

Proposed Adoption of Repeal of 22 Tex. Admin. Code Chapter 221, Pertaining to Advanced Practice Nurses and Proposed New 22 Tex. Admin. Code Chapter 221, Pertaining to Advanced Practice Registered Nurses, Written Comments Received, Oral Comments Received at Public Hearing, if any, and Board Responses to Comments

Background: The proposed repeal of current Chapter 221 and new Chapter 221 were approved by the Board at its April 2014 meeting for submission to the *Texas Register* for public comment. The proposals were published in the *Texas Register* on May 30, 2014, and the comment period ended on June 30, 2014.

The Board received several written comments on the proposals and a rule hearing was held on July 3, 2014, to receive additional comments from interested parties. A copy of the written comments received are attached hereto. In addition, several representatives of organizations spoke at the rule hearing, as well as one individual commenter.

Summary of Comments Received

1. Some commenters were concerned that the proposal would expand the scope of an APRN's practice to include acts of medical diagnosis. Some commenters were concerned that including the word "diagnose" in the proposed text of the rule would unlawfully expand an APRN's scope of practice. Commenters stated that the definition of *professional nursing* in the NPA does not include "diagnosis", and as such, the proposed inclusion of this term throughout the rule would cause an inconsistency between the rule and the NPA.
2. Some commenters perceived an inconsistency between the standards adopted by the Texas Medical Board (ASA standards) and those proposed for adoption by the Board (AANA standards) regarding anesthesia services in outpatient settings.
3. Some commenters questioned the validity of CRNAs providing the *full spectrum* of anesthesia related care.
4. Some commenters wanted additional clarification in the rule that APRNs do not have an independent scope of practice in Texas and that APRNs may only provide medical aspects of care under the delegation and supervision of a physician.
5. Some commenters objected to the use of new specialty titles for APRNs, stating that such titles would further confuse the existing terminology used to describe advanced practice nursing.
6. Some commenters requested that the additional educational requirements

regarding advanced physiology and pathophysiology, advanced health assessment, and advanced pharmacology that includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics not take effect until 2017 in order to give individuals affected by the requirements time to complete the courses.

7. Some commenters felt that special educational requirements should not be imposed on clinical nurse specialists, stating that it is no longer necessary or appropriate to impose such requirements on clinical nurse specialists when such requirements are not imposed on other APRNs.

8. Some commenters were concerned that the proposed requirements regarding random audits of APRN practice to ensure compliance with the requirements of the chapter were overly broad.

9. Some commenters felt that the Board should simplify the requirements regarding the identification of APRNs (name badges, name plates, etc).

10. Some commenters submitted suggested editorial changes to the rule text for clarity and re-organization/re-location of some of the rule's provisions.

11. One commenter questioned the requirements for an individual wishing to practice in more than one specialty.

Staff recommends that the Board withdraw both proposals at this time in order to fully consider the merits of the comments received. Once Staff has time to further review the comments and discuss relevant issues with stakeholders, a new proposal can be considered by the Board at a future date.

Board action: Move to withdraw the proposed repeal of 22 Tex. Admin. Code Chapter 221, Pertaining to Advanced Practice Nurses, and proposed new 22 Tex. Admin. Code Chapter 221, Pertaining to Advanced Practice Registered Nurses, as were published in the *Texas Register* on May 30, 2014.



COALITION FOR NURSES IN ADVANCED PRACTICE

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July 3, 2014

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Re: Proposed New 22 TAC §221

Dear Mr. Johnston,

Below please find the input of the Coalition for Nurses in Advanced Practice (CNAP) with regard to the proposed new 22 TAC §221 currently under consideration by the Texas Board of Nursing (BON). While many of the comments are substantive, some are minor editorial changes that we respectfully recommend. Should you have any questions, or require any additional information please do not hesitate to contact us.

Proposed §221.1(3) Definition of APRN

CNAP requests the proposed definition of APRN be reworded to read:

- (3) Advanced practice registered nurse (APRN)--A registered nurse who:
- (A) Has been granted a license to practice as an APRN in one of the four APRN roles and at least one population focus area recognized by the Board; and
 - (B) Practices by building on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, and greater role autonomy as permitted by state law;

The proposed definition from the consensus model significantly expands the current definition. It seems more expansive than needed for a rule and combines the definition with requirements for licensure.

Another option would be to use the same definition used in Chapter 222 so it would read as follows:

(3) Advanced practice registered nurse (APRN)--As defined by §301.152, Occupations Code. The term includes an advanced nurse practitioner and advanced practice nurse.

Proposed §221.1(5) Title Change for NPs and CNSs

The BON is proposing that the nurse practitioner (NP) and clinical nurse specialist (CNS) titles and acronyms be changed to certified nurse practitioner (CNP) and certified clinical nurse specialist (CNS) [not CCNS]. The title and acronym change for NPs reflects the APRN Consensus Model however not the change for CNSs.

Regardless of the desirability of the proposed changes, CNAP does not support making the changes at this time. There is already confusion at the Capitol over the difference in a "nurse practitioner" and an "advanced nurse practitioner". Additional changes in terminology will add to that confusion.

There is also the complicating factor that some NPs will be exempted from the national certification requirement. BON staff indicates that these practitioners cannot use the "certified" designation so will continue to use the title nurse practitioner and NP. The latter will require explaining to legislators and regulators the difference between a "certified nurse practitioner" and a "nurse practitioner." It also means that in rule making that there is no generic term for nurse practitioners unless either "certified nurse practitioner" or "nurse practitioner" is defined as including both certified and non-certified NPs.

Considering that proposed §221.8(b) will require an APRN to use that designation plus their role, and for NPs and CNS, the population focus, it does not seem likely that the CNP terminology would be used, but rather FNP, PNP, NNP, etc.

CNAP therefore opposes this change. We request it not be implemented at this time and the references to certified nurse practitioners and certified clinical nurse specialists be deleted throughout the proposed rules.

Proposed §§221.1(6) and (23) Definitions of Adverse Actions and Unencumbered

Proposed Rule 221.1 defines "adverse action" and "unencumbered" as follows:

(6) Adverse action--Any action permitted by a state's laws that are imposed on an APRN by a state board of nursing or other authority, including actions against an individual's license, such as: revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting an APRN's authority to practice, including the issuance of a cease and desist action.

(23) Unencumbered--Licensure status that is not subject to current limitation due to adverse action.

Adverse action is used only in the definition of unencumbered license. CNAP requests the definition of "adverse action" be deleted and that the definition of "unencumbered" be reworded to read:

(23) Unencumbered - Licensure status that is not subject to current limitation due to disciplinary action relating to a nurse's license or privilege to practice nursing by any jurisdiction.

The proposed definition of adverse action appears overly broad and ambiguous as to what actions will be covered by the definition. Current Rule 221 defines unencumbered without referring to "adverse action" and CNAP believes eliminating the reference to "adverse action" and its definition will not impair the board's enforcement authority and the recommended definition of "unencumbered" will provide greater clarity to APRNs.

Proposed §221.3(a)(1)(B) Documentation of Education

Proposed Rule 221.3(a)(1)(B) reads:

Documentation of education shall verify the date of graduation; credential conferred; number of clinical hours completed; completion of three separate graduate level courses in advanced physiology and pathophysiology; advanced health assessment; advanced pharmacology that includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics, of all broad categories of agents; role and population focus area of the education program; and evidence of meeting the standards of advanced practice registered nursing education set forth in this chapter.

CNAP feels that this section is not clearly worded, is difficult to understand and could be subject to misinterpretation. We therefore recommend that it be reworded as follows:

(B) Documentation of education shall include evidence of meeting the standards of advanced practice registered nursing education set forth in this chapter and verify:

(i) the date of graduation;

(ii) credential conferred;

(iii) role and population focus area of the education program;

(iv) number of clinical hours completed; and

(v) completion of the following three separate graduate level courses:

(I) advanced physiology and pathophysiology;

(II) advanced health assessment; and

(III) advanced pharmacology that includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.

Proposed §221.5 and §221.15 Audits

Proposed Rules 221.5 and 221.15(a) both give the BON new broader authority to conduct "an audit to determine compliance with the requirements of this chapter". The two proposed rules read:

§221.5. Quality Assurance/Documentation and Audit.

The Board may conduct a random audit of nurses to verify compliance with the requirements of this chapter, including but not limited to compliance with requirements for current practice, current national certification, and/or continuing education. Upon request of the Board, licensees shall submit documentation of compliance.

§221.15. Enforcement.

(a) The Board may conduct an audit to determine compliance with the requirements of this chapter.

It should be noted Rule 221.5 permits the audit to be a random audit.

CNAP requests that Rule 221.5 be deleted so that audits are more appropriately addressed only by Rule 221.15 relating to enforcement and that Rule 215.15(a) be reworded to read:

(a) The board may conduct an audit to determine compliance with §221.3 of this chapter (relating to Licensure as an APRN), §221.4 of this chapter (relating to APRN License Renewal), and §221.14 of this chapter (relating to Provision of Anesthesia Services by Nurse Anesthetists in Outpatient Settings). Upon request of the Board, licensees shall submit documentation of compliance.

This wording is comparable to the BON's current Rule 221.17(a) except for the addition of the last sentence which is taken from proposed Rule 221.5. Current Rule 221.17(a) reads:

(a) The board may conduct an audit to determine compliance with §221.4 of this chapter (relating to Requirements for Full Authorization to Practice), §221.8 of this chapter (relating to Maintaining Active Authorization as an Advanced Practice Nurse), and §221.16 of this chapter (relating to Provision of Anesthesia Services by Nurse Anesthetists in Outpatient Settings).

Proposed Rule 221.5 is based on the NCSBN Model Rules but is also broader than that model rule which reads:

The BON may conduct a random audit of nurses to verify current APRN certification and/or continuing education. Upon request of the BON, licensees shall submit documentation of compliance.

Proposed Rule 221.15(c) deals with behaviors for which an APRN may be disciplined. Proposed subsections (c)(3) and (c)(4) read as follows:

- (c)(3) failure to provide therapeutic or prophylactic evidence-based care within the current and prevailing professional standard;
- (c)(4) failure to properly assess a patient and accurately and completely document the assessment that supports the medical aspects of patient care provided.

Both these subsections contain overly broad language that is subject to interpretation and therefore opens the possibility of unnecessary legal action. The BON has been disciplining APRNs for years without this language; we therefore recommend deleting 221.15(c) in its entirety.

Proposed Rule 221.15(b) gives the BON comprehensive authority to discipline a nurse for any violation of Chapter 221 making §221.15(c) unnecessary.

Both the current BON rule and NCSBN limit audits to compliance with requirements for acquiring and maintaining licensure. The proposed rules extend audits to compliance with all requirements of the chapter which include meeting standard of care in clinical environment. In fact, the proposed rule appears to give the BON the right to conduct an unannounced audit of a practice in the absence of any complaint against the nurse or without the BON having any reason to believe the APRN has not complied with any requirement of Chapter 221. The issue of TMB's and BON's right to audit practices was limited by SB 406. It is also unclear if the BON has the statutory authority to conduct random audits as broadly as proposed.

Proposed §221.6 Temporary Permits

The first sentence of proposed Rule 221.6(d) currently reads as follows:

An APRN who has not completed an advanced practice registered program in the last 24 calendar months and has not practiced in the APRN role and population focus area in Texas or another jurisdiction within the last 24 calendar months shall apply for a six-month temporary permit as specified in paragraph (5) of this subsection to be used only for the completion of the current practice hours required for reinstatement of the APRN.

Subsection 221.6(d), as currently worded, would require completion of both an APRN education program and practice in the APRN role within the past 24 calendar months. Only one of those is required.

We therefore recommend that after “months” and before “has”, strike “and” and substitute “or.”

Proposed §221.7(2) Acceptable Certification Examinations

Proposed Rule 221.7(2) reads:

(2) Conditions for taking the certification examination are consistent with acceptable standards of the testing community and are intended to ensure minimal competence to practice at an advanced practice level.

Other similar rules use the term “entry-level” not “minimal.” We therefore recommend substituting “entry-level” for “minimal” in this section.

Proposed §§221.9(d)(3) and 221.9(h) APRN Education Requirements

Proposed Rule 221.9(d)(3) reads:

Graduates of advanced practice registered nurse education programs who were prepared for two population foci or two different APRN roles shall demonstrate that they have completed didactic content and clinical experience in both functional roles and population foci.

For internal consistency with other rules in this chapter, this subsection should change “or” to “and/or” before “population foci.”

The same change is needed in proposed Sec. 221.9(h).

Proposed §221.9(e) CNS Educational Requirements

Proposed Rule 221.9(e) imposes special requirements on Clinical Nurse Specialists (CNSs). No such special requirements are imposed on NPs, CNMs, or CRNAs. While it may have once made sense to have such special requirements, CNAP believes that is no longer appropriate. We cannot find that either the NCSBN or the Consensus Model contain any such requirements for CNSs.

CNAP therefore requests the proposed §221.9(e) be deleted.

Proposed §221.10(a) and §221.10(c)(2) Petitions for Waivers

Proposed Rule 221.10(a) reads:

A registered nurse who submits a request for waiver from requirements of this chapter must submit documentation as required by the Board to support his or her petition and assure the Board that he or she possesses the knowledge, skills, and abilities appropriate for the role and population focus/specialty area of licensure desired. Those petitioners who are under investigation or current Board order are not eligible for waiver.

As currently defined, "Board" only means the Texas Board of Nursing. As a result, this subsection states that only petitioners under a Board order in Texas are not eligible for a waiver. The BON may want to preclude a petitioner under board order in any jurisdiction from being granted a petition.

We therefore recommend that the subsection be amended to insert, "including an order issued by a Board of Nursing in another jurisdiction," after "Board order" and before "are" in the last sentence of this subsection.

The last sentence of Proposed §221.10(c)(2) reads:

The Board reserved the right to determine an appropriate alternate national certification examination for licensure in those specialty areas for which no specific examination existed for the specialty area.

This appears to be a typo that makes the tense of the sentence inconsistent with the rest of the paragraph. We recommend changing "reserved" and "existed" to "reserves" and "exists."

Proposed §221.12 Nurse-Midwives Providing Controlled Substances

In the title of this section and in Section 221.12(b), (b)(2), (b)(3), and (b)(4)(D) references are made to "nurse-midwives". These references should read "Certified Nurse Midwives" or "CNMs" as that is the term defined in §221.1(9).

Proposed §221.13 Provision of Anesthesia Services by Nurse Anesthetists

In the title of this section and in Sections 221.13(a) through 221.13(d) references are made to "nurse anesthetists." These references should read "Certified Registered Nurse Anesthetists" or "CRNAs" as that is the term that is defined in §221.1(11).

CNAP would also like to draw your attention to the comments submitted by the Texas Nurses Association. We echo many of them in our comments, but also encourage your favorable consideration of their comments relating to:

1. Proposed §221.2(c) relating to APRN Scope of Practice compared to RNs who are not APRNs; and

2. Proposed §221.10(d)(1) and (e)(3) relating to Imposition of Geographical Limits on APRNs Licensed Under Certain Exemptions.

