BEFORE THE BOARD OF NURSING
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.159.301 definitions, 24.159.1405, 24.159.1412 through 24.159.1414, 24.159.1418, 24.159.1427, 24.159.1428, 24.159.1461, 24.159.1463, 24.159.1464, 24.159.1467, 24.159.1468, 24.159.1470, 24.159.1475, 24.159.1480, and 24.159.1485 advanced practice registered nurses, 24.159.2102 biennial continuing education credits, the adoption of NEW RULES I and II APRN practice and competence development, and the repeal of 24.159.1404, 24.159.1411, 24.159.1424, 24.159.1462, 24.159.1466, and 24.159.1490 standards related to APRNs	))	NOTICE OF AMENDMENT, ADOPTION, AND REPEAL

TO: All Concerned Persons

1. On April 11, 2013, the Board of Nursing (board) published MAR Notice No. 24-159-77 regarding the public hearing on the proposed amendment, adoption, and repeal of the above-stated rules, at page 490 of the 2013 Montana Administrative Register, Issue No. 7.

2. On May 6, 2013, a public hearing was held on the proposed amendment, adoption, and repeal of the above-stated rules in Helena. Several comments were received by the May 14, 2013, deadline.

3. The board has thoroughly considered the comments received. A summary of the comments received and the board's responses are as follows:

4. GENERAL COMMENTS: Several commenters expressed general approval or disapproval of one or more rule changes contained in the notice. The board appreciates the active participation of all those who provided comments. The board has adopted the rule amendments, proposed new rules, and the repeal of the rules as shown in the proposal notice, with the exception of ARM 24.159.1414, which the board has determined to take back to the rules committee for additional modifications.

COMMENT 1: Several commenters asserted that Certified Registered Nurse Anesthetists (CRNAs) have been legally performing chronic pain management for over a decade in a safe and effective manner. These commenters cited a recent poll by the Montana Association of Nurse Anesthetists (MTANA), in response to which 49 percent of Montana's CRNAs reported they are currently providing some kind of chronic pain management as part of their practice. Along the same idea, a number of commenters asserted that there is no known difference in the rates of complication between CRNAs licensed by the Montana Board of Nursing and anesthesiologists licensed by the Montana Board of Medical Examiners.

RESPONSE 1: The board agrees that chronic pain management is an established part of the CRNA's scope of practice. In addition, the board is not aware of any complaint to have come against any CRNA for at least the past five years that alleged a failure to practice competently or for exceeding the CRNA's scope of practice. This indicates to the board that CRNAs are practicing within the scope of their licensure in a safe and competent manner. The board is unaware of any studies comparing the rates of complication between CRNAs and anesthesiologists in relation to their respective scopes of practice, and the board believes the current scope of practice is adequately protecting the public.

COMMENT 2: Several commenters asserted that chronic pain management is a critical service in Montana, especially in the less populated areas where patient access to licensed anesthesiologists is insufficient to meet patient needs. The commenters stated that Ronan, Anaconda, and even Butte lack physicians to provide interventional pain management services in these communities.

RESPONSE 2: The board agrees that the existing practice of CRNAs in the area of chronic pain management is critical, so that adequate pain management services continue to be available throughout Montana, especially in rural areas of Montana.

COMMENT 3: Several commenters urged the board to amend the rules as proposed, in particular ARM 24.159.1480, as an appropriate step toward implementing the National Council of State Boards of Nursing's (NCSBN) Consensus Model (the "Consensus Model"). The commenters asserted the proposed rule changes do not expand or alter the scope of practice for Advanced Practice Registered Nurses (APRNs).

RESPONSE 3: The board notes that the Consensus Model is an expression of the national standard of advanced registered nursing practice and is the product of the widely collaborative efforts of educators, certifying agencies, national professional organizations, and regulatory agencies of advanced practice registered nursing across the nation. As national consensus of what the "field of advanced practice registered nursing" is, the Consensus Model provides the best expression of what the scope of practice is for the advanced practice registered nurse in Montana.

The board affirms that the board's intent is to continue to implement the Consensus Model through rulemaking efforts so as to express, not expand, the scope and standards of practice applicable to advanced practice registered nursing.

The board further views the increase of specificity in rule as tightening and clarifying the APRN scope and standards so that APRNs can better understand their boundaries, thereby enhancing patient safety.

