NCSBN
Leading in Nursing Regulation

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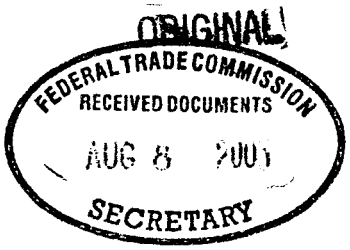

Mr. Donald S. Clark
Office of the Secretary
Federal Trade Commission (FTC)
600 Pennsylvania Avenue NW
Washington, DC 20580

Attention: David Hyman, Special Counsel to the FTC

Comments Regarding Hearings on Health Care and Competition Law and Policy

The National Council of State Boards of Nursing, Inc. ("NCSBN") makes this submission in response to a presentation made before the Federal Trade Commission by the National Association of Clinical Nurse Specialists ("NACNS") on June 11, 2003. The NACNS's presentation, in its advocacy of its members' interests, significantly misstates the record in several important respects. We write to provide a more accurate account of the issues in an admittedly evolving and challenging area of advanced practice nursing regulation.

Who Is The NCSBN?

The NCSBN is a 501(c)(3) Pennsylvania not-for-profit corporation and is made up of 61 member state and territorial boards of nursing. The NCSBN was created to assist boards of nursing in promoting public safety through regulation. NCSBN provides a forum for its members to dialogue and consult with respect to regulatory issues. NCSBN facilitates the collaborative investigation and development of regulatory policies by its member boards through the workings of its staff, as well as committees and task forces made up of volunteers from the member boards. NCSBN may adopt policy positions by vote of its member boards acting through NCSBN's Delegate Assembly.

However, NCSBN's policy recommendations have no effect unless and until they are adopted by individual state licensing boards. The licensing authority of the individual states and territories resides, as always, in the individual state boards and is governed by the various state statutes and regulations. Individual state boards of nursing are free to adopt, modify or reject any policies recommended by NCSBN. NCSBN cannot and has never attempted to impose on its members any mandatory regulatory rules which the individual state boards must adopt as a condition of continued membership in the NCSBN.

What Initiatives Has The NCSBN Undertaken With Respect To The Regulation Of Advanced Practice Nursing?

Changes in the United States healthcare system, including increasing costs and dramatic advances in scientific knowledge, have caused nursing to evolve into multiple levels of advanced practice beyond traditional registered nursing (RN) with increasingly differentiated practitioners in terms of knowledge and skills and with a proliferation of practitioner titles.

The NCSBN has been assisting its member boards since the mid-1980s in exploring effective regulation of advanced practice nursing (APRN). This term, as used herein, includes practice by nurse anesthetists, nurse midwives, nurse practitioners and clinical nurse specialists ("CNSs"). The distinguishing benchmark for advanced practice nursing is the assumption by the nurse of primary and independent responsibility for the direct care of patients. This may or may not include prescriptive authority. Advanced nursing practice, as thus defined, exceeds the scope of practice of registered nurses (RNs).

To the extent CNSs practice within the RN scope of practice, no exceptional regulatory issues arise. But nurses, including CNSs, with advanced skills and education, seek greater legal recognition and expanded scopes of practice. NCSBN's member boards have recognized for sometime that a lack of consistency in advanced practice education requirements, program accreditation, titling, credentialing, scope of practice and reimbursement eligibility have confused the public, regulators and the nurses themselves and have hindered the development of advanced nursing practice.

Accordingly, NCSBN created an Advanced Practice Task Force to investigate ways to foster advance nursing practice while at the same time protecting the public. Two task force initiatives endorsed by NCSBN's membership lie at the center of NACNS's accusations against the NCSBN.

First, in 2000, NCSBN's Delegate Assembly endorsed minimum requirements for a nurse to obtain legal authority for advanced practice: (1) an unencumbered RN license; (2) graduation from a graduate level advanced practice program accredited by a national body; (3) certification by a national certifying body in the advanced practice specialty appropriate to educational preparation; and (4) maintenance of certification or evidence of maintenance of competence. The NCSBN's member boards concluded that adoption of uniform core licensure requirements would promote mobility of APRNs while maintaining consistent standards critical to protecting the public's health. In particular, the Task Force found that the proliferation of specialty designations (over 40 by NACNS's own estimate) presented a clear potential risk of harm to the public due to confusion or misimpressions over the meaning of the various subspecialty designations and the competence of nurses who adopt these titles to undertake direct responsibility for patient care.

In considering the appropriate educational support of advanced practice, NCSBN's Delegate Assembly concluded that a broad advanced education, such as in adult health, pediatrics, psychiatric/mental health, etc., was necessary for legal recognition of advanced practice. Underlying this decision was the determination that, for public protection, advanced practice nurses, as the primary care giver, must be trained to recognize and diagnose a range of commonly occurring health problems to practice safely and effectively and that narrow disease or condition specific

education, certification and scope or practice would not only be unsafe but also would be unenforceable as a practical matter.

