Consideration of Adoption of Proposed Amendments to 22 Tex. Admin. Code Chapter 221, relating to Advanced Practice Nurses, Including Written Comments Received and Results of Public Hearing, if any

Background: Proposed amendments to Chapter 221\(^1\) were approved by the Board at its July 2018 meeting for submission to the Texas Register for public comment. The proposal was published in the Texas Register on October 12, 2018, and the comment period ended on November 12, 2018. The Board received three written comments on the proposal. The Board did not receive any requests for a public hearing. A copy of the written comments received are attached hereto as Attachment “A”.

A summary of the comments received and Staff’s proposed responses are attached as Attachment “B”. Staff recommends making the editorial change to the title of the chapter and some other minor changes to the rule text as adopted.

Board Action: Move to adopt 22 Texas Administrative Code Chapter 221, relating to Advanced Practice Registered Nurses, with changes, as set forth in Attachment “C”. Further, authorize Staff to publish the summary of comments and response to comments attached hereto as Attachment “B”.

\(^1\) Sections §221.2, 221.3, and 221.7 -221.10 were proposed for amendment; new §221.4 and §221.5 were proposed, and existing §221.4 and §221.11 were proposed for repeal. No changes were proposed to §221.1, 221.6, or 221.12 -221.17.
November 4, 2018

Mr. James W Johnston  
Texas Board of Nursing  
Delivery via email to dusty.johnston@bon.texas.gov

Re: Comments on BON Rules 216, 219 and 221

Dear Dusty:

The Coalition for Nurses in Advanced Practice (CNAP) supports the rule amendments proposed in the October 12, 2018, issue of the Texas Register, but suggests a few editorial changes.

Comments on Titles of Chapters 219 and 221

The titles of Chapters 219 and 221 should reflect the new licensure title being proposed in Chapter 221, and the conforming amendments proposed throughout both chapters. CNAP suggests amending the titles by inserting the word, “Registered” so the title of Chapter 219 reads, “Advanced Practice Registered Nurse Education” and the title of Chapter 221 reads “Advanced Practice Registered Nurses”.

Comment on §216.1(2)(A)

For consistency with changes proposed in Chapters 219 and 221, CNAP suggests amending §216.1(2)(A) as follows:

After “practice” and before “nursing”, insert “registered”. This change would be consistent with proposed §219.1(a).

Comments on §221.4(a)(8)(B) and (a)(10)

The term APRN education program is used throughout the proposed rules. Therefore, for consistency, CNAP recommends amending the first line of Paragraph (a)(8)(B) by changing “educational” to “education”. We suggest a similar change in Subdivision (a)(10). At the beginning of the second line, change “educational” to “education”. This would be consistent with the term “education requirement” used in proposed new §221.5(3), and §221.7(d), (f) and (g).

Thank you for considering these comments. If you have any questions, please contact me at lynda.woolbert@gmail.com or by phone at (979) 345-5974.

Sincerely,

Lynda Woolbert, MS, RN, CPNP-PC  
Chief Executive Officer
November 9, 2018

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

Via email to dusty.johnston@bon.texas.gov

Re: Comments on Proposed Rule 22 Tex. Admin. Code §§ 221.2 – 221.5, 221.7 – 221.10 (43 Tex. Reg. 6753)

Dear Mr. Johnston:

The Texas Medical Association (TMA) appreciates the opportunity to provide comments on the Board of Nursing’s (BON) proposed rules in 22 Tex. Admin. Code §§ 221.2 – 221.5, 221.7 – 221.10, as published in the Texas Register on October 12, 2018 (43 TexReg 6753). TMA is a private, voluntary, nonprofit association of more than 51,000 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, its mission is to “Improve the health of all Texans.” TMA’s diverse physician members practice in all fields of medical specialization.

The BON’s proposed rules relate to Advanced Practice Registered Nurses and specifically, are intended to promote “consistency with the Advanced Practice Registered Nurse (APRN) Consensus Model and national nursing licensing standards.” TMA strongly objects to the proposed rules because, while the proposal may be more consistent with the Consensus model, it departs from consistency with state law. In accordance with the objections described below, TMA requests the BON withdraw the proposed rules.

1. Comment 1: General Comment – It is Texas Law—Not the APRN Consensus Model—that the BON Should Follow

The BON declares its purpose in proposing these rules as being “necessary for consistency with the Advanced Practice Registered Nurse Consensus Model.” TMA strongly opposes this effort because the Texas Legislature has not recognized the APRN Consensus Model as the standard for nursing practice and especially because the BON’s proposed rules do not clearly place limits on the applicability of the Consensus Model. Because of fundamental differences between the Consensus Model and Texas law, TMA strongly urges the BON to withdraw these proposed rules.

The APRN Consensus Model provides a definition of an APRN and articulates educational requirements and scopes of services that APRNs in different roles and with different foci provide. In many ways, these standards directly contradict the standards for and scope of APRN practice established by the Texas

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1 43 TexReg 6753.
Legislature, and for this reason alone, the Consensus Model should not be directly followed for nursing regulation in Texas.

For instance and perhaps most significantly, the Consensus Model adopts a position that APRNs are fully “independent practitioners” who must, at their own discretion, “recogniz[e] limits of knowledge and experience.”\(^2\) This wholly contradicts the limitations on scope imposed by the Texas Legislature. The Nursing Practice Act clearly defines the practice of nursing and does not authorize an APRN’s independent practice. That Act instead clearly identifies that many acts performed by APRN require physician delegation and supervision before the APRN can perform them.\(^3\)

As further examples, the Consensus Model adopts a definition of an APRN that includes authority to diagnose and to exercise independent prescriptive authority. As explained above, Texas law expressly omits diagnosis from the scope of the practice of nursing, and Texas law requires that any prescription of medications by an APRN must be done under a prescriptive authority agreement. Here again, the Consensus Model takes positions that are in direct conflict with Texas law.