COMMENT 4: Some commenters pointed out, in support of CRNA qualifications to perform chronic pain management, that CRNAs must receive continuing education in order to maintain their certification, and in addition, each nurse must also meet requirements for credentialing and clinical privileges established by each facility where the nurse provides services. Moreover, some commenters argued that while the certification process is varied among licensed health care professionals, demonstration of competency for all such professionals is provided through hospital privileging criteria, quality assurance programs, and peer review.

RESPONSE 4: The board views these comments as being factually correct, and further notes that the APRN must be certified to practice in a role and upon a population focus, and the combination of which is an area of specialization for the nurse. Certification by a national certifying body ensures the APRN's qualifications to practice "in a field of advanced practice registered nursing," 37-8-409, MCA, which is the legislature's expression of the APRN's scope of practice.

Currently, the preparation for becoming certified as an APRN includes (1) a bachelor of science degree in nursing, followed by (2) a master's or doctoral degree in nursing in the selected specialty area of practice, and finally (3) testing and certification by a national certifying body for the specialty area of practice. APRNs must thereafter maintain competencies through required continuing education courses and must recertify with the national certifying body on a regular basis.

COMMENT 5: Several commenters noted that, although Medicare providers Noridian Administrative Services (contractor currently administering Medicare for Montana and ten other western states), and Wisconsin Physicians Services temporarily refused to reimburse CRNAs for chronic pain management services in or about 2011, Medicare enacted a final rule on January 1, 2013, authorizing Medicare reimbursements for chronic pain management by CRNAs in states where chronic pain management is within the scope of practice, and Noridian began reimbursing CRNAs under Medicare in Montana once again.

RESPONSE 5: The board acknowledges these comments are factually correct. The fact that Noridian reimburses CRNAs for chronic pain management services in Montana supports the board's position that referring to "chronic pain management" in amended ARM 24.159.1480 is simply a clarification of the current scope of practice in Montana.

COMMENT 6: Some commenters reminded the board that a past report of the Institute of Medicine called for APRNs to practice to the fullest extent of their scope and called for a "Consensus Model" to establish standards and a national scope of practice for APRNs. These commenters said that the Consensus Model has been developed by incorporating each individual APRN's national professional organization's practice standards and guidelines – not the opinions of NCSBN's

members – and that the Consensus Model expresses the existing nationally standardized scope of practice for CRNAs. The commenters asserted that the proposed amendments to ARM 24.159.1480 are consistent with the Consensus Model and do not expand the scope of practice of APRNs.

RESPONSE 6: The board believes these comments collectively express the board's position very well with respect to the Consensus Model as providing the national standardized scope of practice, which is not an expansion or other modification of the scope of practice for APRNs in Montana.

COMMENT 7: Several commenters pointed out that the general language describing the scope of practice of all APRNs limits the scope of practice to the individual's area of certification and, further, to the individual's education and skills, countering the position that the amendments expand into the practice of medicine. The commenters stated that the proposed language used to describe the scope of practice does not imply that any CRNA may practice to the same degree as an anesthesiologist in the generally described area of chronic pain management.

RESPONSE 7: The board concurs with these comments. APRNs are held accountable to know the limits of their scope of practice, which is determined by their preparation. The board wishes to emphasize that the scope of a CRNA's practice within the generally described specialty area of chronic pain management is not identical to the scope of practice of an anesthesiologist within the same specialty area.

Like a general physician who may provide limited services in the area of chronic pain management before determining whether to consult with or refer to an anesthesiologist, the CRNA may, likewise, within the CRNA's scope of practice, offer appropriate services for patients. The board holds all APRNs, including CRNAs, accountable for knowing the limits of their respective scope of practice, which is why the clarification of the existing scope is important as direction for the CRNA and protection to the patient.

COMMENT 8: One commenter asserted that the proposed reduction of APRNs' two-year continuing education (CE) requirement to 24 contact hours in ARM 24.159.2102 means that the 40 credits required biennially for APRN certification (e.g., to maintain national certification as a CRNA) will be enough to cover Montana's requirements for licensure and prescriptive authority.

RESPONSE 8: The proposed reduction in board-required CE is not, as a practical matter, a reduction to the number of CE hours required of APRNs in Montana. This is because each APRN must be certified, each certifying body requires CE hours as part of the periodic recertification process, and Montana's rules allow an offset for CE obtained for recertification. In other words, the periodic recertification required of APRNs has always ensured, and will continue to ensure, that competencies are maintained by APRNs.

