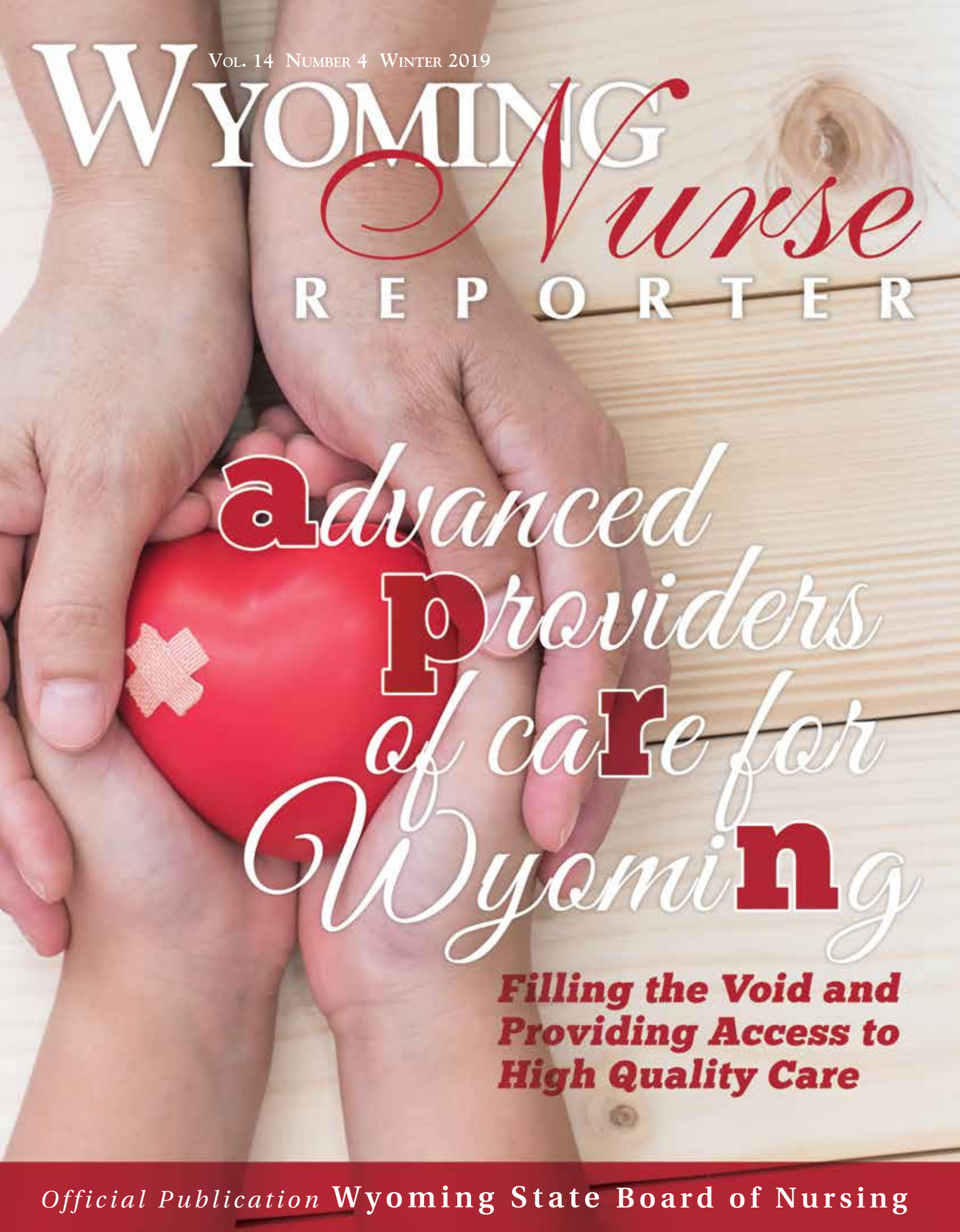
Vol. 14 Number 4 Winter 2019

# Wyoming Nurse Reporter



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# Wyoming Nurse Reporter

Winter 2019 • Vol. 14 Number 4


"Serving and safeguarding the people of Wyoming through the regulation of nursing education and practice"


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**Mission:** *To serve and safeguard the people of Wyoming through the regulation of nursing education and practice.*

**Vision Statement:** *Acknowledging the dynamic nature of healthcare, provides the climate, collaboration and regulatory framework for nurses to practice to the fullest extent of their scope.*

**Values:** *Excellence, Ethics, Education, Safety and Competence.*




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# Greetings

Cynthia LaBonde, MN, RN
*Executive Director*

## 2018 RENEWAL PERIOD ended December 31, 2018

When you receive this winter edition of the Wyoming Nurse Reporter, the 2018 renewal period will have closed. We received a large number of phone calls during the renewal period regarding the renewal process. The most frequent questions were related to the multi-state or compact license. Specifically, nurses asked if they needed to renew the single-state Wyoming license they were issued prior to Wyoming adopting the compact if they hold an active multi-state license in another compact state. The answer was "No, you do not need to renew your Wyoming single-state license as the active multi-state license issued by your state of primary residence grants you the privilege to practice nursing in Wyoming, as Wyoming is a part of the compact!"

## ADVANCED PRACTICE REGISTERED NURSES (APRNS) and ACCESS to CARE

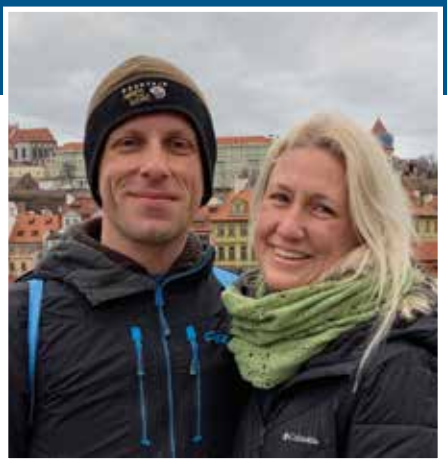
Headlines indicate we have a shortage of primary care practitioners in the United States. Advanced Practice Registered Nurses can fill those voids. A recent on-line article (March 13, 2018) titled, "How Nurse Practitioners Are Filling the Gaps in Healthcare" indicates nurse practitioners are more likely to practice in rural and underserved areas. APRNs are drawn to states like Wyoming, Idaho and North Dakota as they are able to practice independently and to the full extent of their education and population foci. As of January 1, 2018 WSBN licensed 849 APRNs. In 2008, there were 100 licensed APRNs. APRN numbers in Wyoming continue to grow as new positions for APRNs are identified.