Because the Consensus Model adopts a position that is so fundamentally different than what Texas law authorizes, it should not be taken as a model for nursing practice in Texas. Even if the Consensus Model standards that the BON proposes to adopt relate only to educational requirements, the mere use of Consensus Model terminology will still cause confusion. Because the BON announces in this rule proposal that it is following the APRN Consensus Model, one might assert that all elements of the Consensus Model apply.

For example, the BON proposes to use the term “APRN role” in rule as part of the designation of a licensed APRN.\(^4\) These “APRN roles” come from and are based on the Consensus Model. But because the proposed rules do not place limits on or more narrowly define an “APRN role” to be limited according to the Nursing Practice Act, the proposed rules could suggest that one’s scope in a particular APRN role is as broad as the role is determined to be under the Consensus Model, which is, as has already been pointed out, directly in conflict with Texas law.

TMA is thus strongly opposed to the use of the APRN Consensus Model as a foundation for the regulation of nursing practice in Texas. Using it will likely lead to confusion and misunderstanding about the authority for an APRN’s scope of practice, suggesting that it is the Consensus Model rather than state law that establishes that scope. TMA accordingly recommends withdrawing these proposed rules.

If the BON chooses not to withdraw the proposed rules, the BON must at least make it clear that use of terminology found in the Consensus Model does not change an APRN’s scope of practice which is statutorily defined, and that an APRN’s scope of practice is still governed by the Nursing Practice Act. This could be accomplished by adding to the proposed rules in Chapter 221 a provision such as the following:

\[(_\_\_)\text{ Nothing in this chapter may be construed as authorizing an APRN to function in any APRN role in a manner that is not expressly authorized under or that is in conflict with Texas law.}\]

\[\textbf{2. Comment 2: General Comment - Texas Law Expressly Withholds from Nurses the Authority to Diagnose}\]

\(2\) See e.g., Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (July 7, 2008), available at: \url{https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf}

\(3\) See Sec. 301.002(2)(G)

\(4\) See e.g., proposed §221.3(a)(4)
Throughout the proposed rules and the preamble to the proposed rules, the BON refers to a nurse’s ability to diagnose or required education requirements that would teach a nurse to diagnose. TMA strongly opposes any proposed rule (and any current rule that the BON is not presently amending) to the extent that it represents that an APRN has the authority to diagnose because such representation is in direct conflict with state law. Thus, if the BON chooses not to withdraw these proposed rules as requested under Comment 1, TMA strongly urges the BON to correct proposed and current rules to be in alignment with Texas law.

The definition of professional nursing in the Nursing Practice Act expressly provides that professional nursing “does not include acts of medical diagnosis.”5 Indeed, to provide a diagnosis is the practice of medicine,6 and unless the Legislature authorizes a health professional to practice some aspect of the practice of medicine, that practice is unauthorized and is outside the scope of practice laid out by the Legislature.7

Despite clear guidance from the Legislature, the BON is proposing and has adopted rules that represent nurses or APRNs as being authorized to diagnose physical conditions. The BON states, for example, at 43 Tex.Reg. 6756, that an “APRN’s scope of practice includes diagnosing and treating patients within the APRN’s authorized role and population focus area.” The BON’s representations about an APRN’s scope of practice directly contradicts state law and also demonstrates the trouble with proposing rules in order to come into alignment with the APRN Consensus Model. By stating that APRNs diagnose and treat within the “authorized role and population focus area”—terms employed by the Consensus Model—the BON appears to be more concerned with what the Consensus Model says than what state law says.

The proposed rules continue by requiring in proposed §221.3(a)(1) that advanced health assessment courses offer “clinical experience such that students gain the knowledge and skills needed to . . . make diagnoses of health status.” It is unclear how an APRN-in-training will gain clinical experience to develop knowledge and skills to diagnose if the APRN or even its course instructors (if they are not physicians) are not authorized to diagnose.

The proposed rules in §221.3(f)(2) would also require the completion of courses in “diagnosis and management of diseases,” which is defined elsewhere as a “course offering both didactic and clinical content in clinical decision-making and aspects of medical diagnosis and medical management of diseases and conditions.”8 Here again, APRNs have no authority under state law to provide medical diagnosis or medical management of diseases, so learning to do these acts is unnecessary and may mislead an APRN-in-training into wrongly believing that diagnosing is within an APRN’s scope of practice in the state of Texas.

In sum, TMA strongly urges the BON, if the BON does not withdraw these rules, to amend any provision of the proposed and current rules that represent that APRNs have or can be trained to have authority to provide acts of medical diagnosis. Further, TMA urges the BON to correct representations made in the rule proposal’s preamble that diagnosis is within an APRN’s scope of practice.

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5 Sec.301.002(2), Occupations Code (emphasis added)
6 Sec. 151.002(13), Occupations Code
7 See Sec. 151.052, Occupations Code.
8 See proposed §219.2(10). Even though the definition in Chapter 219 applies only to that chapter, it is likely that the definition would still roughly describe the required diagnosis and management curriculum. TMA also notes that this part of the definition is not being amended under the BON’s current proposal, but nevertheless objects to the current rule and urges the BON to amend the current rule to align with state law.
3. The BON Must Be More Consistent and Ensure Adherence to Identification Laws With Respect to “Titles” for an APRN.

If the BON chooses to move ahead with these proposed rules against TMA’s strong opposition, the BON should be careful in its proposed rules to ensure that APRNs are properly identified to avoid confusion with other health professionals. TMA offers the following comments on that issue.

   a. Comment 3: §221.2(b) Should Be Amended to Use Consistent Terminology

The proposed rules in §221.2 (titled “APRN Titles and Abbreviations”) states that APRNs are licensed in a number of “roles” and “populations focus areas.” Subsection (b) requires an APRN to use a “licensure title” granted by the Board. Because Subsection (a) describes “roles” and “population focus areas,” it may not be clear what “title” is granted by the board. Accordingly, TMA encourages the BON to amend the proposed rule to ensure that the rule uses consistent terminology so expectations and requirements for self-identification are clear. Ensuring that an APRN properly identify themselves is important, as it will assist patients in knowing more precisely the educational background and qualifications of the health professional providing services to them.