In addition, the Consensus Model indicates that CE specific to pharmacology should be required, which the board has implemented by increasing CE relative to

pharmacology from 10 to 12 hours every two years. The board also notes that many states do not require CE of their APRNs, nor does the Montana Board of Medical Examiners, in recognition that the certifying bodies require it.

COMMENT 9: One commenter questioned whether the phrase "quality assurance plan," as expressed in ARM 24.159.1427 and New Rule II (APRN Competence Development), should be amended to read "competency plan."

RESPONSE 9: The board believes it is important to continue referring to the quality assurance plan as one part of an APRN's competency development plan. The term "quality assurance" has an established meaning to licensees that is not synonymous with "competency plan," and the suggested substitution would change the meaning and intent of the rule. The board is adopting New Rule II exactly as proposed.

COMMENT 10: A few commenters pointed out that as explained by the Montana Supreme Court in 2007, the scope of practice for CRNAs in Montana is independent of and/or collaborative with physicians. These commenters stated that chronic pain management, as part of the CRNA's scope of practice, is likewise independent of and/or collaborative with physicians.

RESPONSE 10: The board agrees that the CRNA's practice is independent of and/or collaborative with physicians, and the CRNA's scope of practice historically has included, and continues to include, chronic pain management.

COMMENT 11: Several commenters pointed out that the only arguments being submitted against allowing CRNAs to perform chronic pain management come from those who compete with CRNAs, also pointing out that the Montana Hospital Association (MHA) favors the rule change.

RESPONSE 11: The board acknowledges the comments and that the MHA is in favor of the rule changes. However, the source of any comment does not in and of itself present a basis for rejecting or accepting the proposed rule amendments, new rules, or repeal of rules.

COMMENT 12: Although many commenters wished to recognize that CRNAs are important members of the anesthesia care team, several commenters stressed the complexities involved in diagnosing and treating chronic pain, including complex prescription medication regimens and the frequent necessity of a multidisciplinary approach, explaining that such complexities have earned pain medicine recognition as its own medical subspecialty by the American Board of Medical Subspecialties. Some groups and organizations recognizing chronic pain management as a subspecialty within the practice of medicine include the American Medical Association, the American Society of Anesthesiologists, the Montana Society of Anesthesiologists, the American Society of Interventional Pain Practitioners, and the Montana Board of Medical Examiners.

RESPONSE 12: The board recognizes that these comments are factually accurate as they relate to the practice of medicine, but do not preclude advanced practice nursing within the area of chronic pain management. The board appreciates the sincere and collegial recognition and affirmation that CRNAs are an important part of the multidisciplinary approach to diagnosing and treating chronic pain.

COMMENT 13: A few commenters generally opposed the practice of CRNAs in the area of "acute and chronic pain management," alleging that CRNAs lack unspecified qualifications. Other commenters said that chronic pain management requires extensive specialty education, training, and clinical experience, none of which is received in the preparation of a CRNA; that the American Association of Nurse Anesthetist's (AANA's) Standards for Accreditation of Nurse Anesthesia Education Programs provide that no clinical experience with pain management is required as part of nurse anesthesia training; or that weekend courses and on-the-job training in pain management cannot substitute for years of medical training in diagnostic assessment, anatomy in normal or abnormal states, disease presentation, and in prescribing treatment necessary to safely perform chronic pain interventions.

RESPONSE 13: The board recognizes that there are significant differences between the preparation of CRNAs and the training and preparation of anesthesiologists. However, the board concluded that the training and preparation of CRNAs is adequate and appropriate for their scope of practice in anesthesia services, including the practice of chronic pain management. The CRNA receives specialized advanced practice nurse training on chronic pain management, which includes instruction and clinical experience. For example, the curriculum for accredited nurse anesthesia programs includes instruction on the advanced principles in nurse anesthesia and pain management. The AANA reports in its Position Statement number 2.11 "Pain Management," as follows:

The Council on Accreditation of Nurse Anesthesia Education Programs (the "COA") standards mandate nurse anesthesia programs provide content within, but not limited to, the following areas: anatomy, physiology, pathophysiology, pharmacology, and pain management. These areas of study provide the foundation for understanding pain and pain treatment. Similarly, the COA requires that nurse anesthesia students obtain clinical experiences in regional anesthetic techniques (i.e., spinal, epidural, and peripheral). These techniques (e.g., epidural, peripheral) are employed to alleviate both acute pain and chronic pain. The knowledge and skills obtained during a nurse anesthesia educational program, therefore, serve as the foundation for a CRNA's engagement in treating either acute or chronic pain.