Finally, we agree with the comments submitted by the Texas Association of Nurse Anesthetists (TANA) regarding Proposed §221.3(e), the Three Course Requirement. TANA raises legitimate concerns that:

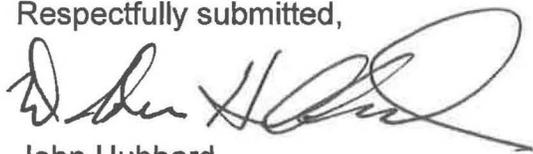
1. the Council on Accreditation for Nurse Anesthesia Educational Programs does not require CRNA educational programs to include three separate courses in advanced physiology and pathophysiology, advanced health assessment, and advanced pharmacology that includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents until 2015; and

2. the waiver provided in §221.10(f) would not appear to apply to CRNAs who graduate before 2015 and may not cover CRNAs moving from other states.

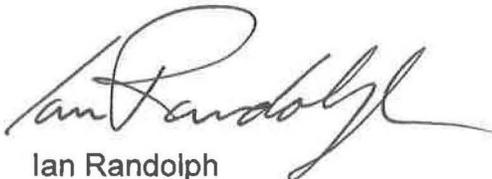
We ask the Board to address these concerns and adjust the rules accordingly as the unintended consequences of these proposed rules could be very detrimental to new graduates and CRNAs wanting to move to Texas.

Thank you for the opportunity to comment. We look forward to working with you as these rules move forward.

Respectfully submitted,



John Hubbard
Public Policy Director



Ian Randolph
Public Policy Director



PRESENTED AT PUBLIC HEARING 7/3/2014

July 3, 2014

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Re: Comments on proposed Rule §221 as published at 39 Tex Reg 4101 (5/30/2014)

Dear Mr. Johnston and Ms. Zych:

The Texas Nurses Association submits the following comments on proposed Rule 221. These comments are divided into two sections

- Section A. Comments substantive in nature and in connection with which TNA is specially requesting changes in proposed Rule 221; and
- Section B. Comments editorial in nature and in connection with which TNA is not specially requesting changes but rather simply identifying for the Board's consideration.

SECTION A. SUBSTANTIVE COMMENTS WITH REQUESTED CHANGES TO PROPOSED RULE

1. Title Change for NPs and CNSs

Proposed Rule. The BON is proposing that the nurse practitioner (NP) and clinical nurse specialist (CNS) titles and acronyms be changed to certified nurse practitioner (CNP) and

certified clinical nurse specialist (CNS) [not CCNS]. The title and acronym change for NPs reflects the APRN Consensus Model however not the change for CNSs.

Requested Change: TNA requests that the proposed title changes not be made at this time.

Rationale: Regardless of the merits of the proposed title changes, TNA does not support making the change at this time. Nursing will continue addressing APRNs issues in both the legislative and regulatory arenas. Changes in APRN titles will likely be confusing to legislators and regulators and result in nursing having to “explain” what the addition of certification means. There is also the complicating factor that some NPs will have been exempted from the national certification requirement. BON staff indicates that these practitioners cannot use the “certified” designation so will continue to use the title nurse practitioner and NP. If this is the case, the latter will require explaining to legislators and regulators the difference between a “certified nurse practitioner” and a “nurse practitioner.” It also means that in rule-making there is no generic term covering all nurse practitioners unless either “certified nurse practitioner” or “nurse practitioner” is defined as including both certified and non-certified NPs. While TNA is not commenting on the merits of the proposed title changes, it does not believe it desirable that the changes be made at this time.

2. APRN Scope of Practice Compared To RNs Who Are Not APRNs

Proposed Rule: Proposed Rule 221.2(c) provides:

(c) The APRN's scope of practice shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the APRN from practicing in those areas deemed to be within the scope of practice of a registered nurse.

Requested Change. TNA requests that Subsection (c) be reworded to read:

(c) The APRN's scope of practice shall be inclusive of and expand and build upon the scope of practice and competencies of a registered nurse who is not an APRN.

Rationale: Because of the overlap in scope of practice between RNs who are not APRNs and RNs who are APRNs, TNA has consistently opposed attempts to list what activities constitute advanced practice since invariably implied that RNs who are not APRN cannot engage in the activities listed. Rule 221.2(c) does not set out a list but does state that “the APRN’s scope of practice shall be **in addition** to the scope of practice permitted an RN” [*emphasis added*] The “in addition to” wording could be misconstrued to imply no overlap between the two scopes and that there is a bright line between the scope of practice of APRNs and other RNs. TNA believes the wording it is proposing more accurately reflects the relationship between the scope of practice of RNs who are APRNs and those who are not. While this may be viewed as wordsmithing, TNA believes there is a need to be careful not to suggest there is not significant overlap between the two scopes. For example, most of the activities listed in Rule 221.2(d) such as observation, assessment, diagnosis (nursing), intervention, etc. are ones RNs also can do “independently and/or in collaboration with health care team.” This overlap is no different than overlap between nursing and medicine.

The proposed wording deletes the phrase “and does not prohibit the APRN from practicing in those areas deemed to be within the scope of practice of a registered nurse” since is not needed. First, because the proposed rewording states the APRN scope of practice is inclusive of RNs who are not APRNs, and secondly, because APRNs are required to maintain an active RN license.

3. BON Enforcement of Rule 221

Proposed Rule. Proposed Rules 221.5 and 221.15(a) both give the BON new authority to conduct “an audit to determine compliance with the requirements of this chapter” (Rule 221). Rule 221 also sets out a number of specific behaviors for which an APRN may be disciplined. The two proposed rules read:

§221.5.Quality Assurance/Documentation and Audit.

The Board may conduct a random audit of nurses to verify compliance with the requirements of this chapter, including but not limited to compliance with requirements for current practice, current national certification, and/or continuing education. Upon request of the Board, licensees shall submit documentation of compliance.

§221.15.Enforcement.

(a) The Board may conduct an audit to determine compliance with the requirements of this chapter.

(b) Any nurse who violates this chapter may be subject to disciplinary action under the Nursing Practice Act and Board rules.

(c) Behaviors for which an APRN may be disciplined by the Board include but are not limited to:

- (1) failure to maintain current national certification or recertification;
- (2) inappropriate use of APRN titles;
- (3) failure to provide therapeutic or prophylactic evidence based care within the current and prevailing professional standard;
- (4) failure to properly assess a patient and accurately and completely document the assessment that supports the medical aspects of patient care provided;
- (5) practicing in a role and/or population focus area for which the APRN has not been educated or licensed; and
- (6) failure to comply with an audit of the Texas Board of Nursing.

(d) Failure to cooperate with a representative of the Board or another state or federal agency who conducts an on-site investigation may result in disciplinary action.

Requested Change. TNA requests 1) Rule 221.5 be deleted and the Board’s audit authority be addressed only in Rule 221.15 relating to enforcement, and 2) that Subsection (a) Rule 215.15 be reworded and (c) and (d) deleted so 221.15 reads:

(a) The board may conduct an audit to determine compliance with §221.3 of this chapter (relating to Licensure as an APRN), §221.4 of this chapter (relating to APRN License Renewal), and §221.14 of this chapter (relating to Provision of Anesthesia Services by Nurse Anesthetists in Outpatient Settings). Upon request of the Board, licensees shall submit documentation of compliance.

(b) Any nurse who violates this chapter may be subject to disciplinary action under the Nursing Practice Act and Board rules.

Rationale. The proposed wording of Subsection (a) is the same as in the BON's current Rule 221 except for the addition of the last sentence which is taken from proposed Rule 221.5.

The BON audit authority in proposed Rules 221.5 and 221.15(a) is broader than that provided for in current Rule 221.17(a) that reads:

(a) The board may conduct an audit to determine compliance with §221.4 of this chapter (relating to Requirements for Full Authorization to Practice), §221.8 of this chapter (relating to Maintaining Active Authorization as an Advanced Practice Nurse), and §221.16 of this chapter (relating to Provision of Anesthesia Services by Nurse Anesthetists in Outpatient Settings).

Proposed Rule 221.5 is based on the NCSBN Model Rules but is also broader than the corresponding model rule which reads:

11.2.5 Quality Assurance/Documentation and Audit

The BON may conduct a random audit of nurses to verify current APRN certification and/or continuing education. Upon request of the BON, licensees shall submit documentation of compliance.

It should be noted that the BON proposed Rule permits the audit to be random. Both the current BON rule and NCSBN model rule limit audits to compliance with requirements for acquiring and maintaining licensure. The proposed rules extend audits to compliance with all requirements of the chapter which include meeting standard of care in the clinical environment. In fact, the proposed appears to give the BON the right to conduct an unannounced audit of a practice in the absence of any complaint against the nurse or without the BON having any reason to believe the APRN has not complied with any requirement of the Rule 221. The issue of TMB's and BON's right to audit practices came up with SB 406 and that authority was limited.

Medical Practice Act

Sec. 157.0514. PRESCRIPTIVE AUTHORITY AGREEMENT: INSPECTIONS.

If the board receives a notice under Section 157.0513(a)(2), the board or an authorized board representative may enter, with reasonable notice and at a reasonable time, unless the notice would jeopardize an investigation, a site where a party to a prescriptive authority agreement practices to inspect and audit any records or activities relating to the implementation and operation of the agreement. To the extent reasonably possible, the board and the board's authorized representative shall conduct any inspection or audit under this section in a manner that minimizes disruption to the delivery of patient care.

It is also unclear if the Board has the statutory authority to conduct random audits as broadly as proposed.

Subsections (c) and (d) of proposed Rule 221 list specific behaviors for which an APRN may be disciplined. TNA believes this listing is redundant of Subsection (b) and is unnecessary. Subsection (b) states that any nurse who violates Rule 221 may be disciplined. The behaviors listed in (c)(1)-(5) are behaviors that clearly violate requirements of Rule 221 and are covered by (b). Subsections (b)(6) and (d) relating to failure to comply with audits and on-site investigation are not as clearly covered and TNA believes it may be appropriate for Subsection 221.15(c) and (d) to be combined into a (c) reads:

(c) Failure to comply with an audit of the Board or to cooperate with a representative of the Board or another state or federal agency who conducts an on-site investigation may result in disciplinary action.

4. Special Provisions for CNS

Proposed Rule. Proposed Rule 221.9(e) imposes special requirements on CNS and reads:

(e) Applicants for licensure as clinical nurse specialists in any population focus area must submit verification of the following requirements, in addition to meeting other advanced practice registered nursing education requirements for licensure:

(1) completion of a minimum of a master's degree in the discipline of nursing;
and

(2) completion of a minimum of nine semester credit hours or the equivalent in a specific clinical major. Clinical major courses must include didactic content and clinical experiences in the clinical nurse specialist role in a specific population focus area. Courses in advanced health assessment, advanced pathophysiology, and advanced pharmacotherapeutics cannot be counted toward meeting the nine semester credit hour requirement.

Requested Change. TNA requests 221.9(e) be deleted.

Rationale: No such special requirements are imposed on NPs, CNMs, or CRNAs. While it may have once made sense to have such special requirements, TNA believes that is no longer the case. TNA cannot find that either the NCSBN Model Rules or the Consensus Model contain any such special CNS requirements.

5. Inclusion of Provisions Relating to CNMs and CRNAs Providing, Ordering and Prescribing Drugs and Devices.

Proposed Rule. Proposed Rules 221.12, .13, and .14 address CNMs and CRNAs providing, ordering and prescribing drugs and devices.

Requested Change. TNA requests 221.12, 221.13. and 221.14 be moved to Rule 222 as the more appropriate place to address providing, ordering and prescribing of drugs and devices.

6. Definitions of Adverse Action and Unencumbered License

Proposed Rule. Rule 221.1 defines “adverse action” and “unencumbered license” as follows:

(6) Adverse action--Any action permitted by a state's laws that are imposed on an APRN by a state board of nursing or other authority, including actions against an individual's license, such as: revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure

affecting an APRN's authority to practice, including the issuance of a cease and desist action.

(23) Unencumbered--Licensure status that is not subject to current limitation due to adverse action.

Requested Change. TNA requests the definition of “adverse action” be deleted and that the definition of “unencumbered license” be reworded to read:

Licensure status that is not subject to current limitation due to disciplinary action relating to a nurse’s license or privilege to practice nursing by any jurisdiction.

Rationale. TNA believes the proposed definition is overly broad and ambiguous as to what actions are covered by the definition. For example, under the proposed definition, the limitation in 221.10(d)(1) and (e)(3) that APRNs with certain waivers (masters and titles) can practice only within geographical boundaries of the State would appear to be an adverse action—it is a limitation on the APRN’s practice imposed by a board of nursing. Since a hospital district is a governmental entity, if it extends limited privileges to an APRN is that an adverse action? This is unlikely to be the intent of the definition but it is not clearly precluded.

TNA also believes there is little need for defining adverse action. The definition is used only for purposes of defining “unencumbered license” and is not used in the body of Rule 221. The term “unencumbered” itself is not used very frequently. Current (not proposed) Rule 221 defines “unencumbered” without referring to “adverse action”:

“a license to practice . . . which does not have stipulations against the license.”

TNA believes “unencumbered” can be adequately defined without referring to “adverse action.” This is particularly true in light of the fact that “adverse action” itself is defined in terms of “encumbrance” making the definition somewhat circular.

7. Definition of APRN.

Proposed Rule. Proposed definition of APRN in 221.1(3) reads:

- (3) Advanced practice registered nurse (APRN)--A registered nurse who:
- (A) Has completed a graduate-level advanced practice registered nursing education program that prepared him/her for one of the four APRN roles;
 - (B) Has passed a national certification examination recognized by the Board and measures APRN role and population focused competencies;
 - (C) Maintains continued competence as evidenced by recertification/certification maintenance in the role and population focus through the national certification program;
 - (D) Practices by building on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, and greater role autonomy as permitted by state law;
 - (E) Is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and non-pharmacologic interventions in compliance with state law;

(F) Has clinical experience of sufficient depth and breadth to reflect the intended practice; and

(G) Has been granted a license to practice as an APRN in one of the four APRN roles and at least one population focus area recognized by the Board.

Requested Change. TNA requests definition be reworded to read either:

(3) Advanced practice registered nurse (APRN)-- As defined by §301.152, Occupations Code. The term includes an advanced nurse practitioner and advanced practice nurse

or

(3) Advanced practice registered nurse (APRN)--A registered nurse who:

(A) Has been granted a license to practice as an APRN in one of the four APRN roles and at least one population focus area recognized by the Board; and

(B) Practices by building on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, and greater role autonomy as permitted by state law;

Rationale. The proposed definition is from consensus model and significantly expands current definition which reads:

(3) Advanced practice nurse--A registered nurse approved by the board to practice as an advanced practice nurse based on completing an advanced educational program acceptable to the board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services.