Subsection (b) further states that the APRN must “at a minimum,” use the designation and title granted by the board. It is unclear what other title an APRN might need to use to properly identify themselves or what restrictions there might be on these self-identifying titles. TMA cautions that the BON should not merely set a minimum on identification of APRNs without any clarification of what other titles must be used, so that an APRN could not use a title that might misrepresent the APRNs qualifications or educational background. If an APRN identifies themselves as an APRN with the appropriate role and population focus, there is no need for any further professional identification that could mislead.

Accordingly, TMA recommends that the BON amend the proposed Subsection (b) to read as follows:

   (b) A registered nurse who holds current licensure issued by the Board as an APRN shall [at a minimum,] use the designation "APRN" and the APRN licensure role and population focus area under Subsection (a) [title] granted by the Board.

   b. Comment 4: §221.2(c) Should Be Amended to Use Consistent Terminology

TMA similarly recommends that the BON amend proposed Subsection (c) in order to use consistent terminology. Subsection (c) requires an APRN to use the appropriate “designation.” There is a risk of confusion because the term “designation” is not used in Subsection (a) and because there is no cross-reference to specify whatever “designation” to which the BON is referring. TMA according recommends that the BON amend proposed Subsection (c) as follows:

   (c) When providing care to patients, the APRN shall wear and provide clear identification that indicates the appropriate APRN role and population focus area [designation], as specified by this section.

4. Conclusion

TMA again expresses appreciation for the opportunity to provide comment on these rules, but strongly urges the BON to withdraw these rules. Should you have any questions, please contact Kelly Walla, Associate Vice President and Deputy General Counsel, at kelly.walla@texmed.org or Jared Livingston,

*TMA notes that the current (proposed to be repealed) rules use the term “title.”*
Assistant General Counsel, at jared.livingston@texmed.org. You may also call TMA’s toll free number at 800-880-1300 and request to speak to these association staff members.

Sincerely,

Douglas Curran, MD  
President  
Texas Medical Association
November 8, 2018

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 §§221.2 – 221.5, 221.7 – 221.10  
October 12, 2018 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 National Council of State Boards of Nursing (“NCSBN”) APRN Consensus Model made the basis of the Board’s proposal is not consistent with Texas law and that the proposed rules should be withdrawn.

In the preamble to the proposed rules, the Board makes the following statements:

- The proposed changes, which were discussed and approved by the Committee, are necessary for consistency with the Advanced Practice Registered Nurse (APRN) Consensus Model.

- Section 221.2 addresses titles and abbreviations. The majority of the changes to this section are necessary for consistency with national APRN standards outlined in the APRN Consensus Model. The Consensus Model is the result of work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. The Consensus Model defines APRN practice, describes the APRN regulatory model, identifies and describes ARPN titles, specialties, roles, and population foci, and presents strategies for implementation among states.
• An APRN’s scope of practice includes diagnosing and treating patients within the APRN’s authorized role and population focus area (emphasis added).

Proposed Rule §221.3(f)(2) includes among requirements for APRN training courses described as:

   • • •

(2) Diagnosis and management of diseases and conditions across practice settings, including diseases representative of all systems appropriate to the role and population focus area of licensure. (emphasis added)

The National Council of State Boards of Nursing APRN Consensus Model is a publication developed by the NCSBN that gives the APRN title to four roles of advanced practice nurses and advocates for multi-state licensure and independent practice for APRNs. The Consensus Model seeks conformity among the states, and nursing trade organizations promote the Consensus Model as simple “name change” language and as providing greater uniformity for training requirements. But, the real purpose behind the NCSBN Consensus Model is to advance independent practice for advanced practice nurses, as reflected by statements found on NCSBN’s website and related NCSBN publications:

• Boards of Nursing will:
  • • •
  • License APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;

• APRN Campaign for Consensus: Moving towards uniformity in state laws.

The campaign for consensus is the NCSBN initiative to assist states in aligning their APRN regulation with the major elements of the consensus model for APRN regulation. Those major elements in each of the four roles (CNS, CNP, CRNA, CNM) are:

   • • •

• Title of APRN in one of the described roles;
  • • •
  • Independent practice;
  • Independent prescribing.

• Independent: no requirement for a written collaborative agreement, no supervision, no conditions for practice.
• Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci.

• APRNs are licensed independent practitioners who are expected to practice with standards established or recognized by a licensing body.

Among the stated purposes of the Consensus Model is improving patient access to care by allowing APRNs to practice without physician supervision, collaboration or oversight. Recent studies include findings contrary to the stated purposes of the NCSBN APRN Consensus Model.

The U.S. Department of Veterans Affairs’ Internal Quality Enhancement Research Initiative Study titled “Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses” raised questions about the safety of nurse-only care, finding evidence supporting a conclusion of equal outcomes with or without physician participation ranged from “insufficient” to “low”.

• Recent publications promoting over-riding state scope-of-practice laws argue that a large body of evidence shows APRNs working independently provide the same quality of care as medical doctors. We found scarce long-term evidence to justify this position.¹

By way of example, several recent studies have examined the impact of state Medicare opt-out policies on access and costs of surgeries and other procedures requiring anesthesia services. In 2001, the federal government issued rules allowing states to opt out of Medicare’s requirement that a physician supervise the administration of anesthesia by a nurse anesthetist. Seventeen states have followed the option, citing increased access to anesthesia care and cost control as the primary reasons.

Schneider, et al² studied data for inpatient and outpatient surgeries, both before and after opt-out and compared these data sets to non-opt-out states. The Study found no evidence to support the belief that access to anesthesia services improved by increasing the scope of practice of nurse anesthetists. Likewise, there was no significant reduction in cost attributable to the elimination of physician participation.

The NCSBN website includes an “APRN Consensus Toolkit”, featuring talking points, tips on communicating with legislators, scope of practice publications supporting APRN independent practice, promotional videos, sample form letters (see attached) and a handbook for legislators that includes this statement:

• An APRN accepts responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which includes the

¹ McCleery E, Christensen V, Peterson K, Humphrey L, Liefland M. Evidence Brief: The Quality of Care Provided by Advanced Practice Registered Nurses, VA-ESP Project #09-199, 2014.
administration and prescription of pharmacologic and non-pharmacologic inventions (emphasis added).