Furthermore, the nurse's training enables the nurse to take a holistic approach to treating the patient, contributing to the advantage of a multidisciplinary approach that incorporates the CRNA in the treatment of chronic pain management.

COMMENT 14: Some commenters expressed concern that "specialized physician training" is necessary to prevent potentially lethal side effects and medication dependency, and that "medical training" is necessary to diagnose and formulate a treatment plan for patients suffering from chronic pain, perform interventional

procedures to diagnose and treat chronic pain, and respond to complications of treatment.

RESPONSE 14: Again, the board would point to the CRNA's preparation, which includes specialized advanced practice nursing training that qualifies the CRNA to practice within the area of chronic pain management.

COMMENT 15: One commenter differentiated between discrete procedures for pain management and the more comprehensive meaning of the phrase "chronic pain management," suggesting that while a discrete procedure related to the management of chronic pain may be performed by a CRNA, especially when done in collaboration with a physician, the practice of chronic pain management encompasses a broader practice that comprises a subspecialty of the practice of medicine that falls outside the scope of practice of CRNAs.

RESPONSE 15: The board believes that the preparation of CRNAs does not limit CRNAs to the performance of discrete procedures. The board's position on this issue is supported by the national professional organization of CRNAs, as well as the Consensus Model. The board also refers these commenters to responses provided to several of the other comments, in particular responses 7, 13, and 14.

COMMENT 16: A few commenters pointed out that data from the Centers for Medicare and Medicaid Services (CMS) shows that out of 51,986 total pain procedures performed in Montana in 2010, only 235 were "Rural Procedures," only 17 of the 235 were performed by CRNAs, all of which were designated by CMS as acute pain treatments. One of these commenters also asserted, anecdotally, that it was believed that only a select few CRNAs currently perform some pain procedures.

RESPONSE 16: The board sees this limited statistical information as providing very little to rely upon regarding current practice of CRNAs in Montana. For example, no explanation was offered as to how the terms "acute" or "rural" were defined by CMS, and only one portion of one year of data was offered. On the other hand, the board has received sufficient comments from practicing CRNAs and other medical professionals to be convinced there is no meaningful dispute that CRNAs have been practicing chronic pain management in Montana for well over a decade, within their scope of practice.

COMMENT 17: Several commenters stated that two major Medicare contractors (Noridian Administrative Services and Wisconsin Physicians Services) collectively serve 19 states, and that these Medicare contractors have concluded that nurse anesthetists do not have the necessary training to qualify for reimbursement of chronic pain management services.

RESPONSE 17: The board was provided specific citation to authority that these commenters have outdated information. In fact, Noridian, in response to changes to Medicare rules, corrected its course of action in January 2013, and returned to its practice of reimbursing CRNAs for Medicare claims in relation to chronic pain

management services in Montana. Although Noridian's reimbursement of CRNAs in Montana indicates Noridian's assessment that CRNAs are already authorized to practice in the area of chronic pain management in Montana, the board notes that Medicare contractors are not certifying bodies or national professional organizations for CRNAs and do not determine the scope of practice for CRNAs.

COMMENT 18: One commenter said that the board's attempt to simplify its description of an APRN's scope of practice does not simplify the qualifications that are necessary for competently practicing within the full breadth of "chronic pain management," most importantly "interventional pain management."

RESPONSE 18: The board meant for this particular rule change to clarify, not simplify, and to further implement the Consensus Model, which is consistent with the scope of practice as stated by the national professional organizations.

COMMENT 19: Some commenters said that "interventional pain medicine" is "chronic pain management" and such is the practice of medicine. The commenters stated that Oklahoma and Missouri laws define interventional pain management as the practice of medicine, that Louisiana requires physician supervision of interventional pain management, and that Louisiana and Iowa have promulgated regulations defining interventional pain management as the practice of medicine. The commenters also referenced a Louisiana Supreme Court holding that nurse anesthetists lack the education or training to engage in chronic pain management.

RESPONSE 19: The board acknowledges that different states will have different laws, which are not applicable to Montana. These commenters are encouraged to review the board's responses to comments regarding CRNA preparation and scope of practice as defined by CRNA-certifying bodies and national professional organizations, and as adopted in the Consensus Model.

COMMENT 20: Two commenters asserted that New Rule I unlawfully expands the APRN's scope of practice because the "interpretation of imaging" is the practice of medicine requiring extensive medical training. One commenter asked whether the board has considered the medical legal risk of having APRNs interpret results of laboratory, imaging, and/or diagnostic studies.