## LOOKING FORWARD to the NEXT LEGISLATIVE SESSION

Wyoming's next Legislative session begins January 8, 2019. WSBN is tracking proposed bills which may relate to or affect nursing regulation. 19LSO-157, the "Controlled Substances Education and Administration" bill is on our radar and was written in response to inquiries of the Wyoming Joint Opioid Task Force which convened on multiple occasions in 2018. If 19LSO-157 passes as proposed, the bill will require, in addition to any other qualifications for renewal of licenses or certificates under this section, three (3) hours of continuing education related to the responsible prescribing of controlled substances or treatment of substance abuse disorders every two (2) years. Stay tuned…

# APRN Specialty Education & Certification

By Wesley Davis, DNP, ENP-C, FNP-C, AGACNP-BC, CEN
Emergency Nurse Practitioner Specialty
Coordinator & Assistant Professor
University of South Alabama College of Nursing
President-elect, Wyoming Council
for Advanced Practice Nurses



Advanced Practice Registered Nurse (APRN) education has evolved into a system consisting of APRN roles (nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist) and population foci (family nurse practitioner, neonatal nurse practitioner, etc.). This educational model prepares graduates for advanced nursing practice as direct care providers within a focused population of care. The population foci is not only defined by diagnosis and age, but also by acuity and type of care needed.

Although not required, an individual APRN may obtain an optional specialty certification. APRN specialty areas must build on the APRN role and population foci competencies. APRNs may enhance their competencies by learning additional skills and procedures within their population foci through additional specialty didactic education and supervised clinical practice. For example, the family nurse practitioner (FNP), through validation of previous APRN experience or by completing a formal educational program, may take the Emergency Nurse Practitioner (ENP) specialty certification exam offered by the American Academy of Nurse Practitioners Certification Board. The ENP specialty certification demonstrates additional knowledge and expertise in a more discrete area of the FNP population foci.

APRN specialty education and certification cannot expand one's scope of practice beyond the role or population foci. For example, since primary care of infants is within their scope of practice, a pediatric or family nurse practitioner could perform a circumcision after obtaining and demonstrating this competency through completion of a formal didactic and clinical instruction course. In contrast, an adult acute or primary care nurse practitioner, even after completion of the same course, could not perform circumcisions because care of infants is outside the population foci of adult nurse practitioner practice.

According to the Consensus Model for APRN Regulation, "Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations." APRNs are expected to utilize appropriate judgement to determine if a specific patient or procedure is within the scope of practice that he or she is educationally prepared to provide.

# Negotiating CHANGE

Kelly Biscombe, MSN, FNP-C

## Introduction

My second job as a family nurse practitioner was a newly created facility employee position at St. John's Living Center, a long term and skilled care facility attached to the hospital in Jackson, WY. I had worked for St. John's Medical Center for many years as a nurse in the acute setting and then as a temporary nurse practitioner hospitalist and was well known to the facility and to the providers. The Living Center has a Medical Director but each resident's medical care is managed by an outpatient physician who is functionally on call 24 hours each day. Physician resources were additionally strained by the unexpected turnover of several primary care providers. Multiple studies have proven the effectiveness of the utilization of an advanced practice nurse in post-acute settings including long term care, skilled nursing care and swing bed programs.

## Implementation

The first step in implementation of this role involved submitting a proposal to the CEO of St John's and the Medical Director of the Living Center by the Executive Director, Malenda Hoelsher, BSN, LNHA. As an advocate for culture change and person-centered care, Hoelscher not only had experience with the effective use of nurse practitioners in the post-acute care settings but knew the value this position could bring. The proposal included the plan for the Living Center to utilize a vacant position to hire a full-time nurse practitioner. The proposal also included the impact this individual could have including enhancing overall patient and resident care through daily enhanced surveillance and more rapid assessment, diagnosis and

appropriate prescribing of drugs and/or treatments, and reducing physician burden. Once the proposal was accepted by the CEO and Medical Director a job description was finalized. The job description and proposal were then presented to the Medical Staff of the Living Center as well as the Nursing team.

## Challenges impacting Implementation

Very quickly it was realized that the practice authority of this new position was limited by hospital bylaws as well as by Centers for Medicare and Medicaid services (CMS) regulations. The position needed buy-in from all involved parties, from physicians to staff and residents.

- ***Medical Staff Bylaws***—Legally within Wyoming nurse practitioners have full admitting privileges to both acute and long term care but each hospital or medical center can limit these privileges based on their prevailing views. At St. John's Medical Center, only physicians and certified nurse midwives (CNM) had admitting privileges to any medical facility, and APRNs in the non-outpatient setting required a supervising or collaborating physician as well as physician sign-off for all orders and notes. This was particularly cumbersome with paper charting. Historically physicians had expressed concern for unregulated practice of nurse practitioners and had sought to limit practice authority. Due to support from influential physicians, including the CEO, the medical staff chair and vice chair who had all been educated on the role of the advanced practice registered nurse (APRN), as well as the physicians who had worked with nurse practitioners, in January of 2018 the medical staff changed the bylaws to grant nurse practitioners full practice authority in long term care and sub-acute settings, with the continued requirement for a supervising or collaborating physician, allowing for autonomy as well as oversight.

This coincided with a grant to support our Swing program, which involved keeping our high-risk discharges for longer sub-acute stays in the hospital setting. My position expanded to manage these sub-acute patients in the acute care setting and the by-laws were once again adjusted in June 2018. Without fireworks or fanfare, a revolution had begun.