The proposed definition seems more expansive than needed for Rule 221 and combines the definition with requirements for licensure. For example, Subparts (A)-(C) and possibly (E) are requirements for APRNs licensure and are addressed elsewhere in rule, e.g., content of (E) is similar to 221.2(d). Subpart (F) doesn't differentiate an APRN from any other nurse. Subpart (G) appears all that is needed to define APRN for the purpose of Rule 221. If Subpart (G) is met then Subparts (A)-(C) and (E) are met since cannot be licensed without demonstrating. Subpart (D) does seem appropriate for a definition.

The proposed definition is also different and more complicated than the definition of APRN in Rule 222.1(4) that reads:

(4) Advanced practice registered nurse (APRN)-- As defined by §301.152, Occupations Code. The term includes an advanced nurse practitioner and advanced practice nurse.

8. Imposition of Obligation of RNs Who Are Not APRNs Not To Use Title APRN

Proposed Rule 221.8(d) and (e) read:

(d) Unless licensed as an APRN by the Board as provided in this chapter, a nurse shall not:

(1) claim to be an APRN or hold himself/herself out to be an APRN in this state; or

(2) use a title or any other designation tending to imply that the person is an APRN.

(e) A nurse who violates subsection (c) or (d) of this section may be subject to discipline under the Nursing Practice Act and Board rules.

TNA requests Subsection (d) be reworded as follows and Subsection (e) be deleted:

(d) Only nurses licensed as APRNs may use APRN title or otherwise claim or hold themselves out as an APRN.

Although the proposed language is same as current Rule 221.2(c), TNA does not believe it is appropriate in Rule 221 because Rule 221 is a rule for APRNs and the obligation applies to RNs who are not APRNs. RNs who are not APRNs are unlikely to read Rule 221. Any obligation on RNs who are not APRNs not to use the APRN title should be set out in Rule 217.10 (Titles). Proposed Subsection (d) does not appear to be part of NCSBN Model Rules. If it is felt language is needed about restricting who can use the APRN title, then it should simply state that only APRNs may use title.

Subsection (e) is redundant of 221.15 (Enforcement) and unnecessary here.

9. Nurse on Inactive APRN Status Who Maintains RN License and Practices as RN

Proposed Rule. Proposed Rule 221.11 provides:

§221.11.Inactive Status.

(a) The APRN may choose to change current APRN licensure status to inactive status by providing a written request for such change.

(b) Inactive APRN licensure status means that the registered nurse may not practice in the APRN role and may not hold himself/herself out to be an APRN by using any titles that imply that he/she is an APRN. Prescriptive authority shall be placed on inactive status concurrent with inactivation of the APRN license.

Requested Change. TNA Requests that a Subsection (c) be added which reads:

(c) A nurse on inactive APRN licensure status who maintains their RN license and practices as an RN shall be held to the standard of care of an RN. However, all nurses when caring for patients are expected to utilize any special individual knowledge, experience and skills they possess.

Rationale. Proposed Rule 221.11 does not address what standard of care applies when a nurse with inactive APRN status retains an active RN license and practices as an RN. Does the APRN standard of care or RN standard of care apply? TNA believes it should be that of an RN but recognizes that all nurses when caring for patients are accountable for properly exercising

any special knowledge, experience or skills they may possess. TNA believes Rule 221 should be clarified as to the standard of care that applies when an APRN with inactive status maintains an active RN license and continues to practice as an RN.

10. Exception Permitting Use of Certain Titles To Identify Population Focus Area

Proposed Rule. Proposed Rule 221.10(e)(2) reads:

(2) The following titles may be considered for exemption if the individual is not qualified to utilize a licensure title authorized by this chapter for qualified applicants who completed their advanced practice nursing education programs prior to January 1, 2015:

- (A) Adult Health Clinical Nurse Specialist;
- (B) Adult Nurse Practitioner;
- (C) Community Health Clinical Nurse Specialist;
- (D) Critical Care Clinical Nurse Specialist;
- (E) Gerontological Clinical Nurse Specialist; and
- (F) Gerontological Nurse Practitioner.

Requested Change. Evaluate if the January 1, 2015 date is appropriate or should be a later date and change if necessary.

Rationale. Proposed Rule 221.8(a)(2) changes the population focus areas in which APRNs may be licensed to the following:

- (A) Adult-gerontology:
 - (i) Acute care; and
 - (ii) Primary care;
- (B) Family/individual across the lifespan;
- (C) Neonatal;
- (D) Pediatrics:
 - (i) Acute care; and
 - (ii) Primary care;
- (E) Psychiatric/mental health; and
- (F) Women's health/gender-related.

Rule 221.10(e)(2) permits APRN applicants who are not qualified to utilize one of these titles to get an exemption to use a currently permitted title. However the exemption is available only if the applicant completed their APRN education program prior to January 1, 2015. It is unknown to TNA how this change will affect students currently enrolled in APRN programs and who complete their program after January 1, 2015. It is also unknown to TNA if APRN education programs will have to make any curriculum changes for their graduates to qualify to be licensed to utilize one of the new titles.

If currently enrolled students are negatively affected, TNA believes the exemption should be available to students enrolled prior to effective date of proposed rules and complete their program by January 1, 2018. This would give currently enrolled students approximately 3 years to complete their program which may be needed for part time students.

If schools will have to make any curriculum changes, the exemption should be available to students who enroll before curriculum changes are made or who enroll before some future date such as January 1, 2016, to give schools time to make the curriculum changes.

11. Imposition of Geographical Limits On APRNs Licensed Under Certain Exemptions

Proposed Rule. Proposed Rules 221.10(d)(1) and (e)(3) provide that APRNs licensed under certain exemptions are limited to practicing within the geographical boundaries of Texas.

Requested Change. TNA requests this geographical limitation be deleted.

Rationale. BON staff has indicated this geographical limitation anticipates Texas adopting the APRN Compact. However, until it does, TNA does not believe the BON has any authority to address the authority of any APRN to practice outside Texas. That is entirely within the authority of the other state or jurisdiction. Stating that certain APRNs may not practice outside of Texas implies that other APRNs are authorized to do so which TNA does not believe the BON currently has the authority to grant.

12. Rule 221.3(4) Reference to “Professional License” and 221.3(5) Reference to “License.”

Proposed Rule. Proposed Rules 221.3(4) and (5) read:

(4) Identification of any state, territory, or country in which the applicant holds a professional license or credential, if applicable, must be provided. Required information includes:

- (A) The number, type, and status of the license or credential; and
- (B) The original state or country of licensure or credentialing.

(5) An applicant must provide the date and jurisdiction the applicant previously applied for a license in another jurisdiction and either was denied a license, withdrew the application, or allowed the application to expire, if applicable.

Requested Change. Clarify what is meant by a “professional license” and “license.”

Rationale. Since “APRN license” is defined in 221.1, TNA assumes “professional license” is a broader term and would include licenses in other professions such as teaching, engineering, pharmacy, chiropractor, etc. TNA also assumes that since use of “license” in Subdivision (5) is not qualified as a “professional license” as in Subdivision (4), that it is being used as a broader term that includes occupations such as plumbers and electricians. BON staff indicated intent was to address situations such as when an applicant had lost a teaching certificate (a “professional license”) because of inappropriate conduct with a student. If this is what is the intent, TNA is not sure Subdivision (4) governs this situation since it uses the present tense terminology “holds a professional license” which would not appear to include a revoked or suspended license. Subdivision (5) also would not apply since it only addresses withdrawn, denied or expired applications.

13. Renewal of License Issued Based on Waiver of National Certification

Proposed Rule. Proposed Rule 221.4(a)(2) provides:

(2) An applicant must attest on forms provided by the Board to maintaining current national certification or recertification as applicable by the national professional certification organization that meets the requirements set forth in this chapter and is recognized by the Board. This requirement shall apply to APRNs who:

(A) completed an advanced practice registered nursing education program on or after January 1, 1996; **or** *[emphasis added]*

(B) were licensed as APRNs based upon obtaining national certification.

Requested Change. TNA requests Subdivision (2) be reworded to read:

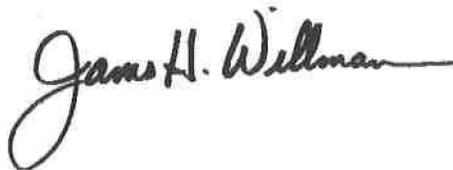
(2) . . . This requirement shall apply to APRNs who were licensed as APRNs based upon obtaining national certification.

Rationale. Because of use of the disjunctive in proposed Subsection (a)(2), TNA believes it will apply to all APRNs licensed after January 1, 1996 including APRNs who were issued a license based on a waiver from national certification. These APRNs will fall under Subdivision (A) based on their date of licensure and because of the use of the disjunctive, (B) becomes irrelevant. Consequently, APRNs licensed after January 1, 1996 based on a waiver of certification would have to demonstrate maintaining national certification which they obviously cannot do.

B. EDITORIAL COMMENTS

TNA has identified a number of editorial changes it believes may be needed in proposed Rule 221. These are identified in the table set out in Attachment A. TNA is identifying these editorial changes for the Board's consideration and is not specifically requesting they be made.

Respectfully submitted,



James H. Willmann, JD
Director Governmental Affairs

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ATTACHMENT A
EDITORIAL COMMENTS OF TEXAS NURSES ASSOCIATION ON PROPOSED RULE 221

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
§221.1 Definitions		
<p>§221.1. Definitions.</p> <p>The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:</p> <p>(1) Accredited program--An advanced practice registered nursing education program that has been deemed to have met certain standards set by the Board or by a national nursing education accrediting body recognized by the Board and the U.S. Department of Education and/or the Council for Higher Education Accreditation.</p> <p>(2) Advanced practice registered nursing education program--A post-basic nursing education program at the master's degree level or higher that prepares its graduates to practice in one of the four APRN roles and at least one population focus area as defined in this chapter.</p> <p>(3) Advanced practice registered nurse (APRN)-</p>	<p>**denotes new definition</p> <p>NCSBN Model Rule. Term is not used in body of rule so no need to define term.</p> <p>Deemed by whom? Similar to current definition except Dept of Ed / CHEA added.</p> <p>Rule is not consistent in requiring be a "master's degree level or higher "Post-basic" only in rule 221.9(b). Add sentence from 221.9(b) that term does not include RN-BSN programs. Similar to current definition but "certificate" deleted</p> <p><i>TNA is requesting substantive changes to definition</i></p>	<p>Recommend use in rules or delete definition as editorial change</p> <p>Add sentence at end of definition that reads: "The term does not include RN to BSN programs." and delete that sentence from 221.9(b)</p> <p><i>TNA's requested changes are addressed in section of comments addressing substantive changes</i></p>
<p>**(4) Advanced practice registered nurse (APRN) license--Authority to practice in one of the four APRN roles and at least one population focus area. The APRN license is a regulatory mechanism used by the Board to grant legal authority to practice as an APRN in the State of Texas.</p> <p>**(5) Advanced practice registered nurse role (role)--One of four categories of APRNs that defines the emphasis and implementation of patient care services across the health wellness-illness continuum by APRNs. The four APRN roles are:</p> <p>(A) Certified Clinical Nurse Specialist (CNS);</p> <p>(B) Certified Nurse-Midwife (CNM);</p> <p>(C) Certified Nurse Practitioner (CNP);</p>	<p>Not clear why need this definition since "license" does not seem to be a term that needs defining. The definition replaces current definition of "authorization to practice."</p> <p><i>TNA is requesting substantive changes relating to titles used to identify NPs and CNSs.</i></p>	<p>Recommend delete definition as editorial change</p> <p><i>TNA's requested changes are set out in section of comments addressing substantive changes</i></p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>and (D) Certified Registered Nurse Anesthetist (CRNA).</p> <p>**(6) Adverse action--Any action permitted by a state's laws that are imposed on an APRN by a state board of nursing or other authority, including actions against an individual's license, such as: revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting an APRN's authority to practice, including the issuance of a cease and desist action.</p> <p>(7)-(11) [omitted]</p>	<p><i>TNA is requesting substantive changes to definition</i></p> <p><i>Use of "encumbrance" makes definition somewhat circular since "unencumbered license" is defined using "adverse action."</i></p>	<p><i>TNA's requested changes are addressed in section of comments addressing substantive changes</i></p>
<p>**(12) Competence--The ability of APRNs to integrate knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and population focus area in accordance with the scope of their practice.</p> <p>(13) - (15) [omitted]</p> <p>(16) Outpatient anesthesia setting--Any facility, clinic, center, office, or other setting that is not a part of a licensed hospital or a licensed ambulatory surgical center, with the exception of all of the following:</p> <p>(A) a clinic located on land recognized as tribal land by the federal government and maintained or operated by a federally recognized Indian tribe or tribal organization as listed under 25 U.S.C. Section 479-1 or as listed under a successor federal statute or regulation;</p> <p>(B) a facility maintained or operated by a state or governmental entity;</p> <p>(C) a clinic directly maintained or operated by the United States or by any of its departments, officers, or agencies; and</p> <p>(D) an outpatient setting accredited by either The Joint Commission relating to ambulatory surgical centers, the American Association for the Accreditation of Ambulatory Surgery Facilities, or the Accreditation Association for Ambulatory Health Care.</p>	<p>Defining in terms of "personal attributes" and "ethical practice" is a bit unusual since "competence" is normally defined as clinical competence.</p> <p>Definition covers licensed freestanding ERs as outpatient setting. Seems like more appropriate to treat same as hospitals and ambulatory surgical centers. However, definition tracks statute so probably cannot be changed.</p> <p>Since not intuitive that licensed freestanding ER would be included as an outpatient anesthesia setting, it may be helpful if definition explicitly stated that outpatient anesthesia setting includes licensed freestanding ERs</p>	<p>No change is being requested</p> <p>No change recommended since tracks statute except may want to explicitly state that term includes licensed freestanding ERs</p>
<p>(17) [omitted]</p>		

