Full Practice Authority: Impact for the CNS

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Veterans Health Administration (VHA)

- Largest health care system in United States
- Large employer of APRNs
  - 5444 NP
  - 386 CNS
  - 937 CRNA
- Wide variation on CNS practice exists within VHA
  - State restrictions
    - VA accepts a license from any state in US; CNS may hold a license from a state different from where s/he is employed
  - Facility restrictions
    - Some facilities are more restricted than the state requires
- Initial purpose of full practice authority (FPA) regulation
  - Reduce variation in practice for all APRNs
    - Independent of state licensure restrictions
Variation of CNS Practice across US: 2016
Arduous Process of Policy Development

2009-2010 Concept of VHA Nursing Handbook
- Institute of Medicine (IOM)
- Future of Nursing
- American Nurses Association (ANA) APRN Consensus Model
- Internal pre-concurrence

2011-2012 VHA Concurrence Process
- Federal Supremacy/Office of General Council
- Joint Commission
- National Council of State Boards of Nursing (NCSBN)

2013 External Stakeholders
- Implementation Plans
- Detail policy expert
- Final concurrence to USH
- Unauthorized release draft of early Handbook to ASA
- Congressional Inquiries

2014 Regulation
- Congressional Briefings
- External Stakeholders
- Regulation - Proposed rule written for VA/VHA/OMB concurrence
- Congressional Inquiries

2015-2017
- Proposed Rulemaking
  - Federal Register 60 days, from 5/25 to 7/25
  - Over 200,000 comments
- Final version published 12/14/16
- Effective 1/13/17
Full Practice Authority - Design

- Eliminates variance in individual state practice regulations
- Permits standardized care across VHA system
- Enhances ability of all APRNs to practice to the full extent of one’s education, licensure and certification

- Permits APRNs to independently:
  - Evaluate patients
  - Diagnose
  - Order/interpret tests
  - Initiate and manage treatments (including prescribing medications)

- Uses Federal Supremacy regardless if State Laws dictate a more restrictive practice
Summary of Final APRN Regulation

• VA Amended Medical Regulations to Nursing Policy
• Established
  • Professional qualifications required to be appointed as an APRN within VHA
  • Criteria whereby full practice authority is granted
  • Definitions of scopes of practice
• Permits full practice authority to 3:4 APRN roles
  • CRNA excluded, can be revisited if necessary
• Provides advanced nursing services to full extent of professional competence
• Intent of regulation is to improve veteran access to care
Myths Related to FPA & the VA CNS

**Myth**
- Mandatory application to all VA facilities
- Applies to all CNSs within a given facility
- Automatic ability to perform procedures & treatments
- Automatic ability to prescribe medications
- Able to prescribe Schedule II medications
- No supervision is required

**Reality**
- Decision at discretion of each VA facility
- May apply to CNSs if facility embraces FPA & CNS has appropriate privileges
- Privileges to perform procedures must be requested and approved
- As above; must have taken graduate level pharm course
- May prescribe ONLY if state law permits
- Collaboration is expected
Impact of Full Practice Authority

• Each facility has discretion in decision to implement FPA
• Uniformity of implementation within a facility may vary
  • Example:
    • Primary care vs. Specialty care
    • NP vs. CNS
What does this mean for the CNS within VHA?
Current Challenges

- CNS relocation to another state
  - More restrictive states to less restrictive states
  - Credentialing and privileging versus scope of practice
  - Prescribing ability

- Role confusion
  - Inpatient versus Outpatient
  - CNS versus NP

- Salary disparity
  - APRN versus RN
  - CNS versus NP
Does Your State Recognize Independent Practice?

https://ncsbn.org/5406.htm
APRN Certification

VHA requires certification for all 4 APRN roles

California does not with exception of CRNA

Kansas and New York do not require certification for any of the APRN roles

Indiana does not require for CNS and NP
Prescriptive Authority

**Blue**
Fully independent

**Red**
Written agreement specifies scope of prescribing part of with/out supervision

**Gray**
No prescribing authority

**White**
No data/not recognized

When did you graduate?
Did you take Advanced Pharmacology?

https://ncsbn.org/5410.htm
How will this affect CNS practice nationally?
• The vast majority of CNSs (85%) work full-time
• 66% work in hospital settings.
• 44% have responsibility across the entire hospital system.
• Concentrated in adult care or gerontology
• CNSs spend most of their time providing direct patient care (25%),
• 25% of CNSs are authorized to prescribe medications.

http://nacns.org/professional-resources/practice-and-cns-role/cns-census/
PRACTICE

CNSs provide care in a range of specialties.
Based on the APRN Consensus Model's certification for licensure based on patient population, what is the population group that you primarily care for?

- 71.01% Adult gerontology
- 9.93% Psychiatric/mental health
- 8.55% Pediatric
- 4.83% Family across the lifespan
- 3.21% Women's health
- 2.6% Neonatal

CNSs have a range of duties, from providing direct patient care, to managing care, to leading research, to nurse, patient and family education. What is the percentage of time you estimate that you spent on the following activities last year?

- 25% Providing direct patient care
- 20% Consulting with nurses/staff/others
- 19% Teaching nurses/staff
- 14% Leading evidence-based practice projects
- 11% Assisting with patient care
- 10% Assisting with EBP projects
- 9% Teaching patients/families
- 6% Assisting with research
- 6% Precepting students
- 5% Conducting research as the primary investigator
- 3% Providing transitional care
- 27% Other

www.nacns.org (2014)
How does this apply to you?
Self Assessment

• Do you have prescriptive authority
  • For medications
  • For DME, consults, labs, prosthetics
• Does your role primarily affect patient care?
  • Defend how the other spheres of influence are critical to the mission of your institution

• Specific to FPA
  • Education requirement
    • Masters or Doctorate as a CNS
    • Advanced pharmacology
  • Certification in area of practice
Personal action plan

• Current individual practice versus optimal practice
  • How would FPA change your daily function?
  • Privileges may be required
• How is your practice strengthened with FPA?
  • Steps required
    • Leadership buy-in
    • Medical bylaws amendments
    • Apply for privileges
• Develop metrics for evaluating impact
Your Personal Action Plan

VHA
- Fill in your personal gaps as a CNS
  - Advanced pharmacology
  - Identify need for privileges
- Will your facility leadership embrace FPA
- Be a leader and help drive CNS practice change
- Be able to articulate
  - the implications of FPA
  - the benefits to the facility

Non VHA
- Independent practice state (FPA)
  - Does your facility support total independent practice?
    - Develop appropriate business case to garner support.
- If not in an independent practice state:
  - Advocate for legislation to promote independent practice for CNSs
Resources needed

• Advanced courses in pharmacology
• Didactic and skills education for procedures
• Meeting criteria for certification exams

• Administrative support
• Data analytics
  • Metric design
  • Metric analysis
Conclusions

• Value-added benefits of a FPA CNS to leadership

• VHA spearheads benefits of FPA for CNS in all states
CNS Spheres of Influence

PATIENT/FAMILY

NURSE

SYSTEM