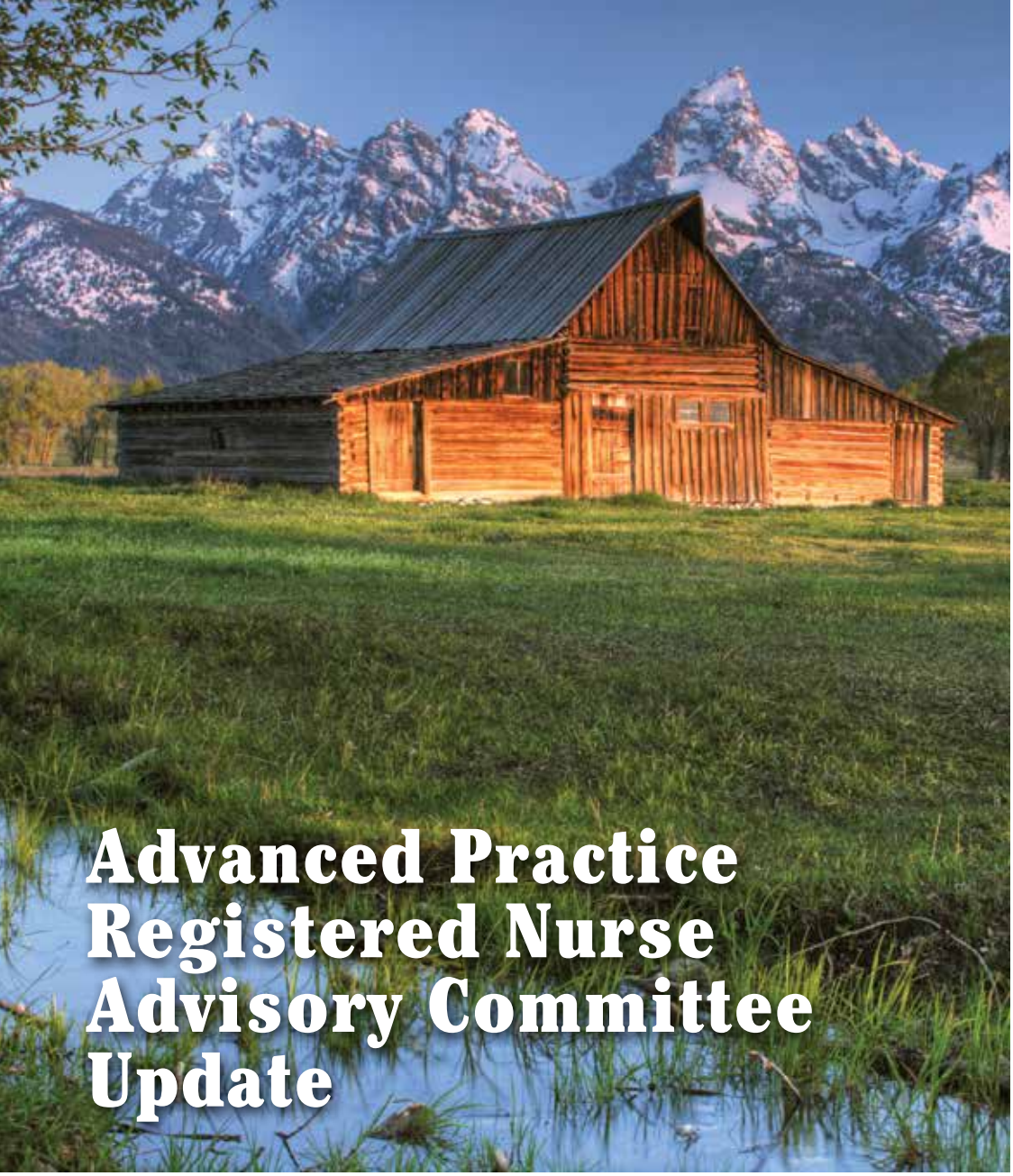
- ***CMS regulations***—Review of Memo Survey and Certification Memorandum 13-15-NH- These regulations state that an APRN or PA employed by a facility may not admit patients or perform certification or regulatory visits (excepting alternate skilled visits) but may perform medically necessary visits and orders and discharge patients without a co-signature, subject to the state Board of Nursing rules.
- ***Medical Staff***—Working with multiple practitioners while having one collaborating physician required adjusting practice to the individual. A relationship and agreement had to be created with each provider to clarify the level of service they would receive, including their preferred method of contact, acute or emergent concerns, pain management, monthly medication reviews, discharge planning, and advanced care planning including the Wyoming POLST (Provider Orders for Life-Sustaining Treatment). With increased familiarity and consistent efforts this collaboration has become almost seamless with most providers.
- ***Nursing Team and residents***—Another learning curve included recognizing that a facility-based nurse practitioner led to role upheaval within the organization. To address this, a series of round table discussions were provided, inviting nursing staff to clarify goals and discuss areas for improvement, as well as more spontaneous time with residents in order to build relationships to establish trust.

## Benefits to the Living Center and Hospital

With support of executive leadership at St John's Medical Center and Living Center, an advanced practice nurse has been a valuable asset to managing patients both in the Living Center as well as the hospital's swing bed program since the fall of 2017. In addition, this nurse practitioner also manages long term care, hospice and respite residents in the Living Center. The CEO, Dr. Paul Beaupre, states, "Kelly has been an outstanding addition to our care team and fulfills a vital role in the care of our residents in our Living Center." In August I was selected as the St. John's Medical Center nursing Employee of the Month for my multiple roles. Strengths lie in continuity of care, chronic disease management, reduced emergency department visits, preventing unnecessary diagnostic testing by providing on-site diagnostic testing, and reducing unnecessary medications with attention to high risk drugs and pain management plans through a coordinated team effort. Other benefits include improving clinical competence of licensed nurses, enhancing end of life care through early engagement and advanced care planning, increased engagement with patients, residents and family, and improved physician satisfaction.

## Summary

What is interesting about this narrative is that it is a little snowball that created an avalanche that ultimately became, well, unremarkable. With education, collaboration, familiarity, and respect physicians were able to envision a change to historic bylaws. Executive leadership views the new position and associated changes as a facility success story. Physicians appreciate the collaborative relationship, decreased burden of communication, and ability to focus on the more complex medical issues. Nationally, it is consistent with a movement towards increased use of APRNs, especially in the rural setting. I was very fortunate to have a strong and supportive director in Malenda Hoelscher, who was a willing advocate for me and for my position, as well as excellent physician mentors who supported my growth and practice.



# Advanced Practice Registered Nurse Advisory Committee Update

The purpose of the Advanced Practice Advisory Committee (collaboration between Wyoming Council for Advanced Practice Nurses and Wyoming State Board of Nursing) is to provide recommendations on issues involving Advanced Practice. Current committee goals are:

- Review national trends in the regulation of advanced practice and make recommendations.
- Evaluate the effects of the Consensus Model for APRN Regulation of 2008.
- Collaborate with other WCAPN committees on matters of mutual interest.
- Clarify and articulate regulatory sufficiency of the four advanced practice roles and recommend changes to the Nurse Practice Act and rules.
- Identify solutions to practice issues related to advanced practice nursing in our state and of particular interest in rural/frontier nursing.

The committee consists of APRNs who are knowledgeable in areas concerning APRN practice. According to the Consensus Model for APRN regulation, the committee should include representatives of all four APRN roles, including the nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist.