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>** (18) Prescriptive authority agreement--An agreement entered into by a physician and an APRN or physician assistant through which the physician delegates to the APRN or physician assistant the act of prescribing or ordering a drug or device.</p> <p>** (19) [omitted]</p> <p>(20) Protocols or other written authorization-- Written authorization to provide medical aspects of patient care that are agreed upon and signed by the APRN and delegating physician, reviewed and signed at least annually, and maintained in the practice setting of the APRN. The term: "protocols or other written authorization" is separate and distinct from a prescriptive authority agreement. However, a prescriptive authority agreement may reference or include the terms of a protocol or other written authorization. Protocols or other written authorization shall be defined to promote the exercise of professional judgment by the APRN commensurate with his/her education and experience. Such protocols or other written authorization need not describe the exact steps that the APRN must take with respect to each specific condition, disease, or symptom and may state types or categories of drugs or devices that may be prescribed or ordered rather than just list specific drugs or devices.</p> <p>(21) – (22) [omitted]</p> <p>(23) Unencumbered--Licensure status that is not subject to current limitation due to adverse action.</p>	<p>This language tracks Rule 222 and SB 406. TMB rule adds sentence that reads:</p> <p>Prescriptive authority agreements are required for the delegation of the act of prescribing or ordering a drug or device in all practice settings, with the exception of a facility-based practice, pursuant to §157.054 of the Act. TMB addition is helpful since makes clear that protocols are not PAAs which is consistent with definition of “protocol” below.</p> <p>Also definition (20) below defining “protocol or other written authorization” explicitly states that a PAA is separate and distinct from a protocol.</p> <p>Qualifier “just” seems inappropriate</p> <p><i>TNA is requesting substantive changes to definition</i></p>	<p>Add sentence to definition that reads:</p> <p>“The term is separate and distinct from protocol and other written authorization to provide medical aspects of care.”</p> <p>Replace phrase that reads:</p> <p>“rather than just list specific drugs or devices.”</p> <p>with:</p> <p>“rather than list each specific drug or device.”</p> <p><i>TNA’s requested changes are addressed in section of comments addressing substantive changes</i></p>
Rule 221.2. Scope and Standards Related to the APRN		
<p>§221.2.Scope and Standards Related to the APRN.</p> <p>(a) Scope of Practice. The APRN shall comply with the standards of nursing practice set forth in §217.11 of this title</p>	<p>First 2 sentences from NCSBN Model Rule.</p>	

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>(relating to Standards of Nursing Practice) and to the standards of the national professional nursing associations recognized by the Board. Standards for a specific APRN role and population focus area supersede standards for registered nurses where conflict between the standards, if any, exists. The APRN shall know and conform to all federal, state, and local laws, rules, and regulations affecting the advanced role and population focus area. When collaborating with other health care providers, the APRN shall be accountable for knowledge of the statutes and rules relating to advanced practice registered nursing and function within the boundaries of the appropriate APRN role and population focus.</p> <p>(b) APRNs shall practice within standards established by the Board and assure patient care is provided according to relevant patient care standards recognized by the Board, including standards of national professional nursing associations. APRNs shall practice within the advanced role and population focus area appropriate to their advanced practice registered nursing educational preparation and national certification. The APRN may perform only those functions that are within relevant patient care standards and that are consistent with the Nursing Practice Act, Board rules, other laws, and regulations of the state of Texas.</p> <p>(c) The APRN's scope of practice shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the APRN from practicing in those areas deemed to be within the scope of practice of a registered nurse.</p>	<p>How does APRN know what are the national associations whose standards it recognizes? Rule 216.3(a) provides for BON to provide list of approved CNE accrediting agencies.</p> <p>Redundant since Standard in 217.11(1)(A) explicitly requires that comply with all laws.</p> <p>It is not clear how this Subsection (b) differs from (a). They seem somewhat redundant. First 2 sentences are from NCSBN Model Rule but add "by rule" after "established by the Board"</p> <p>How does APRN know what are the national associations whose standards it recognizes?</p> <p>Rule 221.15(c)(3) uses different standard of "current and prevailing professional conduct."</p> <p>In last sentence, need "and" after "Board rules" and no comma after "laws"?</p> <p><i>TNA is requesting substantive changes to this Subsection (c).</i></p>	<p>Add language similar to CNE rule that BON will make available a list of national associations of whose standards it has approved.</p> <p>Delete sentence that reads: "The APRN shall know and conform to . . ."</p> <p>Combine content of (a) and (b) into a single section.</p> <p>Add language similar to CNE accrediting approved by BON that BON will make a list of national associations of whose standards it has approved available.</p> <p>Be sure consistent with standard in 221.15(c)(3)</p> <p>Reword last sentence to read: ". . . consistent with the Nursing Practice Act and Board rules and other laws and regulations . . ."</p> <p><i>TNA's requested changes are addressed in section of comments addressing substantive changes</i></p>
<p>(d) [omitted]</p> <p>(e) When providing medical aspects of care, APRNs shall utilize mechanisms that provide authority for that care. These mechanisms include a prescriptive authority agreement or Protocols or other written authorization. This requirement shall not be construed as requiring authority for nursing aspects of care.</p> <p>(1) Prescriptive authority agreements and Protocols or other written authorization shall promote the exercise of professional judgment by the APRN commensurate with his/her education and experience. The degree of detail within prescriptive authority agreements and Protocols or other</p>	<p>May want to say "when making medical diagnosis or providing other medical aspects of care, . . ." to reinforce that the "diagnosis" referred to in (d) includes nursing diagnosis.</p> <p>May be misleading since Medical Practice Act requires (PAAs particularly) address a number of specific areas.</p>	<p>May want to change to read "When making a medical diagnosis or providing other medical aspects of care . . ."</p> <p>Change sentence to read "Prescriptive authority agreements and protocols or other</p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>written authorization may vary in relation to the complexity of the situations covered, the area of practice, the advanced practice registered nursing educational preparation of the individual, and the experience level of the APRN.</p> <p>(2) Protocols or other written authorization:</p> <p>(A) should be jointly developed by the APRN and the appropriate physician(s);</p> <p>(B) shall be signed by both the APRN and the physician(s);</p> <p>(C) shall be reviewed and re-signed at least annually;</p> <p>(D) shall be maintained in the practice setting of the APRN;</p> <p>(E) shall be made available as necessary to verify authority to provide medical aspects of care; and</p> <p>(F) shall be retained for a minimum of two years.</p> <p>(3) A prescriptive authority agreement as required by Chapter 222 of this title (relating to Advanced Practice Registered Nurses with Prescriptive Authority) may be utilized to meet the requirement for a Protocol or other written authorization to provide medical aspects of patient care.</p> <p>(f) [omitted]</p>	<p>Not clear why Subdivision (2) does not also include prescriptive authority agreements. Subdivisions (A)-(D) are redundant of definition of protocol so are unnecessary.</p> <p><i>TNA is requesting substantive changes to this Subsection (c).</i></p>	<p>written authorization must address the areas required by Rule 222 but the degree of detail may vary in relation to . . .”</p> <p>Reword Subdivision (2) to include PAAs and only what not part of definition of protocol so that reads: Prescriptive authority agreements and Protocols or other written authorization: (A) shall be made available as necessary to verify authority to provide medical aspects of care; and (B) shall be retained for a minimum of two years.</p> <p><i>TNA’s requested changes are addressed in section of comments addressing substantive changes</i></p>
§221.3.Licensure as an APRN.		
<p>§221.3.Licensure as an APRN.</p> <p>(a) Application for Initial Licensure as an APRN.</p> <p>(1) An applicant for licensure as an APRN in this state shall submit to the Board the required fee specified in §223.1 of this title (relating to Fees), verification of licensure or privilege to practice as a registered nurse in Texas, and a completed application that provides the following information:</p> <p>(A) Graduation from an APRN graduate or post-graduate program, as evidenced by official documentation received directly from an advanced practice registered nursing education program accredited by a nursing accrediting body that is recognized by the Board and the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as recognized by the Board; and</p>	<p>This overlaps quite a bit with Rule 221.9 (education requirements)</p> <p>From NCSBN Model Rule. But “APRN education program” and “accredited program” are defined in 221.1 and content of (A) duplicates those definitions. Better to just use APRN education program and accredited program as a defined term.</p>	<p>Reword (A) to read: (A) Graduation from an accredited program as evidenced by official . . .”</p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>by the Board to maintaining current national certification or recertification as applicable by the national professional certification organization that meets the requirements set forth in this chapter and is recognized by the Board. This requirement shall apply to APRNs who:</p> <p>(A) completed an advanced practice registered nursing education program on or after January 1, 1996; or</p> <p>(B) were licensed as APRNs based upon obtaining national certification.</p> <p>(3) An applicant must attest, on forms provided by the Board, to having a minimum of 400 hours of current practice within the preceding biennium.</p> <p>(4) An applicant must attest, on forms provided by the Board, to being in compliance with the requirements of Chapter 216 of this title (relating to Continuing Competency) and Chapter 222 of this title (relating to Advanced Practice Registered Nurses With Prescriptive Authority), where applicable.</p> <p>(b) [omitted]</p>	<p>How work for APRNs whose initial license period is six months. CNE Rule 217.8(b), (c) excepts CNE for first license renewal period. Is that needed here?</p> <p>How work for APRN with six month initial license. RN license renewal exempted for first renewal period. CNE Rule 216.8(b), (c) except first license renewal period so referring to requirements of Rule 216 should solve problem.</p>	<p><i>comments addressing substantive changes</i></p> <p>No specific change being requested.</p>
§221.5.Quality Assurance/Documentation and Audit.		
<p>§221.5.Quality Assurance/Documentation and Audit.</p> <p>The Board may conduct a random audit of nurses to verify compliance with the requirements of this chapter, including but not limited to compliance with requirements for current practice, current national certification, and/or continuing education. Upon request of the Board, licensees shall submit documentation of compliance.</p>	<p><i>TNA is requesting substantive changes to this Section .</i></p>	<p><i>TNA's requested changes are described in section of comments addressing substantive changes</i></p>
§221.6.Reactivation or Reinstatement of APRN Licensure		
<p>(a) – (c) [omitted]</p> <p>(d) An APRN who has not completed an advanced practice registered nursing education program in the last 24 calendar months and has not practiced in the APRN role and population focus area in Texas or another jurisdiction within the last 24 calendar months shall apply for a six-month temporary permit as specified in paragraph (5) of this subsection to be used</p>		

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>only for the completion of the current practice hours required for reinstatement of the APRN. (1) – (5) [omitted] (e) [omitted]</p>	<p>Should reference be to “reinstatement of APRN <u>license</u>”?</p>	
§221.7. Acceptable Certification Examinations		
<p>§221.7. [omitted]</p>		
§221.8. Titles and Abbreviations		
<p>§221.8. Titles and Abbreviations.</p> <p>(a) Individuals may be licensed or granted privilege to practice as APRNs in the following roles and population focus areas:</p> <p>(1) Roles:</p> <p>(A) Certified Nurse-Midwife (CNM); (B) Certified Nurse Practitioner (CNP); (C) Certified Registered Nurse Anesthetist (CRNA); and (D) Certified Clinical Nurse Specialist (CNS).</p> <p>(2) Population focus areas:</p> <p>(A) Adult-gerontology: (i) Acute care; and (ii) Primary care; (B) Family/individual across the lifespan; (C) Neonatal; (D) Pediatrics: (i) Acute care; and (ii) Primary care; (E) Psychiatric/mental health; and (F) Women's health/gender-related.</p> <p>(b) [omitted]</p> <p>(c) When providing care to patients, the APRN shall wear and provide clear identification that indicates the appropriate APRN nurse designation, as specified in this section.</p> <p>(d) Unless licensed as an APRN by the Board as</p>	<p><i>TNA is requesting substantive changes relating to titles used to identify NPs and CNSs.</i></p> <p>NCSBN Model requires only APRN and role. It does not require population focus area for NPs and CNSs</p> <p><i>TNA is requesting substantive changes to (c).</i></p>	<p><i>TNA's requested changes are set out in section of comments addressing substantive changes</i></p> <p><i>TNA's requested changes are set out in section of comments addressing substantive changes</i></p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>provided in this chapter, a nurse shall not:</p> <p>(1) claim to be an APRN or hold himself/herself out to be an APRN in this state; or</p> <p>(2) use a title or any other designation tending to imply that the person is an APRN.</p> <p>(e) A nurse who violates subsection (c) or (d) of this section may be subject to discipline under the Nursing Practice Act and Board rules.</p>	<p>Redundant of other sections.</p>	<p>Delete Subsection (e)</p>
<p>§221.9.APRN Education Requirements for Licensure</p>		
<p>§221.9.APRN Education Requirements for Licensure.</p> <p>(a) For purposes of this section, the following terms have the following definitions:</p> <p>(1) - (4) [omitted]</p> <p>(5) Clinical major courses--Courses that include didactic content and offer clinical experiences in a specific population focus area.</p> <p>(6) Practicum/Preceptorship/Internship--A designated portion of a formal advanced practice registered nursing education program that is offered in a health care setting and affords students the opportunity to integrate theory and role in both the APRN role and population focus area through direct patient care/client management. Practicums/Preceptorships/ Internships are planned and monitored by either a designated faculty member or qualified preceptor.</p>	<p>Used only for CNS in (e) and content is repeated there</p> <p>In other sections adds "who meets requirements of §221.6(c)3". See Rule 221.6</p>	<p>Delete definition.</p> <p>Add at end of definition: ". . .who meets the requirements of §221.6(c)3)"a</p>
<p>(b) In order to be eligible to apply for licensure as an APRN, the registered nurse must have completed a post-basic advanced practice registered nursing education program of study appropriate for practice in an APRN role and population focus area recognized by the Board. RN to BSN programs shall not be considered post-basic programs for the purpose of this chapter.</p> <p>(c) [omitted]</p> <p>(d) Applicants for licensure in an APRN role and population focus area recognized by the Board must submit verification of completion of all requirements of an APRN education program that meets the following criteria:</p>	<p>Seems out of place and redundant to 221.3(a) Use of "post-basic" is duplicates content of definition of "APRN education program" in 221.1.</p> <p>Better if last sentence relating to RN to BSN is moved to definition of "APRN education program" in Rule 221.1</p> <p>Appears to be a licensure requirement and may not need to be set out here.</p>	<p>Consider deleting Subsection (b) as redundant and if retain delete "post-basic."</p> <p>Move RN to BSN sentence to definition of APRN education program and delete here.</p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>(1) Graduation from an advanced practice registered nurse graduate or post-graduate program as evidenced by official documentation received directly from an advanced practice registered nursing education program accredited by a nursing accrediting body that is recognized by the Board and the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as recognized by the Board.</p> <p>(2) Programs of study shall be at least one academic year in length and shall include a formal preceptorship.</p> <p>(3) Graduates of advanced practice registered nurse education programs who were prepared for two population foci or two different APRN roles shall demonstrate that they have completed didactic content and clinical experience in both functional roles and population foci.</p>	<p>Subdivision (1) duplicates 221.3(a)(1(A) and also doesn't fit stem. Much of content duplicates content of definitions of "APRN education program" and accredited program" in 221.1</p> <p>Term defined in 221.9(a) is "practicum/preceptor/internship." Should that term be used here.</p>	<p>Delete Subdivision (1).</p> <p>Change to "formal practicum/preceptor/internship"</p>
<p>(e) Applicants for licensure as clinical nurse specialists in any population focus area must submit verification of the following requirements, in addition to meeting other advanced practice registered nursing education requirements for licensure:</p> <p>(1) completion of a minimum of a master's degree in the discipline of nursing; and</p> <p>(2) completion of a minimum of nine semester credit hours or the equivalent in a specific clinical major.</p> <p>Clinical major courses must include didactic content and clinical experiences in the clinical nurse specialist role in a specific population focus area. Courses in advanced health assessment, advanced pathophysiology, and advanced pharmacotherapeutics cannot be counted toward meeting the nine semester credit hour requirement.</p>	<p>TNA has substantive concerns about this Subsection (e).</p> <p>"Clinical major course" is defined in 221.9(a) and (2) repeats content of that definition. This is only place term is used. Definition should be deleted as unnecessary.</p>	<p>TNA's substantive concerns are described in section of comments addressing substantive changes</p> <p>Delete definition in 221.9(a).</p>
<p>(f) [omitted]</p> <p>(g) The curriculum shall be consistent with competencies of the specific areas of practice.</p> <p>(h) – (j) [omitted]</p>	<p>Should this be "role and population focus area"?</p>	<p>Replace: "specific areas of practice" with "specific population focus area"</p>
§221.10.Petitions for Waiver.		
§221.10.Petitions for Waiver.		