1. The Texas 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.

2. Advanced Practices Registered Nurses do not practice independently in Texas and the Board's endorsement and adoption of the APRN Consensus Model is inconsistent with Texas law.

The Medical Practice Act allows physicians to delegate medical acts to non-physicians under certain circumstances. When considering delegation of medical acts to an APRN, the Medical Practice Act provides a two-step analysis. Texas Occupations Code, Section 157.001. General Authority of Physician to Delegate reads in part:

(a) A physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician:

(1) the act:

   (A) can be properly and safely performed by the person to whom the medical act is delegated;

   (B) is performed in its customary manner; and

   (C) is not in violation of any other statute; and
(2) the person to whom the delegation is made does not represent to the public that the person is authorized to practice medicine.

(b) the delegating physician remains responsible for the medical acts of the person performing the delegated medical acts.

c) The Board may determine whether:

(1) An act constitutes the practice of medicine, not inconsistent with this chapter; and

(2) A medical act may be properly or safely delegated by physicians.

... 

The Medical Practice Act includes numerous examples of the Texas Legislature’s clear intent that APRNs perform medical acts only when those acts are delegated by a physician and performed under adequate physician supervision or a prescriptive authority agreement.  

The scope of “professional nursing” includes performance of those medical acts delegated under authority of the Medical Practice Act.  Thus, when an APRN performs a medical act pursuant to a physician order, the APRN is providing a service within the scope of professional nursing. A physician who delegates performance of medical acts to a person whom the physician knows or should know is unqualified to perform the acts or who fails to supervise adequately the activities of those acting under the physician’s delegated authority may be disciplined.

It is sometimes difficult to reconcile rules adopted by the Texas Medical Board and the Board of Nursing when evaluating scope of practice issues. In 1999, former Texas Attorney General John Cornyn issued Opinion No. JC-0117 in response to a question posed by the Board of Nursing. In submitting the issue, the executive director of the Board of Nursing stated that the Board “for many years” had considered the selection and administration of anesthesia and the care of an anesthetized patient by a certified registered nurse anesthetist to be the practice of professional nursing rather than the delegated practice of medicine “requiring oversight/supervision by a physician.”

Attorney General Cornyn concluded that the Board of Nursing’s interpretation of the laws pertaining to physician delegation of administration of anesthesia to a CRNA was partially correct and partially incorrect. After providing a detailed discussion of statutes, case law and previous attorney generals’ opinions, the Attorney General determined that CRNAs administer anesthesia only by virtue of delegation from a physician. The Medical Practice Act does not require that a  

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4 Tex. Occ. Code § 301.002(2)(C), (F), (G)
5 Tex. Occ. Code § 164.053(a)(8)(9)
6 Letter from Penny Puryear Burt, of counsel, Board of Nurse Examiners for the State of Texas, to Honorable Dan Morales, Attorney General (June 5, 1998)
physician directly supervise the CRNA’s selection and administration of anesthesia, and the extent of physician involvement after delegation is based on the physician’s professional judgment in light of standard of care, other federal and state laws, facility policies, medical staff bylaws, and ethical standards. “While Section 157.058 authorizes a physician to delegate to a CRNA without requiring direct physician oversight, a physician is never required to do so. If a physician is concerned about a CRNA’s ability to perform a delegated task or simply wishes to limit the delegation, the physician retains the authority to refrain from delegating to or to limit the delegation.”

The nature of a physician’s responsibilities for medical acts delegated to a CRNA is discussed at length in the opinion. The Attorney General noted that when a CRNA performs a delegated medical act, there is necessarily some overlap between the practice of medicine and the practice of nursing. “[T]hese tasks are within the practice of nursing for a CRNA, but only when the tasks are properly delegated to the CRNA by a physician.”

The term “delegate” is not defined in the Medical Practice Act, and the Attorney General drew on other sources to state “...the term ‘delegate’ denotes a deputization of one person, e.g., a CRNA, to act as the agent of the other, e.g., the physician.” While concluding that the Medical Practice Act does not require a physician to directly supervise a CRNA in the performance of delegated anesthesia-related tasks, the Attorney General noted “...nor does it absolve a physician of responsibility for an imprudent delegation.”

One case classification that differs from the analysis provided by Attorney General Cornyn concerns Medicare patients. Currently, federal regulations limiting Medicare coverage and conditioning hospital participation in Medicare and Medicaid programs require a CRNA to be supervised by a physician when the CRNA administers anesthesia. 8

The Texas Board of Nursing has been a participant in developing the NCSBN APRN Consensus Model and NCSBN APRN Compact for many years, and its executive director has served on the NCSBN APRN Committee for much of that time. The organizations involved in developing the NCSBN Consensus Model include 68 nursing trade organizations and four state nursing licensing agencies (Kentucky, Pennsylvania, Texas and Utah). According to the NCSBN website, two of those states (Kentucky and Utah) have allowed independent practice by APRNs and one (Utah) has approved independent prescribing. The extent of the Board’s involvement in the NCSBN process may be considered by some to raise questions of conflict of interest, since the APRN Consensus Model and APRN Compact would supersede Texas laws that require APRNs to practice under physician supervision, collaboration or oversight. Under the APRN Compact, an APRN issued a multistate license “...is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate license privilege.”

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8 42 CFR § § 416.42(b)(2), 482.52(a)(4), 485.639(c)(1)(v), (2)
9 APRN Compact, Article III, Section h (emphasis added)
The NCSBN APRN Compact represents the ultimate goal of APRNs to achieve multi-state independent practice, free from individual state licensing laws and regulations and physician oversight. This model legislation is much different and much more radical than The Nurse Licensing Compact, adopted by the Texas legislature in 2017. Even so, the legislature specifically stated that any rule adopted by the interstate Commission on Nurse Licensing Compact administers that conflicts with the scope of practice of a Texas nursing license is unenforceable. In 2007, the Texas Legislature adopted a version of the APRN Compact. The Legislature chose to omit Article III of the compact because it allowed independent practice and conflicted with Texas law. The irreconcilable differences between the APRN Compact and Texas law have been recognized by the Board and its Executive Director. The Legislature’s uncertainty about the NCSBN APRN Compact is illustrated by the fact that Chapter 305 of the Occupations Code expired in 2011 and is no longer law in Texas.