The Delegate Assembly also directed the NCSBN to collaborate with APRN certification organizations to develop a process for evaluating the organizations' certification programs to enable state boards to recognize certification by such organizations for licensure purposes. In evaluating the various certification programs, the NCSBN applied the accreditation standards of the National Commission for Certifying Agencies and also required the use of a valid and secure examination in the certification process.

This is the nub of NACNS's criticism of the NCSBN. That is, NCSBN's Task Force determined that for public safety, as well as regulatory effectiveness, advanced practice cannot be defined in terms of narrow subspecialties. NACNS wants recognition on the basis of some of its members' narrows subspecialties such as Congestive Heart Failure CNS, Diabetes CNS, Continence CNS or Wound/Ostamy CNS to advance the professional interests of certain CNSs.

The second Task Force initiative was the development in 2002 of a model Advanced Practice Registered Nurse Compact for the mutual recognition of licensed APRNs by states who are members of the Compact. Such a Compact would provide that member states authorize the practice of an APRN in their state based on licensure in the APRN's "home" state without the necessity of obtaining a separate license in each state in which the APRN practices. This Compact is modeled after the Nurse Licensure Compact for RNs and LPNs, also developed by the NCSBN and adopted as of today by 20 states. To date, no state has yet to adopt the APRN Compact. However, the pro competitive design and potential effect of such a compact in fostering practitioner mobility is self-evident. To facilitate implementation of the Compact and its adoption by state boards of nursing, the model Compact calls for each state to adopt the above-described minimum requirements for advanced practice authorization. Absent such uniform requirements, the wide variation in state APRN regulatory provisions would frustrate any attempt to implement an APRN Compact.

NACNS suggests, without specificity, that the NCSBN initiatives raise certain concerns under the Noerr doctrine. However, NCSBN's conduct in connection with these initiatives can best be viewed as petitioning activity that is directed to state boards of nursing which ultimately will determine what minimum standards for advance practice licensure status will be used in their respective states, and whether to participate in a compact for mutual recognition of advance practice licensure. NCSBN's initiatives have been undertaken in good faith to address important issues confronting state boards of nursing, and are intended to provide the boards with effective and supportable standards for licensure of advance practice nurses. NCSBN's recommendations have no impact on nurse licensure or nursing services unless and until those recommendations are accepted and implemented by individual state boards of nursing. Thus, NCSBN's petitioning activity is properly protected by the Noerr doctrine—the recommendations are directed toward influencing and informing the decisions of state boards of nursing on licensure standards that are clearly within their scope of authority.

Moreover, as shown above, NCSBN's recommendations concerning advance practice licensure standards are procompetitive: (i) they are based on careful study and the experience of state boards of nursing with broad-based advance education requirements and written examinations

as criteria for licensure; (ii) they are similar to licensure and certification requirements used for other health care providers who have direct patient care responsibility and/or the authority to prescribe medications to patients; and (iii) they will serve to protect public health and safety and promote high quality nursing care by ensuring that advance practice nurses are properly educated, trained, and tested to practice safely and effectively and to recognize and diagnose a range of commonly occurring health problems. As above discussed, NCSBN's model compact for mutual recognition of advance practice licensure also offers clear procompetitive benefits in that it would facilitate mobility of licensed advance practice nurses among participating states, and may reduce the burden of compliance with licensure requirements both for nurses and for state boards of nursing. Application of the Noerr doctrine to these initiatives would, therefore, be fully consistent with the interests in balancing antitrust enforcement with the important right to engage in lawful petitioning that is recognized by the First Amendment and long-standing court decisions.

NACNS, of course, is free to advocate a more narrow disease- or condition-specific standards for education, certification, and scope of practice for certified nurse specialists, and such advocacy also may warrant protection under the Noerr doctrine. In any event, state boards of nursing are not limited by virtue of any action by NCSBN from considering or adopting advance practice licensure requirements which differ from those recommended by NCSBN. Curtailing the protection from antitrust claims afforded by the Noerr doctrine, however, could interfere with the ability of state boards to study these issues in a collaborative fashion through NCSBN and to receive broad input from all interested parties, and would not advance any legitimate goal of expanded antitrust enforcement with respect to such conduct.

In addition to setting the record straight in general, we respond more particularly to the more egregious misstatements by the NACNS.

"Some state boards of nursing (e.g. Texas, Ohio, Minnesota, Arkansas) are requiring all CNSs to obtain a second license to practice – this requirement: represents over-regulation for the vast majority of CNSs and creates insurmountable barriers for the CNS to practice (with or without prescriptive authority) when obtaining the 2nd license requires specialty certification as a CNS by exam thus denying the public access to needed services."

NACNS does not appear to dispute that regulation of nursing services through state-administered requirements for education, licensure, and certification of competence is necessary and proper, but it contends that the aforementioned state boards have engaged in over-regulation by requiring all clinical nurse specialists practicing in the state to be licensed as APRNs. In this respect, NACNS takes issue with the merits of particular state licensing statutes, or regulatory actions by state boards of nursing acting pursuant to the authority granted by those statutes, rather than the actions of NCSBN in proposing minimum requirements for licensure of advance practice nurses.