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>(a) – (b) [omitted]</p> <p>(c) Petitions for waiver from the current national certification requirements of this chapter may be granted by the Board as follows:</p> <p>(1) Applicants who completed their advanced practice registered nursing education programs prior to January 1, 1996 may be granted an exemption from the national certification requirement, provided the program was accredited by a national nursing education accrediting body that is recognized by the Board and the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as acceptable to the Board at the time the applicant completed the program.</p> <p>(2) – (3) [omitted]</p> <p>(d) Waivers from the master's degree requirement may be granted to qualified certificate-prepared nurse-midwives and women's health care nurse practitioners who completed their advanced practice registered nursing education programs on or before December 31, 2006. Applicants must meet all other advanced practice registered nursing education requirements as stated in this chapter.</p> <p>(1) Petitioners approved on the basis of this waiver shall be limited to providing APRN care within the geographical boundaries of the State of Texas. This shall not prevent the individual from utilizing Nurse Licensure Compact privileges to practice as a registered nurse.</p> <p>(2) – (3) [omitted]</p>	<p>What role title is used by NPs and CNSs issue a license based on this waiver. Rule 221.8(b) appears to require all NP and CNS to use “certified” in their role title. TNA cannot find any provision that address how NPs and CNSs licensed based on this waiver should identify themselves.</p> <p>Duplicates content of definition of “accredit program” in 221.1</p> <p><i>TNA has substantive concerns about this geographical limitation.</i></p>	<p>Clarify how NPs and CNSs licensed based on this waiver should identify themselves.</p> <p>Use “accredited program”</p> <p><i>TNA’s substantive concerns are described in section of comments addressing substantive changes</i></p>
<p>(e) Exemptions granting authorization to utilize licensure titles not otherwise authorized by this chapter may be granted to qualified petitioners who completed their advanced practice registered nursing education programs prior to the date specified. Petitioners must meet all other education and national certification requirements as stated in this chapter.</p> <p>(1) – (2) [omitted]</p> <p>(3) Those individuals licensed on the basis of this exemption shall be limited to providing advanced practice care within the geographical boundaries of the State of Texas. This shall not prevent the individual from utilizing Nurse Licensure Compact privileges to practice as a registered nurse.</p> <p>(4) – (5) [omitted]</p> <p>The applicant must submit all required documentation necessary</p>	<p>Why is terminology “exemption” used in (e)-(f) and “waiver” in (b)-(d). Is there a difference?</p> <p><i>TNA has substantive concerns about this geographical limitation.</i></p>	<p>If “waiver” and “exemption” are the same thing then same term should be used in (b) – (f)</p> <p><i>TNA’s substantive concerns are described in section of comments addressing substantive changes</i></p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
<p>to demonstrate that all requirements for licensure have been met.</p> <p>(f) [omitted]</p>		
§221.11.Inactive Status		
<p>§221.11.Inactive Status.</p> <p>(a) The APRN may choose to change current APRN licensure status to inactive status by providing a written request for such change.</p> <p>(b) Inactive APRN licensure status means that the registered nurse may not practice in the APRN role and may not hold himself/herself out to be an APRN by using any titles that imply that he/she is an APRN. Prescriptive authority shall be placed on inactive status concurrent with inactivation of the APRN license.</p>	<p><i>TNA is requesting substantive changes to 221.11.</i></p>	<p><i>TNA's requested changes are set out in section of comments addressing substantive changes</i></p>
§221.12.Nurse-Midwives Providing Controlled Substances		
<p>§221.12. Nurse-Midwives Providing Controlled Substances.</p> <p>(a) – (b) [omitted]</p>	<p><i>TNA has substantive questions about inclusive of 221.12 in Rule 221.</i></p>	<p><i>TNA's substantive question are set out in section of comments addressing substantive changes</i></p>
§221.13.Provision of Anesthesia Services by Nurse Anesthetists in Licensed Hospitals or Ambulatory Surgical Centers		
<p>§221.13.Provision of Anesthesia Services by Nurse Anesthetists in Licensed Hospitals or Ambulatory Surgical Centers.</p> <p>(a) – (c) [omitted]</p> <p>(d) A nurse anesthetist to whom a physician has delegated the ordering of drugs and devices necessary for the nurse anesthetist to administer anesthesia or anesthesia-related services pursuant to §157.058, Occupations Code is not required to obtain a prescriptive authority agreement for the ordering of non-prescription drugs, dangerous drugs, controlled substances or devices.</p>	<p><i>TNA has substantive questions about inclusive of 221.12 in Rule 221.</i></p> <p>What else is there. Listing seems to suggest there is something else. If list is exhaustive then why not a period after "... prescriptive authority agreement" and delete list?</p>	<p><i>TNA's substantive question are set out in section of comments addressing substantive changes</i></p> <p>Delete phrase: "for the ordering of non-prescription drugs, dangerous "drugs, controlled substances or devices. and end (d) with: "... prescriptive authority agreement."</p>

PROPOSED RULE	TNA COMMENT	TNA REQUESTED CHANGE
§221.14.Provision of Anesthesia Services by Nurse Anesthetists in Certain Outpatient Settings		
<p>§221.14.Provision of Anesthesia Services by Nurse Anesthetists in Certain Outpatient Settings.</p> <p>(a)-(e) omitted</p>	<p>TNA has substantive questions about inclusive of 221.12 in Rule 221.</p>	<p>TNA's substantive question are set out in section of comments addressing substantive changes</p>
§221.15.Enforcement		
<p>§221.15.Enforcement.</p> <p>(a) The Board may conduct an audit to determine compliance with the requirements of this chapter.</p> <p>(b) Any nurse who violates this chapter may be subject to disciplinary action under the Nursing Practice Act and Board rules.</p> <p>(c) Behaviors for which an APRN may be disciplined by the Board include but are not limited to:</p> <ul style="list-style-type: none"> (1) failure to maintain current national certification or recertification; (2) inappropriate use of APRN titles; (3) failure to provide therapeutic or prophylactic evidence based care within the current and prevailing professional standard; (4) failure to properly assess a patient and accurately and completely document the assessment that supports the medical aspects of patient care provided; (5) practicing in a role and/or population focus area for which the APRN has not been educated or licensed; and (6) failure to comply with an audit of the Texas Board of Nursing. <p>(d) Failure to cooperate with a representative of the Board or another state or federal agency who conducts an on-site investigation may result in disciplinary action.</p>	<p>TNA is requesting substantive changes to Section 221.15.</p> <p>Not same wording of standard as in Rule 221.2(b) which uses "relevant patient care standards recognized by the board"</p> <p>Seems to be analogous behavior to that in (c)(6) so why not listed in Subsection (c) as (7)</p>	<p>TNA's requested substantive question are set out in section of comments addressing substantive changes</p> <p>Use same language to describe applicable standard of care unless positive reason not to do so.</p>



June 30, 2014

James W. Johnston
General Counsel
Texas Board of Nursing
333 Guadalupe
Suite 3-460
Austin, TX 78701

[Submitted via Email: dusty.johnston@bon.texas.gov]

Re: Proposed Rules and Regulations for Advanced Practice Nurses, 22 TAC §§ 221.1 – 221.4, 221.6 – 221.17

Dear Mr. Johnston,

The American Society of Anesthesiologists® (ASA®) appreciates the opportunity to comment on the recently proposed amendments and creation of new administrative code chapters concerning advanced practice registered nurses (APRNs) that were published in the Texas Register on May 30, 2014 (39 TexReg 4101-4118). The ASA is a 52,000 member educational, research, and advocacy organization dedicated to improving the medical care of patients and raising standards in the science and art of anesthesiology. Since its founding in 1905, the ASA's achievements have made it the leading voice and the foremost expert in American medicine on matters of patient safety in the perioperative environment and pain medicine.

On behalf of ASA and its nearly 3,000 Texas members, I am writing to express concern regarding these proposed changes and the impact they would have on patient safety and the Anesthesia Care Team in Texas. Our comments will address the following concerns with the proposal: lack of statutory authority, compliance with state law, and use of nursing over medical guidelines for anesthesia services.

I. The Texas Board of Nursing Lacks the Statutory Authority to Increase APRNs Scope of Practice

The ASA commends the Texas Board of Nursing (BON or Board) for its efforts to set forth minimum standards of practice for APRNs. However, the proposal exceeds authority granted by the Texas Legislature. Specifically, the Board cites TX OCC §§ 301.151, 301.152, and 301.2511 as statutory authority for the proposed regulatory change. None of the cited statutes provide the BON with statutory authority to increase scope of practice for APRNs. In the regulatory background information, the BON claims that it is only implementing those aspects of the Illinois-based National Council of State Boards of Nursing's advocacy language that are permitted under current Texas statute, however, the proposed regulations exceed the authority given to the Board by the legislature in many instances.

A. The proposal would inappropriately bypass the legislature to expand non-physician scope of practice by authorizing nurses to diagnose

Proposed rule § 221.2(d) states that the APRN “acts independently and/or in collaboration with the health team in the observation, assessment, *diagnosis*, intervention, evaluation, rehabilitation, care and counsel, and health teachings of persons who are ill, injured, or infirm or experiencing changes in normal health processes, and in the promotion and maintenance of health or prevention of illness” (Emphasis added). TX OCC § 301.152 says “‘advanced practice registered nurse’ means a registered nurse licensed by the board to practice as an advanced practice registered nurse on the basis of completion of an advanced educational program.”

June 30, 2014

The proposal's addition of the medical term "diagnosis" must be removed from the proposed regulation to correspond with Texas statute. Diagnosis is defined as:

The use of scientific and skillful methods to establish the cause and nature of a person's illness. This is done by evaluating the history of the disease process, the signs and symptoms, and the laboratory data, and by special tests such as radiography and electrocardiography. The value of establishing a diagnosis is to provide a logical basis for treatment and prognosis.¹

Under TX OCC § 151.002, "practicing medicine" means:

..the **diagnosis**, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon; or (B) directly or indirectly charges money or other compensation for those services. (Emphasis added).

TX OCC § 301.002 clearly states that professional nursing "does *not* include acts of medical **diagnosis** or the prescription of therapeutic or corrective measures" (Emphasis added).

APRNs do not have the intensive medical education and background necessary to safely diagnose patients. Physicians have between 12,000–16,000 hours of medical education and training beyond college. In contrast most APRNs have only about 500–700 hours of nursing education and training beyond college. Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses. The breadth of courses plus the duration and hours of course work allow for detailed, comprehensive medical knowledge that prepares the physician to provide a patient with an informed, supportable diagnosis. APRNs, such as nurse anesthetists, take selected courses related to their areas of nursing focus. The limited number of courses plus the shorter duration and fewer hours do not allow for detailed, comprehensive knowledge. Without such a background, Texas patients should not be subjected to the misbelief that they have received an actual medical diagnosis which would serve as the basis of the patient's treatment plan.

Having first been educated and trained as a nurse anesthetist, and having later trained to become a physician anesthesiologist, I am acutely aware of the differences in both length of training as well as depth of knowledge between physicians and APRNs. The additional nine years of education and training – greater than 10,000 additional hours – made a tremendous difference in my ability to provide the comprehensive medical, anesthesia, and surgical care critical to my patients. Furthermore, much of my education, training, and practice have been in Texas, as well as Oklahoma, where the practice of both medicine and nursing is highly similar. It would be a disservice to Texas patients to adopt this new regulatory language when nurses have neither the educational background nor the statutory authority to diagnose patients. While the nurses in this proposed regulation are valuable members of the health care team, the needs of the patients should be the priority. Patients requiring diagnosis and treatment deserve to know a qualified physician is responsible for their care. Moreover, the Court of Appeals of Texas in San Antonio held in 2005 that APRNs are "expressly prohibited from 'acts of diagnosis.'"²

B. The proposal would inappropriately bypass the legislature to expand nurse anesthetists' scope of practice through the definitions of nurse anesthetist, monitored anesthesia care, and outpatient anesthesia setting

The proposed regulations greatly expand the scope of practice for nurse anesthetists, far beyond the statutory authority granted to APRNs and the Texas BON. The proposal would define a nurse anesthetist as:

An APRN who is educated to provide the full spectrum of anesthesia and anesthesia-related care for patients across the lifespan whose health status may range from healthy through all levels of acuity,

¹ Taber, Clarence Wilbur, and Clayton L. Thomas. 1997. *Taber's cyclopedic medical dictionary*. Philadelphia: F.A.Davis.

² *Mann v. Geriatric Services, Inc.*, 2005 WL 3445987 (Tex.App.San Antonio).

including patients with immediate, severe, or life-threatening illnesses or injury in compliance with state law. Certified Registered Nurse Anesthetists provide care in diverse settings.

To be consistent with existing law, the ASA strongly encourages the Board to modify the proposed definition to address the following supervision and scope of practice concerns.

1. The proposal omits an existing statute requiring physician delegation for nurse anesthetist anesthesia-related services

Anesthesiology is the practice of medicine. Texas acknowledges this fact in law at TX OCC § 157.058, which states that anesthesia may only be provided by a nurse anesthetist when a physician delegates this to a nurse anesthetist. For this reason, anesthesia-related services must be ordered by a physician. The ASA strongly urges the BON to comply with existing law and include in this new definition a section clearly indicating that nurse anesthetists must receive their authority to provide anesthesia from a physician. To offer such a definition without affirming the necessary delegatory authority from a physician is an increase in scope of practice, which is outside the Texas BON's authority.

2. The proposal expands nurse anesthetists scope of practice by adding the term “full spectrum” of anesthesia and anesthesia-related care for patients

The ASA is greatly concerned by the inclusion of the words “full spectrum” within the proposed nurse anesthetist definition. Using the phrase “full spectrum” implies that nurse anesthetists have the proper training to provide every aspect of anesthesia care. Examining nurse anesthetist education and training, it is evident this is not the case. According to the American Association of Nurse Anesthetists, nurse anesthetists only receive about 1,651 hours of education and training³ after college, and this training does not involve many critical aspects of “full spectrum” anesthesia care. Most aspects of “full spectrum” care are medical in nature and are learned only through medical education and training. For example, nurse anesthetists are not required to receive education or training in transesophageal echocardiography (TEE), spinal drains, acute and chronic pain medicine, or critical care medicine⁴ – many of which customarily require separate and additional board certification for physician anesthesiologists and all of which are part of “full spectrum” medical anesthesia care. Nurse anesthetists do not receive training in these or any subspecialty training areas; they cannot be board-certified in these aspects of anesthesia care and therefore should not be promoted to the public as being authorized to perform these important medical requirements of “full spectrum” anesthesia care.