*As a result of issues brought by WCAPN attendees in Sheridan, this committee was formed with goals of creating a survey to APRNs and tools for better utilization by employers.*

## Working Together

We shape our self
to fit this world

and by the world
are shaped again.

The visible
and the invisible

working together
in common cause,

to produce
the miraculous.

I am thinking of the way
the intangible air

passed at speed
round a shaped wing

easily
holds our weight.

So may we, in this life
trust

to those elements
we have yet to see

or imagine,
and look for the true

shape of our own self,
by forming it well

to the great
intangibles about us.

*— David Whyte, from*
*The House of Belonging*
*©1996 Many Rivers Press*



Mary E. Burman, Dean
Fay W. Whitney
School of Nursing

# Impact of Nurse Practitioners on Primary Care in Rural Areas: Recent Research

Based on recent research, there is little doubt that nurse practitioners (NPs) have and will have a significant role in primary care, especially in rural areas which face ongoing shortages of primary care providers. The number of NPs, along with physician assistants (PAs), is expected to increase more significantly from 2010 to 2030 than for physicians (Auerbach, Staiger, & Buerhaus, 2018). In addition, the number of client visits by NPs in primary care has increased steadily and NPs work in a wider range of primary care settings (Buerhaus, DesRoches, Dittus & Donelan, 2014; Doescher, Andrilla, Skillman, Morgan & Kaplan, 2014; Graves et al., 2015; Hooker, Benitez, Coplan, & Dehn, 2013; Hooker, Brock & Cook, 2016; Loresto, Jupiter, & Kuo, 2017). Moreover, NPs in primary care are more likely to practice in rural areas than physicians (Buerhaus et al., 2014; Graves et al., 2015). This article summarizes recent research on NPs specifically exploring their impact on primary care in rural areas and the challenges they face in practice.

The evidence continues to grow that NPs provide care that is at least equivalent to that of physicians and PAs (Faza et al.,2018; Jiao, Murimi, Stafford, Mojtabai, & Alexander, 2018; Kuo et al., 2015; Kurtzman & Barnow, 2017; Mafi, Wee, Davis & Landon, 2016). In some cases, studies have found some differences, although generally these differences are not large. For example, Buerhaus et al. (2018) found that Medicare beneficiaries cared for by physicians were more likely to receive chronic disease management and cancer screening; however, Medicare beneficiaries cared for by NPs were less likely to have hospital admissions and readmissions, inappropriate emergency room use, and low-value imaging for low back pain. Although it is encouraging that NP care is equivalent to that of physicians and PAs, it is important that the "value-added" of the nurse practitioner be documented as well. On a different note, a recent study found that the NP work environment, focusing on dimensions such as NP-physician relations, independent practice, professional visibility and NP-administration relations, can also impact quality care in primary care (Poghosyan, Norful, Liu & Friedberg, 2018).

NPs are key to providing access to primary care for acute and chronic illness prevention and treatment, especially for underserved populations. Clients of NPs are more likely to be ethnic minorities, women and uninsured than those seen by

physicians (Buerhaus, et al., 2014; Everett, et al., 2009). NPs more likely to see clients who pay out of pocket or have Medicaid and less likely to see clients with private insurance (Buerhaus et al., 2014; Benitez, Coplan, Dehn, & Hooker, 2015; Doescher et al., 2014; Everett, et al., 2009). This is especially true for NPs in rural settings (Benetiz et al., 2015). In some studies, NPs have been found to see clients with the same complexity as those seen by physicians (Everett, Schumacher, Wright & Smith, 2009; Loresto, Jupiter, & Kuo; 2017); however, in other studies clients of NPs are less complex (Morgan et al., 2017). According to several studies, physicians may see more chronic illness visits, while NPs see more acute and preventive care visits (Hooker et al., 2013; Morgan, Everett & Hing, 2015).

NPs in primary care face financial and regulatory challenges that can impact the provision of primary care and stability of primary care clinics. NPs are more likely to have fixed salary compensation without productivity, financial performance or quality incentives than physicians and have lower salaries (Buerhaus et al., 2014). NPs tend to work fewer hours and see fewer clients (Buerhaus et al., 2014; Doescher, et al., 2014); although Kaplan, Andrilla, Brown and Hart (2009) found that NPs in rural areas saw more clients than NPs in urban areas. Xue and Tuttle (2017) found that NP productivity was similar to that of physicians; however, they had smaller client panels. Moreover, NPs are less likely to provide services outside the clinic setting, e.g., after-hours call, than physicians (Doescher, et al., 2014).

Restrictions in scope of practice continue to be an issue for NPs, although Graves et al. (2015) found that removing restrictive barriers may only have a modest impact on the primary workforce capacity. Interestingly, one of the purported reasons to restrict the practice of NPs was to ensure the care was provided appropriately. However, contrary to this idea, several studies have found that restrictions on NP scope of practice did not improve quality of care thus indicating that these restrictions are not necessary (Kurtzman, Barnow, Johnson Simmens, Infield & Mullan, 2017; Perloff, Clarke, DesRoches, O'Reilly-Jacob & Buerhaus, 2017).

The NP workforce in primary care, while growing, tends to be female and somewhat older and less likely to be a racial/ethnic minority (Buerhaus et al., 2014; Donelan, DesRoches, Dittus & Buerhaus, 2018; Hooker et al., 2015). Attracting early career nurses and diversifying the NP workforce will be important to meet the increasing demand for NPs.

Although efforts need to continue to remove practice barriers, such as restrictions on scope of practice and diversity the NP workforce, the future of NPs in primary care is bright and their capacity to impact rural care is noteworthy! Clients value NPs interpersonal skills and bedside manner, which is no surprise given the grounding of NP practice in nursing (Leach et al., 2018). NPs also can be fundamental to emerging areas of concern, e.g., mental health needs in primary care (see Yang, et al., 2017 and Adrilla, Patterson, Moore, Coulthard & Larson, 2018) and providing patient-centered medical homes (Park, 2015).

