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

In the matter of the amendment of ARM 8.32.303, 8.32.307, 8.32.411, 8.32.425, 8.32.1503, 8.32.1504, and 8.32.1508, pertaining to nursing licensure matters	) NOTICE OF AMENDMENT))))))

TO: All Concerned Persons

1. On June 13, 2002, the Department of Labor and Industry published notice of the proposed amendment of the above-stated rules at page 1621 of the 2002 Montana Administrative Register, Issue Number 11.

2. On July 3, 2002, a public hearing on the proposed amendment of the above-stated rules was conducted in Helena, and members of the public spoke at the public hearing. In addition, written comments were received prior to the closing of the comment period on July 11, 2002.

3. The Board of Nursing (Board) has thoroughly considered all of the comments made. A summary of the comments received (grouped by rule) and the Board's responses are as follows:

8.32.307 CLINICAL NURSE SPECIALIST PRACTICE:

Comment 1: Several commenters opposed the use of the terms "interdependent and collaborative". The commenters felt that the Clinical Nurse Specialist (CNS) practice should be independent. They believed that adding "interdependent" connoted a need for supervision. Likewise, the CNSs providing comment also want the opportunity to be granted prescriptive authority.

Response 1: In proposing these rule changes, the Board concluded that CNS practice is not the independent delivery of health care services. However, the Board recognizes the CNSs' independent and collaborative delivery and management of expert level nursing care and has amended the rule accordingly. Collaboration implies a skill-sharing relationship with another provider. Currently, no non-psychiatric CNS has prescriptive authority. The certification for CNS practice does not include the independent management of disease process, diagnosing and prescribing. The Board believes there is a difference between Nurse Practitioner (NP) practice and CNS practice. This rule change defines the difference. As an illustration, the American Nurses Credentialing Center (ANCC) allows the psychiatric CNSs to take the Psychiatric Mental Health (PMH) NP exam if there is evidence of additional academic credit in physical assessment, advanced pathophysiology, advanced pharmacology, and diagnosis

and management. The Board voted to delete the phrase "interdependent and collaborative" from the proposed rule and substitute the phrase "independent and collaborative", and has amended the rules accordingly.

Comment 2: Comments included opposition to adding the words "according to protocols".

Response 2: The Board states that the reason supporting this change is outlined above, in Response 1. The Board believes that the CNS practice is not independent disease or illness management, and therefore, following established protocols is necessary.

Comment 3: Several commenters asked for a "grandfather clause" for the current CNSs in psychiatric-mental health.

Response 3: The Board believes that the proposed language in ARM 8.32.307(2) is the "grandfather" language. Only those psychiatric mental health CNSs certifying after July 1, 2005, will be affected.

Comment 4: One commenter asked the Board to have the National Academy of Clinical Nurse Specialists review and comment on the proposed rules.

Response 4: The Board reviewed the standards and position of this association before proposing these rules.

Comment 5: An opponent stated that the amendment expanded the CNS practice to include ordering durable medical equipment and non-pharmacological treatment. Confusion was also expressed over sections (1)(d)(iii) and (1)(d)(iv).

Response 5: CNSs have always had the ability to order durable medical equipment. This is outlined in ARM 8.32.307(1)(c) and (d). The new language clarifies this ability and makes the differentiation between CNS and NP practices. Section (1)(d)(iii) allows only non-pharmacological treatment, while (1)(d)(iv) allows the CNS to work under protocols. All RNs can currently work under protocols. This is not a change from existing rules.

Comment 6: An opponent stated that proposed (2) allows for independent practice of the psychiatric CNSs and Medicare does not allow for this.

Response 6: The Board acknowledges these comments, and states that the Board defines nursing practice in Montana, and is not concerned with reimbursement issues.

Comment 7: An opponent stated that APRNs may only prescribe medications with physician collaboration.

Response 7: The Board notes that prescriptive authority for APRNs is recognized under section 37-8-202, MCA. Therefore, no physician collaboration is required.

Comment 8: An opponent argued that regardless of the grandfather clause for current psychiatric CNSs, if the Board requires the psychiatric NP exam in the future for independent practice, insurance companies will no longer recognize the current "grandfathered" CNSs.

Response 8: The Board acknowledges the comments. The Board has the authority to define scope of practice and licensure requirements for nurses in Montana and does not involve itself in reimbursement issues.

Comment 9: An opponent stated that the term "interdependent" is confusing and will not enhance the standard of care. The opponent felt this change would limit access to psychiatric mental health care in Montana.

Response 9: The Board does not intend to limit access to care for any population in Montana. The proposed changes were meant to strengthen the qualifications for those providers who have not been required in the past to prove adequate training and competence. The Board changed the language to read, "independent and collaborative", and has amended the rules accordingly.

Comment 10: An opponent felt that requiring psychiatric CNSs certifying after 2005 to take the NP exam will limit the number of psychiatric mental health providers in the state.

Response 10: The Board acknowledges the comments, but notes that the opponent did not provide any data to support the claim. The Board believes that strengthening the requirements for those who practice as psychiatric nurse practitioners will only enhance the psychiatric mental health care rendered in Montana.

8.32.411 RENEWALS:

Comment 11: Opponents argued against requiring continuing education for all APRNs.

Response 11: In drafting these rules, the Board concluded that the requirement for continuing education is a part of professional practice and responsibility. Furthermore, the same continuing education required for renewing certification will be acceptable for renewing APRN status.

Comment 12: Commenters supported the change to a new 2-year renewal cycle.

Response 12: The Board appreciates the support of this change.

8.32.425 FEES:

This amendment involved no fee increases and there were no comments received on this proposed amendment.