22 TX TAC § 192.2 details the responsibility of physicians in providing full spectrum anesthesia. If the BON is implying that nurse anesthetists can provide the same exact level of care listed under 22 TX TAC § 192.2, then the BON's language should incorporate all aspects of 22 TX TAC § 192.2 (including adherence to ASA standards) within its proposed regulation. It is our belief that the BON cannot legally imply that nurse anesthetists have the requisite education and training to provide every medical aspect of anesthesia care, and therefore the BON is strongly encouraged to remove the misleading words “full spectrum” from the proposed nurse anesthetist definition. To be consistent with Texas law, the BON should also include references to 22 TX TAC § 192.2, specifying that nurse anesthetists are only able to perform anesthesia tasks delegated to them by a physician operating under ASA guidelines.

3. The proposal omits an existing statute requiring physician delegation for the definitions “monitored anesthesia care” and “outpatient anesthesia setting”

As with the reasoning above, the definitions of “monitored anesthesia care” and “outpatient anesthesia setting” in proposed § 221.1, and the application of these definitions in proposed § 221.14 should include the instruction that “monitored anesthesia care” is only allowed to occur after the delegation of that authority by a physician or a

³ <http://www.aana.com/ceandeducation/becomeacrna/Pages/Qualifications-and-Capabilities-of-the-Certified-Registered-Nurse-Anesthetist.aspx>

⁴ <http://home.coa.us.com/accreditation/Documents/Standards%20for%20Accreditation%20of%20Nurse%20Anesthesia%20Education%20Programs%20January%202014.pdf>

dentist. The definition of “outpatient anesthesia setting” would also encompass dental offices that offer anesthesia, and TX OCC § 258.001 requires that anesthesia provided in such an office by a nurse anesthetist is only permitted if a dentist holding an anesthesia permit by the Texas Board of Dentistry delegates authority to the nurse anesthetist. This should be indicated in both the definition section as well as in § 221.14.

Also of concern is the requirement under § 221.14(c)(2)(B) requiring end-tidal CO₂ only for general anesthesia. This requirement is in direct conflict with the ASA’s Standards for Basic Anesthesia Monitoring.⁵ ASA standards provide minimum requirements for clinical practice which are regarded as generally accepted principles of patient management and may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment. As the ASA is the leading voice and foremost expert in American medicine on matters of anesthesia and perioperative care, ASA standards are nearly universally recognized and followed. Last updated on July 1, 2011, ASA’s Standards for Basic Anesthesia Monitoring specify that “During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.” This proposed regulation needs to reflect a higher level of monitoring for moderate sedation, deep sedation, and general anesthesia. Post-anesthesia monitoring of patients is also of critical importance, and the proposed regulations should be amended to reflect their necessity. Neglecting post-anesthesia monitoring is extremely dangerous for patients.

II. The Texas Board of Nursing is Ignoring Strict State Law Concerning Conflicting Language Between the Medical and Nursing Boards

TX OCC § 301.602 provides in part: “The board shall cooperate with the Texas State Board of Medical Examiners in adopting rules under this subchapter to eliminate, to the extent possible, conflicts between the rules adopted by each board.” Numerous provisions with the proposed rules conflict directly with the Texas Medical Practice Act. While the Texas Register noted compliance with existing requirements such as a Fiscal Note, Public Benefit/Cost Note, Request for Public Comment, and the like, the language was notably silent with regard to efforts to address areas of potential language conflict with the Texas Medical Board.

The ASA is highly concerned that the direction of the legislature was not followed. If such communications did take place, for the sake of public transparency, we request summarization and subsequent memorialization of such dialogue prior to the final rule being adopted. Specifically, our members would like to know of which areas the BON was aware were in direct conflict with the Texas Medical Board Administrative Code and what efforts the BON took to cooperate with that board to eliminate such conflicts.

III. The Texas Board of Nursing is Ignoring Strict State Law Concerning Anesthesia Care by Delegating its Authority to the AANA

Proposed regulation § 221.14(b)(1) would forego existing state law and instead require nurse anesthetists to adhere to guidelines adopted by the Illinois-based American Association of Nurse Anesthetists (AANA). Such unilateral deference to a special interest group should be reconsidered since this section would allow nurse anesthetists to follow AANA nursing guidelines instead of the guidelines delineated by the Texas Medical Board for office-based anesthesia. The Texas Medical Board refers to the ASA standards, as these are the highest quality standards for anesthesia in the United States and the Legislature granted the Texas Medical Board authority to regulate office-based anesthesia. Thus, ASA standards should prevail.

Conclusion

Nurse anesthetists are important and highly-valued members of the Anesthesia Care Team. However, the ASA is concerned that amending the Texas Administrative Code in the manner suggested by the proposed regulations would be detrimental to patient safety. Patient safety *must* be the driver behind any modification to our health laws.

⁵<https://www.asahq.org/ForMembers/~media/For%20Members/documents/Standards%20Guidelines%20Stmts/Basic%20Anesthetic%20Monitoring%202011.ashx>

American Society of Anesthesiologists Comments
June 30, 2014

The members of ASA strongly urge the Texas BON to reconsider the proposed regulation's language that exceeds the statutory authority the Texas Legislature granted to the BON.

Thank you again for the opportunity to provide comments on this important issue. If you have any questions or need additional information, please contact Jason Hansen, M.S., J.D., Director of State Affairs, at j.hansen@asahq.org or by phone at 202-289-2222.

Respectfully yours,

A handwritten signature in black ink that reads "Jane C.K. Fitch, M.D." The signature is written in a cursive, flowing style.

Jane C.K. Fitch, M.D.
President

cc: Mari Robinson, Executive Director, Texas Medical Board



Division of Survey and Certification, Region VI

November 18, 2013

To Whom It May Concern:

I am responding to your enquiry regarding anesthesia services in Medicare participating hospitals.

The regulation for Anesthesia Services in Medicare participating hospitals is at 42 CFR § 482.52. The regulation requires that the anesthesia service must be organized under the direction of a qualified physician. The anesthesia services must be provided in accordance with nationally accepted standards of practice, hospital anesthesia service policies and procedures, and must be identical throughout the hospital.

The anesthesia director is responsible for planning, directing and supervising all activities of the service. This is a minimum requirement and entails, at least, the responsibility for organization of the service and liability for ensuring the continuity of care.

The purpose of the guidelines is to ensure that all patients, in all areas of the hospital, at all times, receive the exact same acuity of care. The standard of care within the hospital establishes the expected level of care provided to all patients receiving anesthesia services. For example, if the standard of care in the hospital is a CRNA/MD Anesthesiologist team approach, with direct involvement of the anesthesiologist (either directing or supervising) in all cases; this standard must be met for **all** cases where anesthesia care is delivered. A two-level of anesthesia service, one level of coverage/acuity to most patients and a different level to another group of patients, would not meet the standards established by the regulations at 42 CFR § 485.52.

Furthermore, the guidelines are established to ensure a clear chain of responsibility and oversight, thereby avoiding any possible confusion or delay in the delivery of care in an urgent or semi-urgent situation. This applies to all areas of the hospital including pre-operative screening, pre-operative preparation, intra-operative care, post-operative care and discharge from the facility.

The Governing Body of the hospital must approve the specific anesthesia service privileges for each practitioner who furnishes anesthesia services, addressing the type of supervision of non-physicians. In the State of Texas, a CRNA must be under the supervision of a duly qualified physician.

Sincerely,

A handwritten signature in black ink, appearing to read "Dodjie B. Guioa".

Dodjie B. Guioa, MBA
Hospital/ASC Program Lead
Non-Long Term Care Certification & Enforcement Branch

JOHN ZERWAS, M.D.

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COMMITTEES:
CHAIR, GENERAL INVESTIGATING AND ETHICS
APPROPRIATIONS
CHAIR, S/C HEALTH AND HUMAN SERVICES
HUMAN SERVICES

District 28 TEXAS HOUSE OF REPRESENTATIVES

July 2, 2014

James W. Johnston
General Counsel
Texas Board of Nursing
333 Guadalupe Street
Suite 3-460
Austin, Texas 78701

Re: Proposed Rules and Regulations for Advanced Practice Nurses,
22 TAC §§221.1 - 221.4, 221.6 - 221.17

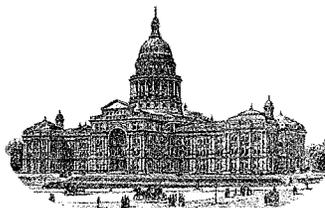
Dear Mr. Johnston,

I have concerns regarding the published amendments to the Texas Administrative Code on the subject of advanced practice registered nurses (published in the Texas Register on May 30, 2014, 39 TexReg 4101-4118). As a physician and a legislator, I have apprehension regarding these possible changes and the impact they may have on public health and patient safety.

It is my understanding that the proposed amendments and Administrative Code chapters closely mirror recommendations for minimum standards recommended by the National Council of State Boards of Nursing (NCSBN). While I firmly believe that broad, national recommendations can be helpful in formulating sound state policy, I think we must further examine such recommendations to determine what is within the scope of existing state law.

I believe you have received public comment on the proposed rules from several state and nationally recognized organizations on this matter, including the Texas Society of Anesthesiologists, the Texas Medical Association and the American Society of Anesthesiologists. I have reviewed the comment from all three of the aforementioned organizations, and I fully agree with the concerns raised by all three entities.

Broadly speaking, any expansion of scope of practice is deserving of a legislative conversation and is not something that should be conducted through the Board's rulemaking process. This includes contemplation of 'diagnosis' as a duty of advanced practice nurses, particularly in light of the fact that diagnosis is explicitly omitted from nursing authority within the Texas Occupations Code. Furthermore, I am gravely concerned with the use of the term "full spectrum" as applied to the scope of practice for nurse anesthetists, because this would seem to imply that these professionals have the proper education and training to provide any and all elements of anesthesia care.

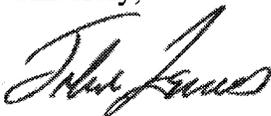


There also appear to be inconsistencies between current state law and the standard of nursing care that would be created through the proposed rules. It results in a dichotomy in which two standards of care would be created – one for physicians and another for those nurses acting under physician-delegated authority. Throughout the proposed rules there is a failure to acknowledge the law's current parameters surrounding delegation of authority. It is important for the rules to acknowledge that those delegated acts are held to the practice standards put in place regarding medicine in general, and not within the bounds of nursing standards. Creating new or different nursing standards without considering those medical standards would simply be inconsistent with good practice in patient care and would create conflict in treatment, diagnosis, and state law. I encourage the Board to reconsider these standards of medical practice in light of those already in place through the Texas Medical Board and the Board of Medical Examiners.

I believe that the unique phraseology used in the NCSBN advocacy language is very broad, and simply put, it conflicts with several areas of current Texas law. I do not believe that the Board of Nursing has intent to create such conflict, and I am sure this can be resolved through thoughtful discussion of actual intent versus the semantics on paper.

Thank you for your consideration of my thoughts. Please contact my office at (512)463-0657 with any questions on this or any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read "John Zerwas". The signature is written in a cursive, flowing style.

John Zerwas, M.D.
State Representative
District 28

From: Emily Forbes
Sent: Tuesday, June 03, 2014 9:57 AM
To: Johnston, Dusty
Subject: Comment related to APRN education rule change

Reading the current proposed rule change to APRN educational requirements with dual degrees: this is my public comment. If I need to send elsewhere let me know.

I submitted my application July 25, 2013 to the Tx BON, RN has been granted. However, I submitted all completed documentation for APRN at same time. I currently am being reviewed to grant me my APRN as a FNP, but the Tx BON is holding this up because I have obtained training that would have allowed me to sit for my WHCNP but obtained a post masters to sit for boards for FNP. With this I completed all the requirements set forth by the National Certifying Boards, successfully completed, and Tx BON is now saying I am short hours from their requirements in the State of Texas. IF anything I have more clinical hours than the majority of applications, and am being reprimanded for my additional education based on the current rule. It is my understanding a rule change proposal is in effect and my comments to this:

If we have met the National Certifying Boards requirement to obtain the APRN speciality (FNP, ANP, GNP, etc) which is required by all state nursing boards then why would this not be sufficient in the state of Texas. With the current national need for midlevel providers, I have endured red tape for being over educated. I fully support that if you desire to practice in 2 specialties an licensure for each be obtained is understandable. However Texas needs to fully adopt this proposed rule change for applicants with more than 1 speciality training. I am professional embarrassed that I have even encountered this holding me from practice in the state of Texas.

Thanks
Emily Forbes



JACKSON WALKER L.L.P.
ATTORNEYS & COUNSELORS

Carla J. Cox
(512) 236-2040 (Direct Dial)
(512) 391-2140 (Direct Fax)
cjcox@jw.com

June 30, 2014

Via Email: dusty.johnston@bon.texas.gov

James Johnston
General Counsel
Board of Nurse Examiners
William P. Hobby Bldg, Suite 3-460
333 Guadalupe
Austin, TX 78701

Re: Chapter 221. Advanced Practice Registered Nurses

Dear Dusty:

I represent the Texas Association of Nurse Anesthetists (“TANA”). TANA is presenting written comments in connection with the proposed revisions to Chapter 221 concerning Advanced Practice Registered Nurses (“APRNs”). TANA has the following concerns regarding the proposed rules::

The proposed rules appear to contain new educational curriculum requirements for CRNAs.

In §221.3 of the proposed rules, “Licensure as an APRN,” the requirements for initial licensure, as well as for licensure by endorsement, include “completion of three separate graduate level courses in advanced physiology and pathophysiology; advanced health assessment; advanced pharmacology that includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.” (“Three Course Requirement”).

The Three Course Requirement in the proposed rules applies to all APRNs, including CRNAs. In current Board of Nursing rules, the Three Course Requirement is §221.3(e) and appears to apply only to nurse practitioners and clinical nurse specialists. The following language is from the current rules:

221.3(e) Those applicants who completed nurse practitioner or clinical nurse specialist programs on or after January 1, 1998 must demonstrate evidence of completion of the following curricular requirements:

(1) separate, dedicated courses in pharmacotherapeutics, advanced assessment and pathophysiology and/or psychopathology (psychopathology accepted for advanced practice nurses prepared

in the psychiatric/mental health specialty only). These must be graduate level academic courses;

The Council on Accreditation for Nurse Anesthesia Educational Programs (COA) is implementing a requirement in its standards for three separate courses in these subjects. However, this requirement does not take effect until 2015. Consequently, nurse anesthetists who graduate before the COA requirement becomes effective may not have transcripts that indicate three separate courses in these subject areas. Therefore, TANA requests that the Three Course Requirement not take effect for CRNAs until 2015 when the COA requirements become effective.

Section 221.10(f) of the proposed rules contains the following language:

221.10 (f) Exemptions from specific curricular requirements may be granted to otherwise qualified applicants based on the education requirements set forth in Board rules that were in effect at the time the applicants completed their advanced practice registered nursing education programs.