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**Wyoming Nurses Association "Nurses Day at the Legislature"**
January 31, 2019
Little America Hotel and Resort

**Wyoming Nursing Education Summit**
May 20-21, 2019
Casper, Wyoming

**Wyoming Council for Advanced Practice Nurses "Advanced Practice Forum"**
October 4-5, 2019
Lander Community and Convention Center

# PRACTITIONERS' Corner

***Essays and Commentary for practitioners who use evidence to improve learning***

- Anesthesia Nursing (2nd revision)
- Practicing Below the Level of Your Licensure (update)
- Role of the LPN-IVC and Curriculum Update (2nd revision)
- Delegation (update)
- Pre Hospital Nursing (update)
- Cosmetic Procedures
- Assuring Safe Healthcare in Alternate Settings

All Advisory Opinions can be located on our website under the "NPA/Rules" tab. Advisory Opinion can be used to guide your internal policies. Do you have a difficult practice or policy related question? Please look up the most evidence based practice standards and refer to national associations for their position statements. Call your P&E Consultant, Jennifer Burns at 307-777-6127. She is willing to help!

# Thinking About Entering Graduate School Online?
# *WSBN Needs to Approve Your Program*

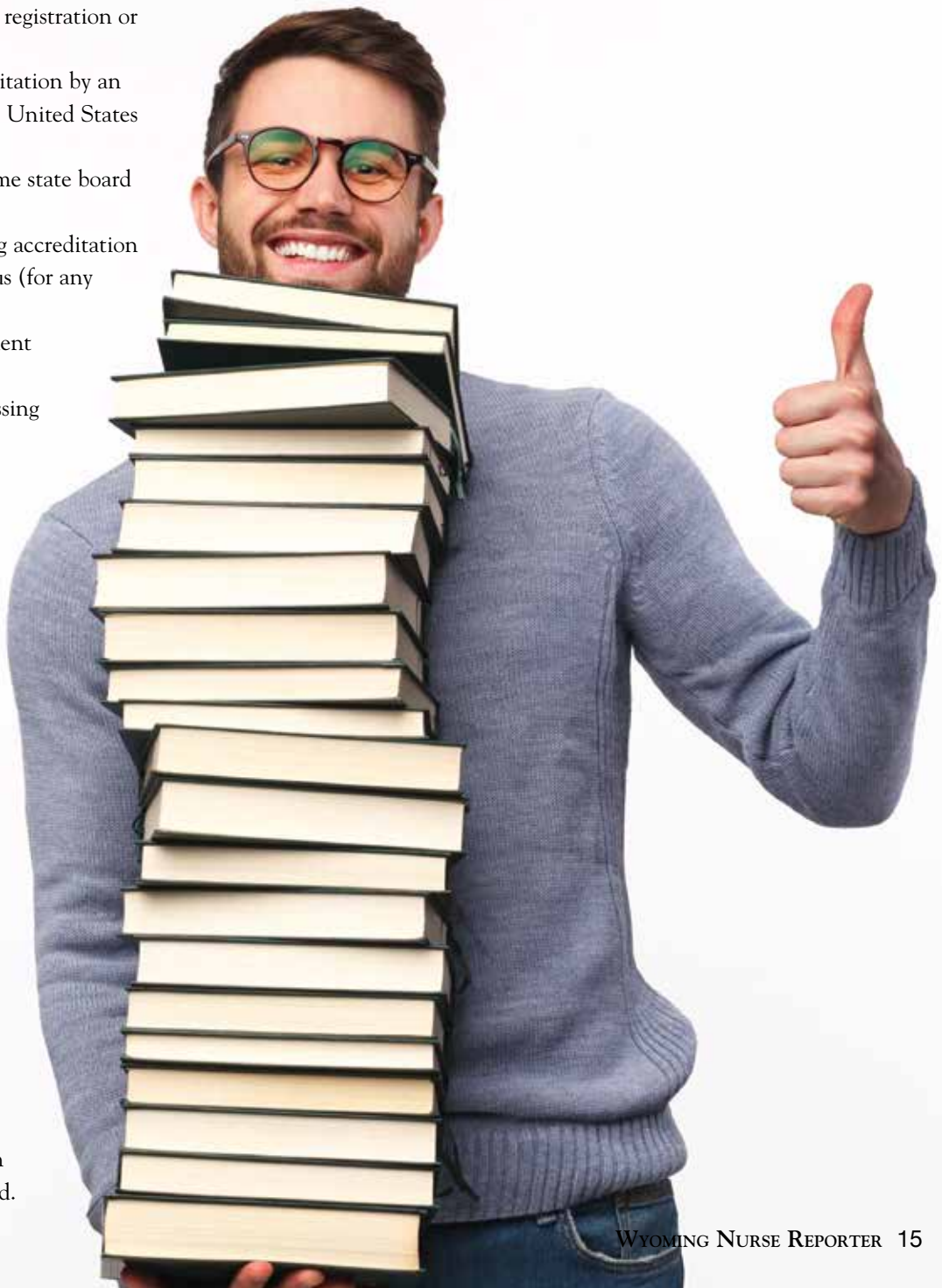
I. First Step: The program must register with the Wyoming Department of Education (WDOE). Application for registration Wyo. Stat. §21-2-401 et. seq., and WDOE Rules and Regulations.

II. Next Steps: The program must email the following registration materials to wsbn-pe-info@wyo.gov for review by the Education committee:

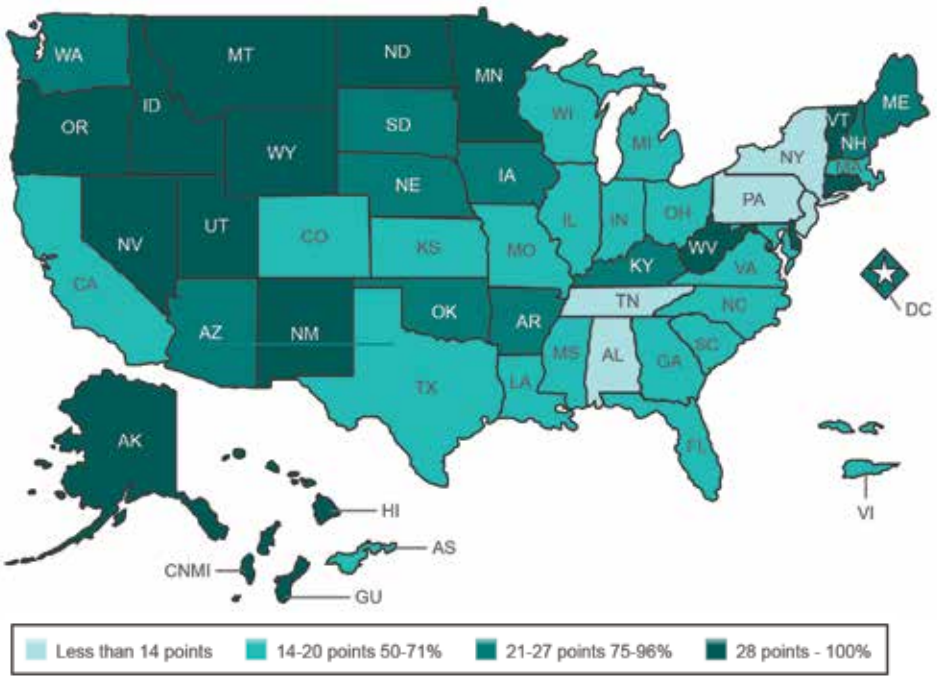
- Completed Faculty Qualification Sheet for any clinical faculty. *Any faculty, preceptor, practicum instructor or didactic course instructor must have either a Wyoming license or a Multistate license from their home state. The APRN student must have an RN license from Wyoming or a Multistate RN license from their home state.*
- Documentation of current WDOE registration or CARA "Welcome Letter"
- Proof of parent institution's accreditation by an accrediting body recognized by the United States Secretary of Education
- Documentation of approval by home state board of nursing
- Documentation of national nursing accreditation
- Curriculum outline, Course syllabus (for any courses offered in Wyoming)
- Copy of the signed clinical agreement between the facility and school
- Submit fee for new program processing (quote will be provided)