RESPONSE 20: The board is primarily concerned about patient care, i.e., the safety of the public. Just as in the area of chronic pain management with respect to CRNAs, APRNs are generally qualified within their scope of practice to interpret, and are currently interpreting, results of laboratory, imaging, and/or diagnostic studies. This change, like the change to the CRNA rule, clarifies the existing scope of practice for APRNs using language approved by the national professional organizations and incorporated into the Consensus Model. By adding clarity, these changes are expected to enhance both patient safety and legal defensibility of the rules.

COMMENT 21: Several commenters stated that the scope of practice for any licensed profession may not be expanded simply through the rulemaking process, and asserted that the proposed amendments to the rules addressing APRN scope of practice do not simply express the existing scopes of practice, but effectively expand those scopes.

RESPONSE 21: The board understands that it may not expand or limit the scope of practice of APRNs in Montana, and the board strongly disagrees with each and all assertions that the board has proposed to do so with the proposed rule changes. The proposed rule amendments relative to APRN scopes of practice merely clarify the rules for APRNs and express the longstanding, existing practice in Montana. Such clarification offers more clear delimitations or boundaries, but neither expands nor narrows the available scope of practice, and thereby increases the safety of our public without further restricting access to care.

COMMENT 22: Some commenters said that including gynecology, neonatal care, and male reproductive health care within the scope of practice of Certified Nurse Midwives (CNM) in ARM 24.159.1475 is an unlawful expansion of the scope of practice of CNMs, and offered alternative language to address this concern. The commenters further suggested that such a broad definition of those services encompasses the practice of medicine.

RESPONSE 22: The board understands that CNMs in Montana currently practice in the areas of "gynecologic care, . . . care of the newborn . . . [and] treating the male partner of their female clients for sexually transmitted diseases and for reproductive health," which is the proposed rule language. For example, "care of the newborn" is what necessarily immediately follows childbirth and does not add a new aspect to the existing scope of practice for CNMs.

Also, the proposed language is consistent with both the national professional organization for CNMs and the Consensus Model. The American College of Nurse Midwives (ACNM) is the national professional organization for CNMs and is an authority on what the scope of practice is for CNMs. The ACNM defines the scope of practice for CNMs as follows:

"Midwifery as practiced by [CNMs] encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections."

The board notes that the Consensus Model provides the following definition of a CNM:

"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 board believes that the proposed changes are consistent with the scope of practice as it currently exists in Montana and as expressed by the ACNM and the Consensus Model.

COMMENT 23: One commenter opposed any expansion of the CRNAs' scope of practice into "chronic pain management," and suggested the board amend ARM 24.159.1480 to specifically require that CRNAs practice pain management in consultation with or when referring patients to other health care providers.

RESPONSE 23: The board's rules already state that an APRN's practice is "collaborative and/or independent." Because the commenter's suggested language addition would not substantively change the meaning of the rule, the board is amending the rule exactly as proposed.

COMMENT 24: Some commenters said that the phrase "medical diagnosis" in ARM 24.159.1470, regarding a Certified Nurse Practitioner's scope of practice, should be replaced with the phrase "nursing diagnosis," and that the words "medical and" in the proposed New Rule I (APRN Practice) should be removed. This commenter explained that including the word "medical" in Board of Nursing rules defining the scope of practice is endorsing the practice of medicine (i.e., physician practice) by nurses.

RESPONSE 24: The board directs these commenters to the existing rule, ARM 24.159.1470, which has, for years, included a reference to "medical diagnosis." That term is not an expression of the APRN's scope of practice, but it is a part of the taxonomy currently used by all APRNs when ordering medical equipment or treatment for patients. Use of the term should not be construed as indicating the practice of medicine. Rather, a medical diagnosis is a foundational part of the nursing process for all APRNs' specialty roles in Montana.

COMMENT 25: Two commenters stated that the board's reasonable necessity statements failed to address rule changes that the commenters asserted expand the scopes of practice for CRNAs, CNSs, and CNMs. The commenters further opined that this omission violated the Montana Administrative Procedure Act (MAPA).

RESPONSE 25: The board disagrees that any of the scopes of practice were proposed to be expanded through the proposed rule changes, and encourages the commenters to refer to previous responses that demonstrate how the scopes of practice are being clarified but not changed. The board disagrees that it has violated MAPA. The board began the process of rule amendments to Subchapter 14 of its rules in April of 2011 with a subcommittee appointed by the board under the leadership of APRN board member Ms. Laura Weiss. This subcommittee met in 14 open and noticed meetings over the period of approximately 15 months until amendments were approved by the full board for the MAR Notice No. 24-159-77 in

July 2012. The board has substantially and conscientiously complied with MAPA with respect to rules addressing APRN scopes of practice.