Moreover, the states of Texas, Ohio, Minnesota and Arkansas clearly have the right to require a license for APRNs in order to practice in their jurisdiction as means to protect their citizenry. State boards of nursing establish and implement nurse licensing requirements pursuant to state laws that expressly authorize such conduct, and articulate a clear policy favoring effective regulation of nursing services over unfettered competition by all who might wish to provide such

services. The regulatory actions by state boards of nursing with respect to nurse licensure fall squarely within the state action doctrine—the actions in question are those of boards of nursing appointed by each state and are taken pursuant to express authorization under state laws. Nor does NACNS contend that state boards of nursing have exceeded the authority conferred on them under state law in requiring advance practice licensure status for nurses seeking to provide certain specialized services. Indeed, NACNS acknowledges that where clinical nurse specialists engage in direct patient care and are authorized to prescribe medications, additional regulation beyond the normal registered nurse license may be warranted. In fact, CNSs in these states do have prescriptive authority and, therefore, even NACNS in their testimony admit that a more rigorous level of regulation is an appropriate safeguard for the public.

"Regarding issue of over-regulation; There is no evidence over the past 50 years of public safety issues regarding CNS specialty nursing services."

- APRNs have similar public safety issues as licensed practical nurses (LPNs) and registered nurses (RNs). Results of a study conducted by the NCSBN through the Commitment of Public Protection Through Excellence in Nursing Regulation Project, indicated that the rates for all of the discipline-related variables such as: nurses disciplined in past three years, nurse disciplined during 2000, licensees with new complaints during 2000 while under investigation, and previously disciplined nurses who were disciplined during 2000, were similar across LPN, RN and APRN groups including CNSs. Moreover, as discussed above, the independent practice of APRNs makes public safety issues even more important than for LPNs and RNs.

"Regarding the issue of over-regulation: The level of regulation needed for CNS practice without prescriptive authority is designation/recognition."

- The NCSBN does not disagree with this statement so long as a CNS is not practicing outside the scope of the RN license. However, it has been the experience of boards of nursing that most CNSs want to practice in the advanced practitioner role including independent practice, medical diagnosing and prescriptive authority. According to data collected by NCSBN in 1999, 17 states grant some level of prescriptive authority to CNSs. Currently, the professional CNSs groups are lobbying additional states to grant prescriptive authority to CNSs.

"The issue of insurmountable barriers: the requirements to obtain a 2nd license and to be certified by exam as a CNS adversely affects the majority of CNSs who practice within the domains authorized by the RN license: there are over 40 CNS specialty areas of practice; only 9 CNS specialty exams exist. Therefore, the vast majority of CNSs will never be able to obtain certification in their specialty area, it is not economically feasible to develop exams in areas where there are not large numbers of practitioners, thus it is impossible for the vast majority of CNS to meet this regulatory requirement."

- If, as NACNS claims, CNSs do not desire to practice in the role of the advanced practice nurse, there would not be a need for CNSs to take an APRN certification examination. A CNS acting in this capacity would be practicing within the scope of

the RN license. However, as explained above, for those nurses practicing in the advanced practice nurse role, broad-based examinations, such as medical-surgical, psychiatric, etc., are necessary to ensure that the APRN has the necessary broad preparation to recognize a range of commonly occurring health problems and to practice safely.

Currently, "NCSBN Advanced Practice Task Force is advocating the development of a standardized 'generalist' exam to evaluate safe advanced practice nursing" and that NCSBN has "a vested economic interest" in doing so because it would develop the exam.

- This assertion is particularly galling and inaccurate in its claims that NCSBN has been acting out of self-interest. Rather than developing one "generalist exam" for APRN licensure, as shown above, NCSBN for the last ten years has been working with the various APRN certification organizations to enable state boards of nursing to use APRN certification examinations as a basis for APRN licensure decisions. As a result of these efforts, there are a wide range of broad based certification examinations available to CNSs who wish to practice at an advanced level.

"National Council has undue and inappropriate control over state regulatory processes."

- NCSBN has no control whatsoever over state regulatory processes. NCSBN is the forum for its members, state boards of nursing, to dialogue and counsel with each other. NCSBN is not a regulatory authority and supports the autonomy of its 61 member boards as independent state and territorial regulators of nursing practice. Boards of nursing, through individuals acting in the capacity of NCSBN committee members, board of directors and voting delegates, control the direction of the work of the NCSBN.

"National Council does not allow for input of other organizations"

- NCSBN takes great care to solicit input from nursing groups, healthcare organizations and other interested parties. Its meetings are open to all, and comments and participation are invited. Regarding advanced practice regulatory issues, the NCSBN sponsors an annual APRN Roundtable during which the activities of the Advanced Practice Task Force are discussed with APRN stakeholders.

We hope this letter addresses the charges made by the NACNS during their testimony presented to the FTC. We would appreciate an opportunity to answer any questions you may have. You can contact Kathy Apple, Executive Director at kapple@ncsbn.org (312.525.3610) or Kristin Hellquist, Associate Director of Policy and External Relations at khellquist@ncsbn.org (312.525.3665) if the FTC or the Department of Justice (DOJ) requires any additional information regarding NCSBN.

Sincerely,

Donna M. Dorsey

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