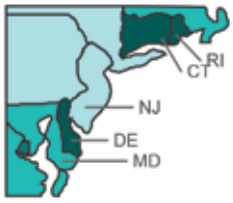
III. Final Steps: Program must provide clinical facility copy of WSBN approval of registration of each student. All students roles require registration (APRN, Leadership, Education, Informatics, Public Health, etc.) Program must assist clinical facility in providing preceptor qualifications (CV, biography, certifications, license number, etc) to WSBN by the first day of clinical via email, if preceptor has changed unexpectedly.

There are many programs currently approved by the WSBN. Please see the list located under the "Education" tab on our website. This process is relatively quick. Do not get discouraged if you are investigating an online program not currently approved.



# APRN Consensus Implementation of Independent Practice Across the United States




- **Independent:** no requirement for a written collaborative agreement, no supervision, no conditions for practice.

- **Not Independent:** a written agreement exists that specifies scope of practice and medical acts allowed with or without a general supervision requirement by a MD, DO, DDS or podiatrist; or direct supervision required in the presence of a licensed, MD, DO, DDS or podiatrist with or without a written practice agreement.

- **Prescriptive Authority:** an APRN is authorized to prescribe pharmacologic and non-pharmacologic therapies beyond the perioperative and periprocedural periods.

*Updated as of 04/23/2018. Maps will be periodically updated as APRN laws change.*

*Reference: National Council of State Boards of Nursing, APRN Consensus 2018.*



***New Rules have been signed by the Governor for Chapters 1, 2 & 8.***

***Please visit the website for these revised chapters.***




# How to Effectuate Regulatory Changes

School nurses Janet Farmer, MSN, RN and Pam Schultz, BSN, RN joined the Practice Committee monthly meeting to discuss issues related to a recent Advisory Opinion. They stated, "School nurses have a unique practice compared to other RNs in the state, especially when it comes to medication administration." This prompted a meeting and discussion on what can be done to attain mutual goals of safe medication administration, helping students remain healthy in school and providing access to care. The school nurses are collaborating with the WSBN Practice Committee on this issue and look forward to ad-hoc meetings to identify other challenges needing regulatory support or guidance.

# Full Scope-of-Practice Regulation Is Associated With Higher Supply of Nurse Practitioners in Rural and Primary Care Health Professional Shortage Counties

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**Introduction:** Access to quality primary care is challenging for rural populations and individuals residing in primary care health professional shortage areas (HPSAs). The ability of nurse practitioners (NPs) to provide full care is governed by state scope-of-practice (SOP) regulation, which is classified into three types: full SOP, reduced SOP, and restricted SOP. Understanding how legislative and regulatory decisions can influence supply of NPs in underserved areas can help guide effective health policies to reduce disparities in access to care. **Objective:** To investigate the trends in NP supply in rural and primary care HPSA counties and their relationship with SOP regulation. **Methods:** The authors conducted longitudinal data analyses using an integrated county-level national data set from 2009 to 2013. A hierarchical mixed-effects model was performed to assess the relationship between state SOP regulation and NP supply in rural and primary care HPSA counties. **Results:** The number of NPs per 100,000 population increased in rural and primary care HPSA counties across states with various types of SOP regulation between 2009 and 2013. Compared with the NP supply in rural or primary care HPSA counties in states with reduced or restricted SOP regulation, NP supply in those counties in states with full SOP regulation was statistically significantly higher. **Conclusions:** State full SOP regulation was associated with higher NP supply in rural and primary care HPSA counties. Regulation plays a role in maximizing capacity of the NP workforce in these underserved areas, which are most in need for improvement in access to care. This information may help inform state regulatory policies on NP supply, especially in underserved areas.

**Keywords:** Access to care, health professional shortage areas, nurse practitioners, rural health, scope-of-practice regulation

Access to quality primary care, which has been linked to improved health outcomes (Friedberg, Hussey, & Schneider, 2010), is particularly challenging for rural populations and those residing in primary care health professional shortage areas (HPSAs), as designated by the Health Resources and Services Administration (HRSA). These areas face great challenges in meeting demand for primary care and are disproportionally affected by the worsening primary care physician shortage (Huang & Finegold, 2013).

The growing supply of nurse practitioners (NPs) presents a potential solution to address rising demand for primary care and primary care physician shortages (Streeter, Zangaro, &

Chattopadhyay, 2017). However, a larger supply does not guarantee a fair geographic distribution of NPs in areas most in need. A recent HRSA analysis indicated that "…considerable effort has focused on examining the distribution of primary care physicians, but less research has focused on NPs and PAs (physician assistants)" (Streeter et al., 2017). The equitable distribution of NPs in relation to disease burden and health care needs is critical, given their important and evolving role in health care delivery (Naylor & Kurtzman, 2010).

The ability of NPs to provide care to the fullest extent of their education is governed by scope-of-practice (SOP) regulation, which varies from state to state. The American Association of Nurse Practitioners (AANP) classified SOP into three types:

- Full SOP regulation: "state practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments including prescribe medications under the exclusive licensure authority of the state board of nursing";
- Reduced SOP regulation: "state practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care"; and
- Restricted SOP regulation: "state practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care" (AANP, 2016).

As of 2016, 21 states and the District of Columbia had full SOP regulation, 17 had reduced SOP regulation, and 12 had restricted SOP regulation (AANP, 2016).

