-gerontology CNP population foci. *Scope of practice of the primary care or acute care CNP is* ***not setting specific*** *but is based on patient care needs.*"[11] As such, even an individual with a pediatric or geriatric primary care certification

[10] APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, 12 (July 7, 2008).
[11] *Id.*, at 10.

is not limited in scope of practice based on their practice setting or certification but instead should use and build upon their competencies to conform their scope of practice to meet patient needs.

Furthermore, since the Consensus Model specifically states that the acute care and primary care CNP delineation applies *only* to the pediatric and adult-gerontology CNP population foci, there **is not** an acute care versus primary care delineation for CNPs with a family certification. Accordingly, there is absolutely no basis for the BON to prevent family-certified CNPs from engaging in acute care practice, even under the flawed reasoning of the Article.

The Consensus Model describes the role of specialty certifications as a way to add depth to a CNP's practice, not to limit their scope of practice to one specific area. The Consensus Model states that "specialties can provide depth in one's practice within the established population foci" and that educational "preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies."[12] If preparation in a specialty area is optional then it is wholly possible that even a CNP with an acute care certification did not obtain his or her acute care skills through her formal graduate education, so it would contradict the BON's reasoning in the Article that the CNP is limited to practicing those skills learned through formal graduate education. Indeed, the BON regulations regarding nursing educational programs do not impose requirements for education related to CNP specialty certifications.

The Consensus Model elaborates that "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."[13] The Consensus Model makes it clear that a CNP's specialty certification is not a limitation on a CNP's abilities but instead one method through which the CNP can gain additional knowledge in a certain area. The fact that a CNP has specialized knowledge in a particular specialty area gives the CNP more experience in a particular area of nursing but should not limit the CNP to only practicing only within that area of nursing. This is particularly true if the CNP undertakes additional educational and practical experiences to provide services in other areas and credentialed through the rigorous hospital privileging process to provide such services.

Importantly, the Consensus Model makes it clear that a CNP's scope of practice cannot be limited to his or her nursing school education or the practices covered on a CNP's certification exam because "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. . . . 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.)."[14] This guidance, endorsed by numerous nursing trade associations and organizations, and provided to Ohio-licensed CNPs on the BON's website, explicitly provides that a CNP's scope

[12] *Id.*, at 6 and 11.
[13] *Id.*, at 12.
[14] *Id.*

of practice will evolve after graduation and passing a certification exam and continue to evolve throughout their careers depending on the needs of patients. Competence to expand a CNP's scope of practice into a different specialty area can come from education or experiential learning and assessment—not just the courses they took in nursing school or the practices covered on a certification examination.

This interpretation is consistent with the BON's Decision Making Model and will lead to greater access to patient care if CNPs are allowed to practice beyond the confines of their formal graduate education and national certification. A CNP's education and certification give the CNP a foundation for quality nursing care and specialized knowledge in a particular area. They do not, however, limit a CNP to practicing within one particular area if they are able to properly document the knowledge, skills, and abilities to practice in other areas, such as an acute care setting, according to the Decision Making Model.

Further, CNPs rendering acute care services do not go unchecked. All CNPs must practice in collaboration with a physician. Additionally, before a CNP renders any acute care services, he or she will have been assessed and credentialed by a hospital or other institution and only granted privileges to provide those services that the hospital determines are within the CNP's clinical abilities.

The BON guidance in the Article cannot be enforced, and the attempt by the BON to overstep their authority under the Nurse Practice Act by adopting this strict interpretation that is inconsistent with Ohio law will have implications and effects that reach well beyond just those CNPs who are practicing in acute care settings without an acute-care certification. It will be detrimental to the hospitals and health systems in the State of Ohio providing high-quality care to Ohio's citizens because they will have to expend resources to replace experienced and properly credentialed CNPs who are already working in acute care settings. It will create confusion and an administrative burden for health care providers. Most importantly, it will lead to decreased access to care for those patients who need it the very most—the critically ill and unstable.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.

Sincerely,

Jeana M. Singleton