However, for CRNAs who graduate before 2015 but after the adoption of the Three Course Requirement would not appear to be eligible for the §221.10(f) exemption.

Also, there are CRNAs currently practicing in other states who graduated previously whose transcripts do not meet the Three Course Requirement although their transcripts would meet the requirements that were in place at the time they received their license. It is unclear whether §221.10(f) of the proposed rules is intended to address currently practicing applicants from other states. The proposed rules include the two following paragraphs, that appear to apply to applicants from other states::

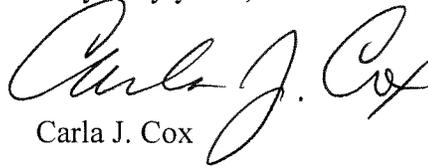
221.10(g) Applicants who are endorsing APRN licensure in Texas and have practiced in the APRN role and population focus in another state for a minimum of 24 months following completion of the APRN education program who are required to take a single academic course in order to meet the education requirements for Texas licensure may be issued a six-month temporary permit as specified in §221.6(d)(5) of this chapter (relating to Reactivation or Reinstatement of APRN Licensure) to practice in a limited capacity while completing the academic course.

(1) Only those applicants who need to complete a dedicated, graduate-level course in advanced health assessment, advanced pathophysiology, or advanced pharmacotherapeutics may be considered for a permit. If more than one course is required, the applicant shall not be eligible for the permit.

TANA is concerned that if CRNAs who are endorsing from other states are *not* covered by §221.10(f) and only covered by §221.10(g), CRNAs from other states will be adversely impacted. As we have pointed out, the COA will not implement the Three Course Requirement for CRNAs until 2015. Therefore, most CRNAs endorsing for APRN licensure in Texas will not meet the Three Course Requirement until after 2015. CRNAs will likely need to take all three courses, not just one of the three courses and will not qualify for the six month temporary permit. If CRNAs endorsing from other states are allowed to obtain an exemption under §221.10(f) because they met the education requirements set forth in Board rules that were in effect at the time the applicants completed their advanced practice registered nursing education programs, this concern will be addressed.

TANA thanks the Board for the opportunity to address these concerns. TANA is aware that the Texas Nurses Association (“TNA”) and the Coalition of Nurses in Advanced Practice (“CNAP”) will also have comments to the proposed rules. TANA may have additional comments at the public hearing after reviewing the comments and concerns of TNA and CNAP.

Very truly yours,



Carla J. Cox

cc: Jolene Zych RN, WHNP

10711051v.3 216765/00001



Physicians Caring for Texans

June 30, 2014

Mr. James W. Johnston
General Counsel
Texas State Board of Nursing
333 Guadalupe St.
Suite 3-460
Austin, Texas 78701
Email: dusty.johnston@bon.texas.gov

Re: Proposed Rules, 22 TAC §§221.1-221.15, Advanced Practice Registered Nurses, as published in the Texas Register on May 30, 2014.

Dear Mr. Johnston:

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: “Physicians Caring for Texans.” TMA’s diverse physician members practice in all fields of medical specialization.

On behalf of our over 48,000 members and the members of the Texas Academy of Family Physicians, Federation of Texas Psychiatry, Texas Ophthalmological Association, Texas Orthopaedic Association, Texas Osteopathic Medical Association, Texas Pain Society, Texas Pediatric Society, Texas Society of Anesthesiologists and Texas Society for Gastroenterology and Endoscopy (hereinafter collectively referred to as “TMA”), we provide these comments to the Texas Board of Nursing’s May 30, 2014 proposed rules (hereinafter “Proposed Rules”) regarding the scope of practice of advanced practice registered nurses (hereinafter “APRNs”) in order to express our concerns with, and opposition to, certain provisions in the rules.

I. General Comments and Concerns Regarding the Proposal

Throughout the Proposed Rules APRNs are given the authority to “diagnose” medical conditions, yet the Texas Occupations Code at §§301.002(2) expressly defines “professional nursing” as not including the acts of medical diagnosis:

The term (“professional nursing”) does not include the acts of medical diagnosis or the prescription of therapeutic or corrective measures.

Providing in the Proposed Rules that the APRN may “diagnose” and then stating that APRNs can “...only perform those functions... that are consistent with the Nursing Practice Act...” is both internally inconsistent and misleading. (*See* TBN Proposed Rule 221.2(b)). To be valid and enforceable the rules must conform to statutory requirements and restrictions in Texas laws.

The Proposed Rules throughout would require the APRN to adhere to nursing practice standards promulgated by national nursing organizations. APRNs are also performing medical services beyond the scope of statutorily permitted Registered Nurse (hereinafter “RN”) services under the delegated authority of physicians. When performing those delegated acts, the standards that should be adopted are those of medicine, not nursing. There should not be two standards for medicine in Texas, as the APRN is operating under the delegated authority of a physician when performing medical services.

The level of training and experience of each and every APRN is of concern. Due to the limited training and experience required in the programs leading to licensure of each APRN, it is the delegating physician who is tasked with assessing the education, training, experience and competence of each nurse practitioner to determine the appropriate delegation, in consultation with the APRN.

The rules should recognize that medical acts are delegated by licensed physicians and the same medical standards of practice should apply to APRNs when performing delegated medical acts as apply to physicians.

Texas Occupations Code, §301.602 provides in part:

The board shall cooperate with the Texas State Board of Medical Examiners in adopting rules under this subchapter to eliminate, to the extent possible, conflicts between the rules adopted by each board.

No reference is made in the preamble to the Proposed Rules to efforts to cooperate with the Texas Medical Board (hereinafter “TMB”) (formerly designated the Texas State Board of Medical Examiners).

II. MD, not APRN, Practice Standards Apply to Delegated Acts

TBN Rule, §221.2, requires APRNs to adhere to standards of nursing practice set forth in the rules and to standards of nursing practice as stated by national professional nursing associations recognized by the TBN.

Two medical practice standards or “schools of medicine,” one for APRNs (when operating under a physician’s delegated authority) and one for physicians should not be the result of these Proposed Rules. (*See* Texas Constitution, Article 16, section 31). Only one school of medicine is supported

by the Texas Constitution, and the Texas laws authorizing delegation. The TBN rules on APRNs should complement and not conflict with the TMB rules and Texas law.

The board shall cooperate with the Texas State Board of Medical Examiners in adopting rules under this subchapter to eliminate, to the extent possible, conflicts between the rules adopted by each board. (Texas Occupations Code, §301.602)

In fact, in a communication from the Centers for Medicare and Medicaid Services (“CMS”) dated November 18, 2013, by Dodjie B. Guioa, MBA, Hospital/ACS Program Lead, Non-Long Term Care Certification and Enforcement, Mr. Guioa opined that having two levels of service in a hospital does not meet Medicare Standards of Participation applicable to participating hospitals. (*See* letter attached).

The TBN rules should recognize that medical acts delegated by licensed physicians should be consistent with the standards of care recognized by the TMB. No reference to efforts to cooperate with the TMB is mentioned in drafting these rules. No reference or assurance is made to the requirements that the rules do not conflict with the TMB rules and vice-versa. There is no statement that a comparison of the Board of Nursing Proposed Rules to the TMB rules was performed, nor that conflicts were identified and addressed with the TMB prior to publication of the Proposed Rules in the Texas Register.

Whether in an inpatient or an outpatient environment, such as in a physician’s office, where emergency medical resources are less available than a hospital or ambulatory surgery center, patient safety is better served by implementation of uniform standards of medical care and procedures.

III. Texas Law versus Nursing Developed “Model Rules”

In reviewing the Texas Board of Nursing’s Proposed Rules, it appears that the TBN has followed the Illinois-based National Council of State Boards of Nursing positions and has given little credence to what the Texas Legislature has passed and the Texas Governor has signed into law. Adding to the end of the rules what appears to be attempts to expand scope of practice for APRNs a phrase that says “in accordance with state law” (TBN Proposed Rule §221.2(b)) only pays lip service to the statutory authority that grants the TBN’s rulemaking authority. For example, in TBN Proposed Rule 221.2 (d), the Proposed Rule states that the APRN “...acts independently and/or in collaboration with the health team in the observation, assessment, diagnosis, intervention, evaluation, rehabilitation, care and counsel, and health teachings of persons who are ill...” Making a “medical diagnosis” specifically is not authorized by statute (Texas Occupations Code, §301.602). Employing the terms “independent” and “diagnosis” in the same sentence only adds to the confusion, is disingenuous and is misleading. The rules should recognize that medical functions are delegated by licensed physicians to APRNs and not confuse delegated APRN functions with other functions that nurses may perform independently.

(The) delegated physicians remain responsible to the Board and to their patients for acts performed under the physicians' delegated authority. (TMB Rule 193.5(b)).

Also, citing to the definition of an "advanced practice registered nurse" as found in the "Consensus Model and model rules" developed by the NCSBN, the term "diagnosis" is used. (Proposed Rules §221.1(3)(E)) As mentioned above, the Texas Occupations Code, §301.602 specifically prohibits a nurse from making a medical diagnosis. No explanation is given in the preamble to the proposed rule to describe the need to use a definition of an APRN that is different than the one included in the Texas Occupations Code, §301.152(a).

IV. Specialty Titles

The list of "specialty titles" under Proposed Rules §221.10, has very limited information with respect to the education and training needed to meet the requirements for each designation listed.

The delegating physicians and the patients being treated should have more information and definitive guidance on the required education and training of these "specialty title" APRNs.

V. Prescriptive Authority Agreements

The reference in the TNB Proposed Rules to "prescriptive authority agreements," (Proposed Rules §221.2(e)(1)), should be amended by adding at the end of the subsection the phrase, "as determined by the delegating physician." Also, the TMB requirement to register delegation and prescriptive authority agreements with respect to "Standing Delegation Orders," "Delegation to Certified Registered Nurse Anesthesiologist," or "Delegation Related to Obstetrical Services" should be referenced. These terms are defined, and extensively developed, in the TMB rules. (*See* TMB rules, Chapter 193.6-15)) Coordination between the TBN and TMB is also discussed in the TMB rules (Chapter 193.10), and is consistent with the state law mandate.

VI. "Independent" Practice

APRNs receive their expanded authority to perform delegated medical acts from licensed physicians as prescribed in the TMB rules at Chapter 191 and as stated in the Texas Occupation Code, §301.152(a). There is no authority in Texas for APRNs to act independently in areas where delegation from a licensed physician is needed. The definition of APRNs in the Texas Occupation Code does not include independent practice.

VII. Medical Diagnosis

Section 301.002(2)(G) of the Nursing Practice Act states that a nurse licensed by the Board may perform medical acts delegated by a physician under authority provided by the Medical Practice Act. Review of the enumerated sections of the Medical Practice Act reveals that medical diagnosis is not among the acts that may be delegated by a physician to a nurse under any circumstances. There is not reference in the Texas Occupation Code allowing the APRN to diagnose. In fact, as

described above, there is a ***prohibition*** for APRNs to make a medical diagnosis. Yet, TBN Proposed Rule §221.1(8) and (10) specifically authorizes diagnosis and treatment of health/illness. Rule §221.1(9) uses different language in the definition of the Certified Nurse-Midwife in an apparent attempt to reach the same result: "...to provide a full range of primary care services to women across the lifespan...." *See* also, §221.2(d) (which easily can be incorrectly interpreted as allowing diagnosis and independent practice of APRNs). *See* also TBN Rule 221.9(f)(2). None of this language is included in the statutory definition of "advanced practice registered nurse." (Texas Occupation Code, §301.152(a)).

Whether it can be argued that an individual APRN may or may not have sufficient training and education to diagnose a particular medical condition is not an issue the Board is authorized to decide. Adding the phrase "... in compliance with state law" does not resolve the issue. The Board's reference to diagnosis only confuses the authority of an APRN. It is inconsistent with Texas law.

VIII. Concerns Regarding Level of Training

The level of training and experience required of each and every APRN and his or her use of the specialty titles granted under the waiver authority as proposed in these Proposed Rules is of concern. Due to the limited training and experience required in the abbreviated programs leading to licensure of APRNs (as compared to the required education and training of licensed physicians), it is the delegated physician who must assess the education, training, experience and competence of each APRN to determine the appropriate amount and type of delegation of medical services. Both the delegating physician and the APRN are responsible for meeting the applicable medical standards of care. Both need to understand and agree to the scope and extent of the delegated authority for the safety and welfare of their patients. (*See* TMB Rules, Chapter 193. Standing Delegation orders).

IX. ASA Comments Supported

TMA supports the letter from the American Society of Anesthesiologists to James W. Johnston, General Counsel of the Texas Board of Nursing, dated June 26, 2014, focusing on the delegation of authority and the practice of APRNs as applied to nurse anesthetists.

X. Summary

The TBN, working with the TMB, should modify its rules for delegation of medical services to APRNs in order to conform with the TMB's delegation rules (Chapter 193), thereby satisfying its legislative directive to eliminate conflicts between the rules. This change would best serve the health and safety interests of Texas patients.

Establishing nursing standards without taking into consideration medical standards is inconsistent with good practice and creates confusion and needless conflicts in diagnosis and treatment. When the Texas legislature enacted the NCSBN Advanced Practice Nurse Compact in 2007, it carefully

stipulated that if a provision of the APRN compact, or another state's law, conflicts with the laws of Texas, the laws of this state prevail (Texas Occupation Code, §305.004). The term "diagnosis" should be removed from the Proposed Rules governing APRN's scope of practice. These include Proposed Rule §§221.1(3)(E)(8) and (10), 221.2(d), 221.9(f)(1) and (2), as well as any other section of the rules that could be construed to imply that APRNs are authorized by law to medically diagnose health conditions.

Thank you for your consideration of these comments. Please let us know if you need further information or have any questions. Feel free to contact Donald P. Wilcox, Vice President and General Counsel, Texas Medical Association at 512-370-1336.

Sincerely,



Austin I. King, MD
President
Texas Medical Association



Clare Hawkins, MD
President
Texas Academy of Family Physicians



Andrew Harper, MD
Immediate Past Chairman
Federation of Texas Psychiatry



Sidney K. Gicheru, MD
President
Texas Ophthalmological Association



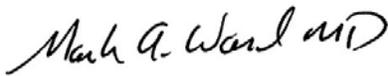
Marc DeHart, MD
President
Texas Orthopaedic Association



John L. Wright, D.O.
President
Texas Osteopathic Medical Association



Graves T. Owen, MD
President
Texas Pain Society



Mark A. Wood, MD
President
Texas Pediatric Society



David Mercier, MD
President
Texas Society of Anesthesiologists



Michael Guirl, MD
President
Texas Society for Gastroenterology and Endoscopy

Attachment: Dodjie B. Guioa letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202



Division of Survey and Certification, Region VI

November 18, 2013

To Whom It May Concern:

I am responding to your enquiry regarding anesthesia services in Medicare participating hospitals.