COMMENT 26: While expressing support for the idea of increasing the educational standard for becoming licensed as an APRN in Montana, several commenters asserted that the lack of a "grandfather" clause would effectively invalidate the licenses of a majority of Montana's APRNs. Other commenters asserted that the proposed language would prohibit an APRN from becoming licensed in Montana who was educated and certified, but not licensed in Montana prior to the rule change, which would effectively limit Montanans' access to service. Various commenters pointed to NCSBN's APRN Uniform Requirements, the NCSBN's APRN Model Act/Rules and Regulations, or the Consensus Model in support of why grandfathering APRNs should be provided in ARM 24.159.1414. In addition, one commenter suggested that, in violation of MAPA, no statement of reasonable necessity exists for why the board is removing the grandfathering of currently certified APRNs.

RESPONSE 26: The board intended to maintain grandfathering of currently certified APRNs. However, the confusion expressed by those to whom these rules are directed, as well as other concerned persons and entities, indicates that the proposed amendments to ARM 24.159.1414 should not be finalized at this time. The board is not proceeding with the proposed amendments to ARM 24.159.1414 at this time, so that the amendments may be reconsidered in a later rules project.

COMMENT 27: Two commenters said that increasing the number of annual continuing education hours in pharmacology from 10 to 12 is not necessary, because advancements in techniques and medications do not justify more hours of continuing education for the APRN.

RESPONSE 27: The board's decision to increase these hours of continuing education is consistent with requirements proposed in the Consensus Model. The board is of the opinion that the increase in continuing education is relevant and appropriate and, especially in light of removing the face-to-face component, obtaining the increased amount of continuing education is not an onerous requirement.

COMMENT 28: One commenter said that requiring licensees to add the letters "APRN" before each certification is confusing and cumbersome.

RESPONSE 28: The board understands the burden being placed upon the licensees, but maintains that the proposed change is an appropriate step toward implementing the Consensus Model. The board believes that this step will assist the board to educate the consumer and provide greater accountability of the licensee to the public.

COMMENT 29: A couple of commenters opposed reducing continuing education requirements of APRNs to the level of licensed practical nurses and registered

nurses while, at the same time, expanding the scopes of practice for CNSs, CNMs, and CRNAs. The reduction in continuing education does not take into account the ongoing educational needs for health care professionals.

RESPONSE 29: The board in several earlier responses has explained that no APRN's scope is being changed. As to comments about reducing the continuing education requirement for APRNs, the board also disagrees that such is the case and encourages these commenters to review the board's response to Comment 8.

COMMENT 30: A few commenters suggested that, until collaborative meetings can be conducted by the Board of Nursing, the Board of Medical Examiners, and certain industry organizations, the board should delay implementation of the proposed rule changes addressing the scope of practice for APRNs.

RESPONSE 30: The board would like to remind the commenters that the board appointed a committee that conducted 14 public meetings over a period of 15 months before these rules were accepted at a publicly noticed board meeting, after which the proposal notice was filed. Further, the underlying concerns as expressed by these commenters in their written and oral presentations have been specifically addressed in the board's responses to each of those comments. The board is amending and adopting the rules addressing APRN scope of practice exactly as proposed.

5. The board has amended ARM 24.159.301, 24.159.1405, 24.159.1412, 24.159.1413, 24.159.1418, 24.159.1427, 24.159.1428, 24.159.1461, 24.159.1463, 24.159.1464, 24.159.1467, 24.159.1468, 24.159.1470, 24.159.1475, 24.159.1480, 24.159.1485, and 24.159.2102 exactly as proposed.

6. The board has adopted NEW RULES I (24.159.1406) and II (24.159.1469) exactly as proposed.

7. The board has repealed ARM 24.159.1404, 24.159.1411, 24.159.1424, 24.159.1462, 24.159.1466, and 24.159.1490 exactly as proposed.

8. The board is not amending ARM 24.159.1414 as proposed.

BOARD OF NURSING
HEATHER O'HARA, RN, PRESIDENT

/s/ DARCEE L. MOE
Darcee L. Moe
Rule Reviewer

/s/ PAM BUCY
Pam Bucy, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 26, 2013