Three states have adopted the NCSBN ARPN Compact. Four states considered bills in 2018 that would have adopted the Compact, and all failed to pass.

In conclusion, the Texas Society of Anesthesiologists opposes the proposed rules and urges the Board to withdraw them because they conflict with Texas law.

Thank you for your consideration. Please advise if you have questions.

Sincerely yours,

G. Ray Callas, M.D., FASA
President

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10 Tex. Occ. Code §304.005-304.008
11 Tex. Occ. Code §304.0025
13 Board of Nursing Meeting date April 16-17, 2015 (Agenda Item :7.6)
14 Iowa, Minnesota, Nebraska and West Virginia
A commenter representing the Texas Medical Association (TMA) states that TMA objects to the proposed rules because, while the proposal may be more consistent with the APRN Consensus Model, it departs from consistency with state law. The commenter states that the Texas Legislature has not recognized the Consensus Model as the standard for nursing practice and the Board's proposed rules do not clearly place limits on the applicability of the Consensus Model. Because of fundamental differences between the Consensus Model and Texas law, TMA strongly urges the Board to withdraw the proposed rules.

The commenter states that the Consensus Model provides a definition of an APRN and articulates educational requirements and scopes of services that APRNs in different roles and with different foci provide. In many ways, these standards directly contradict the standards for and scope of APRN practice established by the Texas Legislature, and for this reason alone, the commenter states that the Consensus Model should not be directly followed for nursing regulation in Texas. For instance, the commenter states that the Consensus Model adopts a position that APRNs are fully independent practitioners who must, at their own discretion, recognize limits of knowledge and experience. The commenter states that this wholly contradicts the limitations on scope imposed by the Texas Legislature. The Nursing Practice Act (NPA) clearly defines the practice of nursing and does not authorize an APRN’s independent practice. The NPA instead clearly
identifies that many acts performed by APRNs require physician delegation and supervision before the APRN can perform them.

As further examples, the commenter states that the Consensus Model adopts a definition of an APRN that includes authority to diagnose and to exercise independent prescriptive authority. The commenter further states that Texas law expressly omits diagnosis from the scope of the practice of nursing, and Texas law requires that any prescription of medications by an APRN must be done under a prescriptive authority agreement. Here again, the commenter states, the Consensus Mode takes positions that are in direct conflict with Texas law.

The commenter continues by stating that, because the Consensus Model adopts a position that is so fundamentally different than what Texas law authorizes, it should not be taken as a model for nursing practice in Texas. Even if the Consensus Model standards that the Board proposes to adopt relate only to educational requirements, the commenter states that the mere use of Consensus Model terminology will still cause confusion. The commenter states that because the Board announces in this rule proposal that it is following the Consensus Model, one might assert that all elements of the Consensus Model apply.

For example, the Board proposes to use the term “APRN role” in rule as part of the designation of a licensed APRN. The commenter states that these “APRN roles” come from and are based on the Consensus Model. Because the proposed rules do not place limits on or more narrowly define an “APRN role” to be limited according to the NPA, the commenter states that the proposed rules could suggest that one’s scope in a particular
APRN role is as broad as the role is determined to be under the Consensus Model, which is, as has already been pointed out, directly in conflict with Texas law.

The commenter continues by stating it is strongly opposed to the use of the APRN Consensus Model as a foundation for the regulation of nursing practice in Texas. Using it will likely lead to confusion and misunderstanding about the authority for an APRN’s scope of practice, suggesting that it is the Consensus Model, rather than state law, that establishes that scope. TMA accordingly recommends that the Board withdraw the proposed rules. Alternatively, TMA states, that if the Board chooses not to withdraw the proposed rules, the Board must at least make it clear that use of terminology found in the Consensus Model does not change an APRN’s scope of practice which is statutorily defined, and that an APRN’s scope of practice is still governed by the NPA. The commenter recommends adding clarifying language to the rule in this regard.

A commenter representing the Texas Society of Anesthesiologists (TSA) states that the National Council of State Boards of Nursing ("NCSBN") APRN Consensus Model made the basis of the Board's proposal is not consistent with Texas law and that the proposed rules should be withdrawn. The commenter states that the Consensus Model is a publication developed by the NCSBN that gives the APRN title to four roles of advanced practice nurses and advocates for multi-state licensure and independent practice for APRNs. The Consensus Model seeks conformity among the states, and nursing trade organizations promote the Consensus Model as simple "name change" language and as providing greater uniformity for training requirements. But, the real purpose behind the NCSBN Consensus Model, the commenter states, is to advance independent practice for advanced practice nurses, as reflected by statements found on
NCSBN’s website and related NCSBN publications. The commenter continues by stating that, among the stated purposes of the Consensus Model is improving patient access to care by allowing APRNs to practice without physician supervision, collaboration or oversight. The commenter states that recent studies include findings contrary to the stated purposes of the NCSBN Consensus Model. The commenter state that the U.S. Department of Veterans Affairs’ Internal Quality Enhancement Research Initiative Study titled "Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses" raised questions about the safety of nurse-only care, finding evidence supporting a conclusion of equal outcomes with or without physician participation ranged from "insufficient" to "low". Recent publications promoting over-riding state scope-of-practice laws argue that a large body of evidence shows APRNs working independently provide the same quality of care as medical doctors, but the commenter states that TSA found scarce long term evidence to justify this position. The commenter goes on to say that, by way of example, several recent studies have examined the impact of state Medicare opt-out policies on access and costs of surgeries and other procedures requiring anesthesia services. In 2001, the federal government issued rules allowing states to opt out of Medicare's requirement that a physician supervise the administration of anesthesia by a nurse anesthetist. Seventeen states have followed the option, citing increased access to anesthesia care and cost control as the primary reasons. Schneider studied data for inpatient and outpatient surgeries, both before and after opt-out, and compared these data sets to non-opt-out states. The study found no evidence to support the belief that access to anesthesia services improved by increasing the scope of practice of nurse anesthetists. Likewise, there was no significant reduction in cost attributable to the
elimination of physician participation.