Substantial evidence shows that SOP regulations affect NP workforce supply: states with full SOP regulations have more NPs per capita and exhibit greater growth of the NP workforce (Graves et al., 2016; Kuo, Loresto, Rounds, & Goodwin, 2013; Reagan & Salsberry, 2013; Stange, 2014). In addition, state SOP regulation has been associated with NPs' migration, with NPs more likely to move from states without controlled substances prescription authority to states with this authority (Perry, 2012).

Few studies have examined the geographic distribution of NPs nationally and the effect of state SOP regulations on the geographic distribution of NPs (Graves et al., 2016; Lin, Burns, & Nochajski, 1997; Skillman, Kaplan, Fordyce, McMenamin, & Doescher, 2012). Some of these studies are outdated (e.g., Lin et al., 1997) given that major changes have occurred that transformed the NP workforce, including expansive adoption of NPs as primary care providers beginning in the early 1990s (DeAngelis, 1994) and enactment of direct Medicare and Medicaid reimbursement (Chapman, Wides, & Spetz, 2010). Other studies are cross sectional in design and do not provide insights for future trends (Graves et al., 2016; Skillman et al., 2012). In addition, none have directly examined the trends in NP distribution in primary care HPSAs. Research is needed on the extent to which state SOP regulation affects the geographic distribution of NPs.

The objective of this study was to investigate the trends in NP supply in rural and primary care HPSAs and their relationship with state SOP regulation. Understanding how legislative and regulatory decisions can influence supply of NPs in these underserved areas is essential for the development of effective health policy directives and levers to address increasing demand for care and to reduce disparities in access to care in underserved areas.

## Methods

### Study Design

This study used a longitudinal observational study design to investigate temporal trends in NP supply in rural and primary care HPSAs and to assess their relationship with state SOP regulation in 50 states and the District of Columbia. As NP supply can be affected by the supply of primary care physicians and PAs through either competition or collaboration in an area, we studied NP supply together with primary care physician and PA supply. The study was approved by the University of Rochester Research Subjects Review Board.

### Data Sources

An integrated county-level national data set from 2009 to 2013 was constructed and included the Area Health Resources File (AHRF) and the National Provider Identifier Registry. The AHRF is one of the most extensive national data sets on the health care professions; health facilities; and population, economic, and environmental characteristics (U.S. Department of Health and Human Services, Health Resources and Services Administration, & Bureau of Health Professions, 2013). The National Provider Identifier Registry consists of all active health care provider identifier records. In addition, the integrated data set included American Medical Association Physician Masterfile data, American Hospital Association annual survey data, Bureau of Labor Statistics state-level NP wage data, HRSA data on health center and look-alike service delivery sites, and Henry J. Kaiser Family Foundation data on state-level health maintenance organization (HMO) enrollment. We also obtained annual state-level data on the number of NP graduates from the American Association of Colleges of Nursing and collected state-level NP SOP regulation from the AANP for the study period.

**Variables and Measures**

The geographic variables include state, county, rural/urban, and primary care HPSAs. We defined "rural county" based on the 2013 rural/urban continuum code as having a designation of completely rural or an urban population of less than 2,500 people. We considered a county as a "primary care HPSA" if primary care HPSA status was designated for the entire county according to the code in each study year in the AHRF (U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, & National Center for Health Workforce Analysis, 2013).

County-level provider supply was measured as the number of providers per 100,000 population in a county, which was calculated separately for NPs, primary care physicians, and PAs in each study year. Primary care physician was defined in the AHRF as nonfederal physicians in the specialties of general family medicine, general practice, general internal medicine, or general pediatrics (U.S. Department of Health and Human Services, Health Resources and Services Administration, & Bureau of Health Professions, 2013). Because data for these providers were not available from the AHRF in 2009, we obtained physician data from the American Medical Association Physician Masterfile and extracted data on NPs and PAs from the National Provider Identifier Registry, the same data sources used by the AHRF.

For state SOP regulations for NPs, we used the AANP's classification, which is an ordinal categorical variable with three levels: full SOP regulation, reduced SOP regulation, and restricted SOP regulation (AANP, 2016). Type of SOP regulation was specified for each state in each study year accordingly.

Covariates that might influence the availability of NPs were also examined for each study year. These included county-level population characteristics, indicators for capital input, geographic region, and state-level factors including annual number of NP graduates, average wage for NPs, and health maintenance organization penetration rate. Population characteristics consisted of population size, and the proportion of the county population that was elderly (i.e., aged 65 years or older), black or Hispanic, without high-school education, unemployed, and had a family income-to-poverty ratio at or under the federal poverty level (FPL) of 138% or 200%. Indicators for capital input include the total number of hospital beds, and the number of federally qualified health centers and look-alike service delivery sites. Because rural health clinics were incentivized to employ NPs and PAs (Krein, 1999), we also controlled for the number of Medicare-certified rural health clinic providers. State-level annual number of NP graduates, average wages for NPs, and HMO penetration rate were included to adjust for their potential influence on the availability of NPs in a given area (Auerbach, 2000). Census region was included to control for variation in provider supply across geographic areas.

TABLE 1

**County Population Characteristics by Type of State Nurse Practitioner SOP Regulation and by County Rural and Primary Care HPSA Status, 2013**

| | Full SOP | | | Reduced SOP | | | Restricted SOP | | |
|---|---|---|---|---|---|---|---|---|---|
| | All | Rural | Primary care HPSA | All | Rural | Primary care HPSA | All | Rural | Primary care HPSA |
| State, n | 18 | NA | NA | 21 | NA | NA | 12 | NA | NA |
| County, n (%) | 559 | 162 (29) | 271 (48) | 1,381 | 291 (21) | 502 (36) | 1,202 | 191 (16) | 421 (35) |
| ***County population characteristics*** | | | | | | | | | |
| Population size | 74,796 | 5,440 | 80,714 | 89,870 | 7,270 | 76,228 | 124,949 | 9,050 | 133,549 |
| Percent of individuals aged 65 years or older | 17.77 | 20.13 | 17.92 | 15.75 | 20.18 | 17.23 | 15.36 | 21.02 | 17.38 |
| Percent of black or Hispanic | 12.25 | 7.73 | 12.72 | 12.54 | 9.87 | 15.50 | 24.49 | 19.26 | 32.28 |
| Percent of individuals without high school education | 11.59 | 11.55 | 11.75 | 16.32 | 15.43 | 16.19 | 20.57 | 19.59 | 20.60 |
| Unemployment rate | 6.42 | 5.84 | 6.46 | 8.61 | 6.72 | 7.75 | 9.85 | 7.58 | 7.95 |
| Percent of nonelderly individuals at or under FPL 138% | 24.12 | 23.80 | 24.19 | 24.53 | 28.00 | 28.09 | 27.51 | 30.84 | 30.19 |
| Percent of nonelderly individuals at or under FPL 200% | 36.39 | 36.21 | 36.33 | 37.05 | 41.56 | 41.05 | 40.96 | 45.33 | 44.13 |

*Note.* FPL = federal poverty level; HPSA = health professional shortage area; NA = not applicable; SOP = scope of practice.