The regulation for Anesthesia Services in Medicare participating hospitals is at 42 CFR § 482.52. The regulation requires that the anesthesia service must be organized under the direction of a qualified physician. The anesthesia services must be provided in accordance with nationally accepted standards of practice, hospital anesthesia service policies and procedures, and must be identical throughout the hospital.

The anesthesia director is responsible for planning, directing and supervising all activities of the service. This is a minimum requirement and entails, at least, the responsibility for organization of the service and liability for ensuring the continuity of care.

The purpose of the guidelines is to ensure that all patients, in all areas of the hospital, at all times, receive the exact same acuity of care. The standard of care within the hospital establishes the expected level of care provided to all patients receiving anesthesia services. For example, if the standard of care in the hospital is a CRNA/MD Anesthesiologist team approach, with direct involvement of the anesthesiologist (either directing or supervising) in all cases; this standard must be met for all cases where anesthesia care is delivered. A two-level of anesthesia service, one level of coverage/acuity to most patients and a different level to another group of patients, would not meet the standards established by the regulations at 42 CFR § 485.52.

Furthermore, the guidelines are established to ensure a clear chain of responsibility and oversight, thereby avoiding any possible confusion or delay in the delivery of care in an urgent or semi-urgent situation. This applies to all areas of the hospital including pre-operative screening, pre-operative preparation, intra-operative care, post-operative care and discharge from the facility.

The Governing Body of the hospital must approve the specific anesthesia service privileges for each practitioner who furnishes anesthesia services, addressing the type of supervision of non-physicians. In the State of Texas, a CRNA must be under the supervision of a duly qualified physician.

Sincerely,

A handwritten signature in black ink, appearing to read "Dodjie B. Guioa".

Dodjie B. Guioa, MBA
Hospital/ASC Program Lead
Non-Long Term Care Certification & Enforcement Branch



TEXAS SOCIETY OF ANESTHESIOLOGISTS

401 W. 15th, Ste. 990 • Austin, Texas 78701 • (512) 370-1659 • Fax (512) 370-1655
E-mail: info@tsa.org • Web site <http://www.tsa.org>

June 27, 2014

James W. Johnston
General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701

Via Email: Dusty.Johnston@bon.texas.gov

Re: Texas Board of Nursing; Proposed Rules for Advanced Practice Registered Nurses
22 TAC §§221.1 – 221.15
May 30, 2014 issue of Texas Register

Dear Mr. Johnston:

The Texas Society of Anesthesiologists (“TSA”) is the Texas component of the American Society of Anesthesiologists and counts among its members over 3,000 physicians who practice the medical specialty of anesthesiology in health care facilities throughout Texas.

The Texas Society of Anesthesiologists appreciates the opportunity to provide comments regarding the Texas Board of Nursing’s proposed changes to Chapter 221, and acknowledges the time and resources the Board has devoted to the proposed rules. But, TSA believes that the Board has exceeded its statutory authority in some respects, and has proposed a dual standard of care for outpatient anesthesia services that is not in the best interests of Texas patients.

1. The Nursing Practice Act prohibits the Board of Nursing from adopting rules that expand the scope of practice of advanced practice registered nurses to include diagnosis of medical conditions.

Section 301.151 of the Texas Occupations Code says the Board of Nursing may adopt and enforce rules consistent with the Nursing Practice Act. TEX. OCC. CODE §3.01.152 authorizes the Board to adopt rules for licensure of registered nurses as advanced practice registered nurses (“APRNs”), and provides guidance for education, training, and prescriptive authority requirements. Absent from the authorizing statute is any reference to medical diagnosis. For good reason, because §301.002 of the Nursing Practice Act, defining “Professional Nursing,” states that the term does not include acts of medical diagnosis. Section 301.002 lists many examples of healthcare tasks and activities that are encompassed within the scope of practice of registered nurses, including advanced practice registered nurses, but medical diagnosis is noticeably absent and expressly excluded.

Section 301.002(2)(G) of the Nursing Practice Act states that a nurse licensed by the Board may perform medical acts delegated by a physician under authority provided by the Medical Practice Act (TEX. OCC. CODE, Chapter 157), but a review of the enumerated sections of the Medical Practice Act confirms that medical diagnosis is not among the acts that may be delegated by a physician to a nurse under any circumstances.

The Board's proposed rules include many references to "diagnosis" as being within acceptable scope of practice for APRNs. For example:

§221.1 *Definitions*

- (3) Advanced Practice Nurse (APRN) – a registered nurse who:
 - (e) Is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, **diagnosis**, and management of patient problems, including the use and prescription of pharmacological and non-pharmacological interventions **in compliance with state law**. (Emphasis added)

Whether an individual APRN may or may not have sufficient training and education to diagnose a particular medical condition is not an inquiry the Board is authorized to make. By adding the phrase “. . . in compliance with state law” the Board's reference to diagnosis is a nullity, and must be disregarded. However, the Board's inclusion of the term in this proposed rule, as well as other sections of the proposed rules, creates an ambiguity that will cause confusion among the Board's licensees, healthcare administrators, physicians, and patients.

The Board's inclusion of diagnosis within the APRN scope of practice is apparently based on the Consensus Model for APRN Regulation, which is a work product of the APRN Consensus Work Group and the National Council of State Boards of Nursing's APRN Advisory Committee. The Board's interest in encouraging uniformity in nursing regulations is understandable, but cannot take precedence over the Board's statutory authority. When the Texas legislature enacted the NCSBN Advanced Practice Nurse Compact in 2007, it carefully stipulated that if a provision of the APRN compact, or another state's law, conflicts with Texas law, the laws of this state prevail. TEX. OCC. CODE §305.004. The term “diagnosis” should be removed from the proposed rules governing APRN's scope of practice. These include §§221.1(3)(E)(8)(10), §221.2(d), §221.9(f)(2), as well as any other section of the rules that could be construed to imply that APRNs are authorized by law to medically diagnose health conditions.

2. The Board's directive to CRNAs that they shall follow standards and guidelines put forth by the American Association of Nurse Anesthetists (AANA) when performing delegated anesthesia services in outpatient settings creates an impermissible double standard of care and conflicts with rules adopted by the Texas Medical Board and the State Board of Dental Examiners.

The Texas legislature's passage of TEX. OCC. CODE §§301.601 – 301.607 and TEX. OCC. CODE §§162.101 – 162.107 began with the tragic circumstances of Kami Favors' death in 1997. Kami was a nine-year old girl who underwent a myringotomy tube placement in a physician's office in Odessa, Texas. The procedure was performed under general anesthesia. Over a 45 minute period, Kami's heart rate gradually increased, and she was noted to have premature ventricular contractions. Attempts were made to establish intravenous access in the patient's left hand, and she was intubated. The attempt at intravenous access failed. The premature ventricular contractions progressed to ventricular tachycardia, and then ventricular fibrillation. Emergency medical personnel were summoned, but were unable to successfully resuscitate Kami in the physician's office or en route to the hospital emergency room.

During the litigation that followed Kami's death, it was established that the patient's CO2 level was not monitored, and that no intravenous access was established after induction. It was also learned that the anesthesia equipment had not been properly maintained, and that office personnel were not appropriately trained in emergency procedures.

Kami's death provided the impetus for passage of amendments to the Nursing Practice Act and the Medical Practice Act, known as "Kami's Law." Among other things, these statutes charge the Board of Nursing and the Texas Medical Board with responsibility for adopting rules designed to protect the health, safety, and welfare of the public, and to address patient evaluation, patient monitoring, equipment maintenance, and emergency procedures. The legislature directed the Boards to cooperate with each other to eliminate, to the extent possible, conflicts between their rules. TEX. OCC. CODE §§162.102 and 301.602. In that regard, TSA supports the Board of Nursing's efforts to adopt and implement appropriate patient safety procedures in outpatient settings.

Both the number and scope of outpatient procedures are growing rapidly. New techniques, equipment, and pharmaceuticals have made ambulatory and office surgery more feasible, and the current economic environment in which healthcare is delivered, encourages further expansion of office-based outpatient procedures. As technology improves and forces of economic change emphasize cost-efficient ways of delivering healthcare, outpatient procedures – and morbidity and mortality due to errors in the outpatient setting – can be expected to increase as well. Medicare and other healthcare payers have overtly encouraged procedures to be performed in the lowest cost setting. In addition, cosmetic surgical procedures (which are typically not covered by insurance) performed in office settings reduce cost to the patient and provide an attractive direct payment income stream to healthcare providers. These factors have combined to make surgery more likely to occur in the outpatient/office-based setting.

The legislature's purpose in passing Kami's Law was to protect patients by regulating the provision of anesthesia services in outpatient settings. This is best accomplished by establishing uniform guidelines that apply to all regulated medical procedures. For example, the Centers for Medicare and Medicaid Services, in an opinion letter dated November 18, 2013, stated that anesthesia services in Medicare participating hospitals ". . . must be provided in accordance with nationally accepted standards practice, hospital anesthesia service policies and procedures, and must be identical throughout the hospital." (Attached). In other words, whether anesthesia

services are provided by an anesthesiologist, another physician, an anesthesiologist assistant, or a certified registered nurse anesthetist performing a delegated medical act, patient interests are always best served by uniformity in policies and procedures.

CRNAs provide anesthesia services in outpatient settings as delegated medical acts under authority provided by the Medical Practice Act. The Texas Medical Board has recognized a physician's role and responsibilities when providing or delegating anesthesia services in outpatient settings, and has adopted rules establishing minimum acceptable standards. These rules are codified in 22 TAC Chapter 192, and set out in considerable detail standards for outpatient anesthesia services. In doing so, the Medical Board has adopted the American Society of Anesthesiologists ("ASA") descriptions of Levels I – IV anesthesia services, and set minimum standards for pre-anesthesia evaluation, patient monitoring, personnel training, equipment, drugs, and anesthesia techniques. Specifically, the Medical Board has adopted ASA Standards for Post-Anesthesia Care in cases where Levels III and IV anesthesia services are provided. Further, the Medical Board has adopted ASA Basic Standards for Pre-Anesthesia Care, Standards for Basic Anesthesia Monitoring, Standards for Post-Anesthesia Care, Position on Monitored Anesthesia Care, the ASA Physical Status Classification System, Guidelines for Non-Operating Room Anesthetizing Locations, Guidelines for Ambulatory Anesthesia and Surgery, and Guidelines for Office-Based Anesthesia for all cases where Level IV anesthesia services are provided.

The Medical Practice Act and rules adopted by the Texas Medical Board control when and how physicians may delegate the performance of medical acts, including administration of anesthesia, to APRNs. Although CRNAs act within the scope of their license when performing delegated medical acts, the Medical Board is authorized, and has, established standards for outpatient anesthesia that must be followed, regardless of whether the healthcare provider is a physician or CRNA. Otherwise, physicians risk exposure for improper delegation, and patients are subjected to inconsistent standards of care.

In 22 TAC §192.2(b), the Medical Board says:

A physician delegating the provision of anesthesia or anesthesia-related services to a certified registered nurse anesthetist shall be in compliance with ASA standards and guidelines when the certified registered nurse anesthetist provides a service specified in the ASA standards and guidelines to be provided by an anesthesiologist.

In other words, in an outpatient setting, the physician may delegate the provision of anesthesia services to a CRNA, but only if the CRNA follows applicable ASA standards and guidelines.

The Board of Nursing's proposed rules for provision of anesthesia services by nurse anesthetists in certain outpatient settings, at §221.14(b)(1), state that:

“Certified registered nurse anesthetists shall follow current applicable standards and guidelines as put forth by the American Association of Nurse Anesthetists

and other relevant national standards regarding the practice of nurse anesthesia as adopted by the AANA or the Board.”

The proposed rules do not mention ASA Guidelines and Standards. Likewise, at proposed §221.14(c)(1), the CRNA is directed to perform a pre-anesthetic assessment and to prepare the patient for anesthesia per current AANA Standards, not ASA Standards and Guidelines. At §221.14(c)(2)(F), the proposed rule states that a CRNA will monitor and document the patient’s perioperative condition per AANA Standards, and makes no mention of ASA Standards and Guidelines.

A side-by-side comparison of ASA Standards and Guidelines and AANA Standards is virtually impossible, because of the disparate manner in which the organizations present and address what should be similar risks and directives. These differences support TSA’s concerns regarding differing standards of care that cannot be easily reconciled.

But, it is possible to identify some important differences. For example, the Texas Medical Board’s rules for Levels III and IV office-based anesthesia services adopt ASA Standards for Post-Anesthesia Care, and ASA Guidelines for Ambulatory Anesthesia and Surgery. 22 TAC §§192.2(c)(3) and (4). The ASA Standards/Guidelines require the presence of a physician in attendance in the facility until all patients are medically discharged. And, the ASA Standards/Guidelines clearly state that discharge of a patient after anesthesia is a physician’s responsibility. (ASA Guidelines for Ambulatory Anesthesia and Surgery, Section VII. F.; ASA Standards for Post-Anesthesia Care, Standard V.).

AANA Standards for Office-Based Anesthesia Practice, which the Board proposes to adopt, do not require physician presence in the facility until all patients are discharged, and do not place discharge responsibility on a physician. Rather, the AANA standard requires only the presence of a single “qualified provider,” who might be “. . . a surgeon, anesthesia professional, or ACLS-certified registered nurse . . .” until all patients are discharged. (AANA Standards for Office-Based Anesthesia Practice, Standard VII.).

Interestingly, AANA Standards for Office-Based Anesthesia Practice direct the CRNA to determine whether his/her liability insurance provides coverage for office anesthesia. While this “standard” is undoubtedly practical advice, it has little to do with quality of patient care.

The dual standard proposed by the Board harbors risks for its licensees in the future. For example, AANA might amend its standards to say that CRNAs provide outpatient anesthesia independently, without physician delegation. This hypothetical standard would clearly violate Texas law, but would still be part of the Board’s directives to its licensees.

Not only do the Board of Nursing’s proposed rules conflict with those of the Texas Medical Board, they also conflict with rules adopted by the State Board of Dental Examiners, as set out in 22 TAC §§110.1 – 110.6. The Board of Dental Examiners has adopted ASA standards for patient evaluation, regardless of whether the attending dentist personally performs sedation and anesthesia, or if anesthesia services are delegated to a CRNA.

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In an outpatient environment such as a physician's or dentist's office, where emergency medical resources are less available than a hospital or ambulatory surgery center, patient safety is better served by implementation of uniform standards of medical care and procedures. In fact, a higher standard of vigilance and supervision is more appropriate in an office-based setting, precisely because of the lack of additional resources and personnel in the event of an emergency.

The Board of Nursing should modify its rules for delegation of anesthesia services to CRNAs in outpatient settings to conform with the Texas Medical Board's outpatient anesthesia rules, and those adopted by the State Board of Dental Examiners, thus satisfying its legislative directive to eliminate conflicts between the rules. This change would best serve the interests of Texas patients in what is a growing and important area of healthcare delivery.

Thank you for your consideration of these comments. Please advise if you have questions.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'D. Mercier', with a long horizontal stroke extending to the right.

David W. Mercier, M.D.
President