8.32.1503 ADVANCED PRACTICE NURSING COMMITTEE:

Comment 13: Commenters supported the formation of this new Board committee to encompass the current Prescriptive Authority Committee. A suggestion was made for the Board to require membership on the committee of at least one APRN with prescriptive authority.

Response 13: As the Board does not currently have an APRN board member position, the suggested requirement is not possible at this time. The Board retains the consultative services of an APRN consultant who does have prescriptive authority. It may be possible in the future to add an APRN position to this committee if the 2003 legislature approves legislation that would add 2 additional member positions to the Board.

8.32.1504 INITIAL APPLICATION REQUIREMENTS FOR PRESCRIPTIVE AUTHORITY:

Comment 14: An opponent felt that 15 hours of continuing education for a new applicant was too little.

Response 14: The 15 hours of continuing education is above and beyond the pharmacological courses required in the basic education of APRNs. The continuing education requirement is in place to address the need for a current level of minimum competency. Many other states do not have this requirement.

8.32.1508 QUALITY ASSURANCE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE:

Comment 15: Opponents commented against mandatory quality assurance.

Response 15: The Board states that quality assurance is generally recognized as part of professional practice, and the Board included this to reflect that responsibility. The amended rules are liberal as they allow for either a peer or a physician reviewer. This rule pertains to all APRNs who provide direct patient care.

Comment 16: One commenter asked the Board to provide a standardized tool for measuring quality assurance.

Response 16: The Board does not want to dictate the use of any particular tool, but rather wants the individual APRN to devise a tool that is meaningful to the APRN's practice.

Comment 17: Commenters were concerned that if their patients

had negative outcomes, it might reflect poorly upon the APRNs in their quality assurance audits.

Response 17: The Board acknowledges the concerns, and states that quality assurance is measured in terms of patient response to provider interventions. The Board recognizes that negative outcomes do occur and may not be the result of poor care or inappropriate treatment.

Comment 18: A commenter asked that an institutional quality assurance program be acceptable to meet the Board's quality assurance requirements.

Response 18: The Board will accept any plan that adequately addresses the individual APRN's practice.

Comment 19: A commenter suggested that the language read, "the charts being reviewed must be evaluated by a peer reviewer, OR by a physician of the same specialty, OR by others as approved by the board."

Response 19: The Board notes that according to the style guidelines established by the Secretary of State's Administrative Rule Bureau, the preferred grammar in this case is to use only one "or". An "or" before "by others as approved by the board" means an "or" between the other optional reviewer types.

General Comments Received:

Comment 20: Opponents criticized the Board for not including more of their peers in the rulemaking subcommittee meetings.

Response 20: The Board acknowledges these comments, but notes that the subcommittee's work was described in several of the Board's recent newsletters. The meetings were also discussed in full Board meetings, and advertised on the Board's website. Eleven meetings were held regarding revision of the APRN rules, and included board members (NP and CNS), a representative of the Montana Nurses Association, and one other APRN representative. CRNAs and a psychiatric mental health CNS were present at some of the subcommittee's meetings. Since the subcommittee met every month, it would have been unreasonable and financially restrictive to mail a hard copy meeting notice to each APRN.

Comment 21: Opponents stated that the Board did not allow enough time and notice for the proposed amendments, and that because the notice was published during the summer, many APRNs were on vacation and could not comment.

Response 21: The Board followed Montana Administrative Procedure Act (MAPA) procedures for appropriate notice and comment periods. Additionally, all APRNs, regardless of whether their names were on the Board's interested parties' list, were

mailed copies of the notice. The Board exceeded the MAPA requirements for notice and proceeded through the entire process per legal counsel's advice.

Comment 22: Another opponent argued that having a hearing the day before a holiday was bad judgment and limited participation in the process.

Response 22: The Board chose the hearing date so that the rules could be adopted at their regularly scheduled July meeting, while all necessary MAPA timelines were followed. The Board mailed notices to all APRNs and interested parties on June 12, 2002. The Board also accepted written, faxed and electronic (e-mail) versions of testimony. While the Board was not present for the hearing, the Board members received copies of all testimony and a transcript of the hearing.

4. After consideration of the comments, the Board has amended the following rules, exactly as proposed:

8.32.411 RENEWALS

8.32.425 FEES

8.32.1503 ADVANCED PRACTICE NURSING COMMITTEE

8.32.1504 INITIAL APPLICATION REQUIREMENTS FOR PRESCRIPTIVE AUTHORITY

8.32.1508 QUALITY ASSURANCE OF ADVANCED PRACTICE REGISTERED NURSE PRACTICE

5. After consideration of the comments, the Board has amended the following rule as proposed, with the following changes, stricken matter interlined, new matter underlined:

8.32.307 CLINICAL NURSE SPECIALIST PRACTICE (1) Clinical nurse specialist practice means the ~~interdependent~~ independent and collaborative delivery and management of expert level nursing care to individuals or groups, including the ability to:

(a) through (j) same as proposed.

(2) For the psychiatric clinical nurse specialist certified before July 1, 2005, the practice of that clinical nurse specialist also includes the independent~~, interdependent,~~ and collaborative practice of psychiatric nursing and management of expert level psychiatric nursing care to individuals or groups of individuals. The practice requires the integration of clinical knowledge with clinical practice, and may include pharmacological management.

AUTH: 37-8-202, MCA
IMP: 37-8-202, MCA

6. The Board is not taking action to amend ARM 8.32.303

and is not addressing any comments received pursuant to that rule at this time.

BOARD OF NURSING
JACK BURKE, RN, Chair

/s/ KEVIN BRAUN
Kevin Braun
Rule Reviewer

/s/ WENDY J. KEATING
Wendy J. Keating, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: August 19, 2002.