The commenter continues by stating that the NCSBN website includes an "APRN Consensus Toolkit", featuring talking points, tips on communicating with legislators, scope of practice publications supporting APRN independent practice, promotional videos, sample form letters, and a handbook for legislators.

General Comments - Diagnosis

A commenter representing TMA states that, throughout the proposed rules and the preamble to the proposed rules, the Board refers to a nurse’s ability to diagnose or required education requirements that would teach a nurse to diagnose. TMA strongly opposes any proposed rule to the extent that it represents that an APRN has the authority to diagnose because such representation is in direct conflict with state law. Thus, the commenter states that if the Board chooses not to withdraw these proposed rules, TMA strongly urges the Board to align the proposed rules with Texas law.

The commenter states that the definition of professional nursing in the NPA expressly provides that professional nursing “does not include acts of medical diagnosis.” Indeed, to provide a diagnosis is the practice of medicine, and unless the Legislature authorizes a health professional to practice some aspect of the practice of medicine, that practice is unauthorized and is outside the scope of practice laid out by the Legislature. The commenter states that, despite clear guidance from the Legislature, the Board is proposing and has adopted rules that represent nurses or APRNs as being authorized to diagnose physical conditions. For example, the Board states that an APRN’s scope of practice includes diagnosing and treating patients within the APRN’s authorized role and population focus area. The commenter states that the Board’s representations about an
APRN’s scope of practice directly contradicts state law and also demonstrates the trouble with proposing rules in order to come into alignment with the Consensus Model. By stating that APRNs diagnose and treat within the “authorized role and population focus area”—terms employed by the Consensus Model—the Board appears to be more concerned with what the Consensus Model says than what state law says.

Further, the commenter states that the proposed rules require in proposed §221.3(a)(1), that advanced health assessment courses offer “clinical experience such that students gain the knowledge and skills needed to . . . make diagnoses of health status.” The commenter states that it is unclear how an APRN-in-training will gain clinical experience to develop knowledge and skills to diagnose if the APRN or even its course instructors (if they are not physicians) are not authorized to diagnose. The commenter states that the proposed rules in §221.3(f)(2) would also require the completion of courses in “diagnosis and management of diseases,” which is defined elsewhere as a “course offering both didactic and clinical content in clinical decision-making and aspects of medical diagnosis and medical management of diseases and conditions.” The commenter re-iterates that APRNs have no authority under state law to provide medical diagnosis or medical management of diseases, so learning to do these acts is unnecessary and may mislead an APRN-in-training into wrongly believing that diagnosing is within an APRN’s scope of practice in the state of Texas. TMA again strongly urges the Board to withdraw the proposed rules, but if the Board does not withdraw the rules, the commenter recommends amending its rules that represent that APRNs have or can be trained to have authority to provide acts of medical diagnosis. Further, TMA urges the Board to
correct representations made in the rule proposal’s preamble that diagnosis is within an APRN’s scope of practice.

A commenter representing TSA states that the NPA prohibits the Board from adopting rules that expand the scope of practice of APRNs to include diagnosis of medical conditions. The commenter states that §301.151 of the Texas Occupations Code says the Board may adopt and enforce rules consistent with the NPA. Section 301.152 authorizes the Board to adopt rules for licensure of registered nurses as ARPNs and provides guidance for education, training, and prescriptive authority requirements. Absent from the authorizing statute is any reference to medical diagnosis. The commenter states that, for good reason, §301.002 of the NPA, defining "Professional Nursing," 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 APRNs, but medical diagnosis is noticeably absent and expressly excluded. The commenter continues by stating that §301.002(2)(G) of the NPA states that a nurse licensed by the Board may perform medical acts delegated by a physician under authority provided by the Medical Practice Act (Occupations 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 commenter states that APRNs do not practice independently in Texas and the Board's endorsement and adoption of the Consensus Model is inconsistent with Texas law. The Medical Practice Act allows physicians to delegate medical acts to non-physicians under certain circumstances. When considering delegation of medical acts to an APRN, the commenter states that the Medical Practice Act provides a two-step
analysis. The commenter states that the Medical Practice Act includes numerous examples of the Texas Legislature's clear intent that APRNs perform medical acts only when those acts are delegated by a physician and performed under adequate physician supervision or a prescriptive authority agreement. The scope of "professional nursing" includes performance of those medical acts delegated under authority of the Medical Practice Act. The commenter goes on to say that, when an APRN performs a medical act pursuant to a physician order, the APRN is providing a service within the scope of professional nursing. A physician who delegates performance of medical acts to a person whom the physician knows or should know is unqualified to perform the acts or who fails to supervise adequately the activities of those acting under the physician's delegated authority may be disciplined. The commenter states that it is sometimes difficult to reconcile rules adopted by the Texas Medical Board and the Board when evaluating scope of practice issues. The commenter refers to a 1999 Texas Attorney General Opinion, Opinion No. JC-0117, issued by John Cornyn, in which the commenter states that the Attorney General determined that CRNAs administer anesthesia only by virtue of delegation from a physician. The Medical Practice Act does not require that a physician directly supervise the CRNA's selection and administration of anesthesia, and the extent of physician involvement after delegation is based on the physician's professional judgment in light of the standard of care, other federal and state laws, facility policies, medical staff bylaws, and ethical standards. While Section 157.058 authorizes a physician to delegate to a CRNA without requiring direct physician oversight, a physician is never required to do so. If a physician is concerned about a CRNA's ability to perform a delegated task or simply wishes to limit the delegation, the physician retains the authority
to refrain from delegating to or to limit the delegation. The commenter states that the nature of a physician's responsibilities for medical acts delegated to a CRNA is discussed at length in the opinion. The commenter states that the Attorney General noted that when a CRNA performs a delegated medical act, there is necessarily some overlap between the practice of medicine and the practice of nursing. "[T]hese tasks are within the practice of nursing for a CRNA, but only when the tasks are properly delegated to the CRNA by a physician."

The commenter goes on to state that the term "delegate" is not defined in the Medical Practice Act, and the Attorney General drew on other sources to state "... the term 'delegate' denotes a deputization of one person, e.g., a CRNA, to act as the agent of the other, e.g., the physician." While concluding that the Medical Practice Act does not require a physician to directly supervise a CRNA in the performance of delegated anesthesia-related tasks, the Attorney General noted "... nor does it absolve a physician of responsibility for an imprudent delegation." One case classification that differs from the analysis provided by Attorney General Cornyn concerns Medicare patients. Currently, federal regulations limiting Medicare coverage and conditioning hospital participation in Medicare and Medicaid programs require a CRNA to be supervised by a physician when the CRNA administers anesthesia.

The commenter continues by re-iterating that the Board has been a participant in developing the Consensus Model and APRN Compact for many years, and its Executive Director has served on the NCSBN APRN Committee for much of that time. The organizations involved in developing the NCSBN Consensus Model include 68 nursing trade organizations and four state nursing licensing agencies (Kentucky, Pennsylvania,
Texas and Utah). According to the NCSBN website, two of those states (Kentucky and Utah) have allowed independent practice by APRNs and one (Utah) has approved independent prescribing. The extent of the Board’s involvement in the NCSBN process may be considered by some to raise questions of conflict of interest, since the Consensus Model and APRN Compact would supersede Texas laws that require APRNs to practice under physician supervision, collaboration or oversight.

Under the APRN Compact, the commenter states, an APRN issued a multi-state license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multi-state license privilege. The commenter states that the APRN Compact represents the ultimate goal of APRNs to achieve multi-state independent practice, free from individual state licensing laws and regulations and physician oversight. This model legislation is much different and much more radical than the Nurse Licensing Compact, adopted by the Texas legislature in 2017. Even so, the legislature specifically stated that any rule adopted by the interstate Commission on Nurse Licensing Compact administers that conflicts with the scope of practice of a Texas nursing license is unenforceable. In 2007, the Texas Legislature adopted a version of the APRN Compact. The Legislature chose to omit Article III of the compact because it allowed independent practice and conflicted with Texas law. The irreconcilable differences between the APRN Compact and Texas law have been recognized by the Board and its Executive Director. The commenter states that the Legislature’s uncertainty about the NCSBN APRN Compact is illustrated by the fact that Chapter 305 of the Occupations Code expired in 2011 and is
no longer law in Texas. Three states have adopted the NCSBN ARPN Compact. Four states considered bills in 2018 that would have adopted the Compact, and all failed to pass. The commenter concludes by stating that TSA opposes the proposed rules and urges the Board to withdraw them because they conflict with Texas law.

**Agency Response to General Comments Regarding Definitions, the APRN Consensus Model, and Diagnosis:** The Board respectfully declines to withdraw the proposed amendments, as urged by the commenters. The Consensus Model was developed by the National Council of State Boards of Nursing as a uniform model of national nursing standards for APRNs. The Consensus Model was intended to address existing licensing inconsistencies among states, which can limit the mobility of APRNs and in turn, affect the availability of competent healthcare providers. However, the Board recognizes that its provisions are only suggestive and are not controlling law in the state of Texas, particularly where the Model’s provisions conflict with existing state statute. This is not a situation unique to Texas, as other states must also consider the provisions of the Consensus Model in conjunction with their own controlling state laws.

The commenters express a great deal of concern over the Board’s reference to the Consensus Model in its preamble to the proposed rules. To the extent that the provisions of the Consensus Model are consistent with state law, the Board believes alignment with national licensing standards is a necessary and appropriate step in alleviating unnecessary licensure burdens for qualified and competent practitioners. However, neither the Board’s preamble nor the Board’s proposed rules contain provisions that contradict existing state statute. In fact, the Board has not proposed any rule
amendment that authorizes the independent practice of APRNs in Texas, implies independent practice, or that changes the existing authorized scope of practice for an APRN, the existing standards of nursing practice for an APRN, or the requirements of the Medical Practice Act that relate to physician delegation, collaboration, supervision, or prescriptive authority.

A commenter states that the Medical Practice Act includes numerous examples of the Texas Legislature’s clear intent that APRNs perform medical acts only when those acts are delegated by a physician and performed under adequate physician supervision or a prescriptive authority agreement. The Board does not disagree, nor has the Board proposed any amendment that would alter this interpretation of Texas law. The Board agrees that an APRN may only perform medical aspects of care through proper physician delegation, supervision, and collaboration. The Board also agrees than an individual must be properly educated and qualified to perform such delegated functions. If that were not the case, patient safety would be at optimum risk. As such, an APRN who receives delegated authority from a physician to perform medical aspects of care, to include prescribing medications through a prescriptive authority agreement, must be sufficiently educated to perform such delegated tasks. Physicians routinely delegate medical aspects of care to APRNs. If it were not so, an APRN could never issue a prescription under a prescriptive authority agreement because the APRN would not be able to diagnosis the underlying medical condition that the prescription was meant to treat. It is inconsistent, then, to state, on one hand, that a physician may delegate medical aspects of care to a qualified APRN, including diagnosis of the condition(s) for which the APRN will be issuing prescriptions under a prescriptive authority agreement,
while, on the other hand, stating that the APRN cannot obtain the educational foundation in order to perform the medical aspects of care being delegated to him/her. The proposal does not imply that an APRN may provide medical aspects of care independent of proper physician delegation, supervision, and collaboration. Rather, when an APRN is delegated medical aspects of care, he/she must be appropriately educated and trained to safely execute the delegated tasks. ARPN educational programs are meant to ensure that APRN graduates are safe and competent to do just that. The Board's proposal does not expand an APRN's authorized scope of practice or alter the existing law in Texas in this regard.

To this end, the Board re-iterates that its reference to the Consensus Model in the preamble to the rule proposal should not be construed to mean that all elements of the Consensus Model apply in Texas or that an APRN may function in a manner that is not expressly authorized under, or is in conflict with, Texas law. The Board does not believe the proposed rules are confusing or misleading in this regard, and therefore, declines to include additional language in the rule text as adopted to clarify the same. Further, the Board re-iterates that the proposed amendments are consistent with existing state law and do not contradict any provision of the NPA or the Medical Practice Act.

*General Comments – Titles*

A commenter representing TMA states that it should be careful in its proposed rules to ensure that APRNs are properly identified to avoid confusion with other health professionals. The commenter states that that APRNs are licensed in a number of “roles” and “populations focus areas.” Section 221.2(b) requires an APRN to use a
licensure title” granted by the Board. Because §221.2(a) describes “roles” and “population focus areas,” the commenter states that it may not be clear what “title” is granted by the Board. Accordingly, TMA encourages the Board to amend the proposed rule to ensure that the rule uses consistent terminology so expectations and requirements for self-identification are clear. Ensuring that an APRN properly identify themselves is important, as it will assist patients in knowing more precisely the educational background and qualifications of the health professional providing services to them.

The commenter further states that §221.2(b) states that the APRN must “at a minimum,” use the designation and title granted by the Board. The commenter states that it is unclear what other title an APRN might need to use to properly identify themselves or what restrictions there might be on these self-identifying titles. TMA cautions that the Board should not merely set a minimum on identification of APRNs without any clarification of what other titles must be used, so that an APRN could not use a title that might misrepresent the APRN’s qualifications or educational background. If an APRN identifies themselves as an APRN with the appropriate role and population focus, there is no need for any further professional identification that could mislead. The commenter suggests amending subsection (b) to eliminate the phrase ‘as a minimum’, along with other editorial changes.

The commenter also recommends that the Board amend §221.2(c) in order to use consistent terminology. Subsection (c) requires an APRN to use the appropriate “designation.” There is a risk of confusion because the term “designation” is not used in subsection (a) and because there is no cross-reference to specify the “designation” to which the BON is referring. TMA recommends editorial changes to subsection (c).
Agency Response to Comment: The Board agrees and has made changes to the rule text as adopted to clarify subsections (b) and (c).

General Comments - Title of Section

Summary of Comment: A commenter representing the Coalition for Nurses in Advanced Practice recommends amending the title of the chapter by inserting the word “Registered” so the title reads “Advanced Practice Registered Nurses”.

Agency Response to Comment: The Board agrees and has made the recommended change to the rule text as adopted.

Comments Regarding §221.4(a)(8)(B) and (a)(10)

Summary of Comment: A commenter representing the Coalition for Nurses in Advanced Practice recommends amending the first line of (a)(8)(B) by changing “educational” to “education”. The commenter recommends a similar change to (a)(10) by changing “educational” to “education” at the beginning of the second line. These changes are consistent with the use of the term “education requirement” used in proposed new §221.5(3), and §221.7(d), (f) and (g).

Agency Response to Comment: The Board agrees and has made the recommended change to the rule text as adopted.
Chapter 221. Advanced Practice Registered Nurses.

§221.2. APRN Titles and Abbreviations

(a) An advanced practice registered nurse (APRN) must be licensed in one or more of the following roles and population focus areas:

(1) Roles:

(A) Certified Nurse-Midwife (CNM);

(B) Certified Nurse Practitioner (CNP);

(C) Certified Registered Nurse Anesthetist (CRNA); and/or

(D) Clinical Nurse Specialist (CNS);

(2) Population focus areas:

(A) Adult-gerontology:

   (i) Acute care; and/or

   (ii) Primary care;

(B) Family/individual across the lifespan;

(C) Neonatal;

(D) Pediatrics:

   (i) Acute care; and/or

   (ii) Primary care;

(E) Psychiatric/mental health; and/or

(F) Women’s health/ gender-related.

(b) A registered nurse who holds current licensure issued by the Board as an...
APRN shall, at a minimum, use the designation “APRN” and the APRN licensure title, which consists of the current role and population focus area, granted by the Board.

(c) When providing care to patients, the APRN shall wear and provide clear identification that indicates the current appropriate APRN designation and licensure title being utilized by the APRN, as specified by this section. An APRN may also include additional certifications or educational credentials in his/her identification, so long as the certifications and/or credentials are current, accurate, and not misleading as to their meaning.

§221.4. Licensure as an APRN.

(a) Application for Initial Licensure as an APRN.

(8) An applicant must attest, on forms provided by the Board, to having completed a minimum of 400 hours of current practice with the last 24 calendar months in the APRN role and population focus area for which the applicant is applying, unless the applicant has completed an APRN education program in the advanced practice role and population focus area within the last 24 calendar months.

(A) If less than four years, but more than two years, have lapsed since completion of the APRN education program, and/or the applicant does not have 400 hours of current practice in the APRN role and population focus area during the previous 24 calendar months, the APRN shall be required to demonstrate proof of completion of 400 hours of current practice obtained under the direct supervision of a qualified preceptor who meets the requirements of §221.10 of this chapter (relating to Reactivation or Reinstatement of APRN Licensure).
(B) If more than four years have lapsed since completion of the APRN education program, and/or the applicant has not practiced in the APRN role during the previous four years, the applicant shall successfully complete a refresher course or extensive orientation in the appropriate APRN role and population focus area that includes a supervised clinical component by a qualified preceptor who meets the requirements of §221.10 of this chapter.

(10) APRN applicants who wish to practice in more than one role and/or population focus area shall complete additional education in the desired area(s) of licensure in compliance with the education requirements set forth in this chapter and meet all requirements for licensure in each additional role or population focus area. To apply for licensure for more than one role and/or population focus area, the applicant shall submit a separate application and fee for each desired role and/or population focus area. Additional licensure is required for those licensed APRNs seeking to include an additional:

(A) APRN role and population focus area;
(B) Population focus area within the same APRN role; or
(C) APRN role within the same population focus area.