### Statistical Analysis

Descriptive statistics for county population demographics and provider supply were calculated by type of state SOP regulation and by county status for each study year. A three-level (year, county, and state) hierarchical mixed-effects model was used to model the between- and within-county variation in NP supply over time. NP supply was modeled as a function of independent variables including time, SOP regulation, and other state- and county-level covariates. We selected residual maximum likelihood estimation method and specified both intercept and time as random effects with unstructured covariance structure. The random effects imply that county-level temporal trends in NP supply were modeled as random trajectories. We included an interaction term between type of SOP regulation and year to test for a potential moderation effect of SOP regulation. All statistical tests were two-sided with significance level set at the nominal .05 level. Analyses were performed using SAS version 9.4 (SAS Inc., Cary, NC).

## Results

### Characteristics of Rural and Primary Care HPSA Counties

In 2013, 17 states and the District of Columbia had full SOP regulation, 21 had reduced SOP regulation, and 12 had restricted SOP regulation. Between 2009 and 2013, five states changed their SOP regulation: Colorado and Hawaii in 2010, North Dakota and Vermont in 2011, and Nevada in 2013. All the changes were made from reduced SOP to full SOP regulation.

Table 1 shows county population characteristics by type of state SOP regulation and by county status in 2013. The analysis included a total of 3,142 counties. States with full SOP regulation had the highest proportion of rural and primary care HPSA counties, followed by states with reduced SOP regulation and states with restricted SOP regulation. Across states with various types of SOP regulation, rural and primary care HPSA counties had a higher percentage of the population who were elderly, black or Hispanic, without high school education, unemployed, and had family income at or below FPL138% or FPL 200%. Overall, the more restricted the SOP regulation in a state, the more prevalent these population characteristics were in that state's rural and primary care HPSA counties, except for the percentage of elderly individuals, which was similar across groups.

### Trends in NP Supply in Rural and Primary Care HPSA Counties by Type of SOP Regulation

The trends in NP supply, along with the trends in primary care physician supply and PA supply, in rural counties by type of state SOP regulation from 2009 to 2013 are presented in Figure 1. On average, rural county NP supply grew from 31.70 per

TABLE 2

**Results of Hierarchical Mixed-Effects Model on the Relationship Between County-Level Nurse Practitioner Supply and State SOP Regulation in Rural and Primary Care HPSA Counties, 2009–2013[a]**

| | Rural Counties | | | | Primary Care HPSA Counties | | | |
|---|---|---|---|---|---|---|---|---|
| | Estimate | 95% CI | | *P* Value | Estimate | 95% CI | | *P* Value |
| Intercept | −92.39 | −152.66 | −32.12 | .003 | −35.82 | −73.55 | 1.91 | .062 |
| ***SOP*** | | | | | | | | |
| Reduced | −6.60 | −11.04 | −2.15 | .004 | −2.87 | −5.60 | −0.13 | .040 |
| Restricted | −10.19 | −20.10 | −0.29 | .044 | −7.07 | −13.50 | −0.64 | .032 |
| Full | ref | | | | ref | | | |
| Year | 1.80 | 0.80 | 2.79 | < .001 | 1.98 | 1.29 | 2.68 | < .001 |
| ***Interaction SOP & year*** | | | | | | | | |
| Reduced | 0.16 | -1.03 | 1.34 | .796 | −0.01 | −0.82 | 0.81 | .985 |
| Restricted | 0.02 | -1.36 | 1.39 | .982 | −0.49 | −1.50 | 0.51 | .329 |
| Full | ref | | | | ref | | | |

*Note.* CI = confidence interval; HPSA = health professional shortage area; nurse practitioner supply: number of nurse practitioners (NPs) per 100,000 population; ref = reference group; SOP = scope of practice.

[a]Results on the following variables included in the model are not shown in the table: number of primary care physicians per 100,000 population, number of physician assistants per 100,000 population, number of hospital beds, number of federally qualified health centers and look-alike service delivery sites, number of Medicare-certified rural health clinic providers, percent of individuals aged 65 years or older, percent of black or Hispanic, percent of nonelderly individuals with family income at or below 138% FPL, state-level health maintenance organization penetration rate, state-level average wages for NPs, state-level number of NP graduates, and region.

100,000 population in 2009 to 40.93 in 2013 in states with full SOP regulation, from 25.83 to 34.06 in states with reduced SOP regulation, and from 23.94 to 32.12 in states with restricted SOP regulation. Primary care physician supply changed from 43.33 per 100,000 population in 2009 to 44.78 in 2013 in states with full SOP regulation, from 40.74 to 37.53 in states with reduced SOP regulation, and from 32.17 to 29.36 in states with restricted SOP regulation. PA supply increased from 35.80 per 100,000 population in 2009 to 40.77 in 2013 in states with full SOP regulation, from 22.40 to 26.88 in states with reduced SOP regulation, and from 10.93 to 13.38 in states with restricted SOP regulation.

Similarly, as shown in Figure 2, NP supply grew in primary care HPSA counties with various types of SOP regulation: from 31.29 per 100,000 population in 2009 to 40.61 in 2013 in states with full SOP regulation, from 25.40 to 34.91 in states with reduced SOP regulation, and from 21.03 to 27.47 in states with restricted SOP regulation. Primary care physician supply decreased from 52.82 per 100,000 population in 2009 to 49.56 in 2013 in states with full SOP regulation, from 43.13 to 40.35 in states with reduced SOP regulation, and from 36.47 to 34.40 in states with restricted SOP regulation. PA supply increased from 30.10 per 100,000 population in 2009 to 35.69 in 2013 in states with full SOP regulation, from 17.91 to 18.87 in states with reduced SOP regulation, and from 12.15 to 15.12 in states with restricted SOP regulation.

### Relationship Between NP Supply in Rural or Primary Care HPSA Counties and SOP Regulation

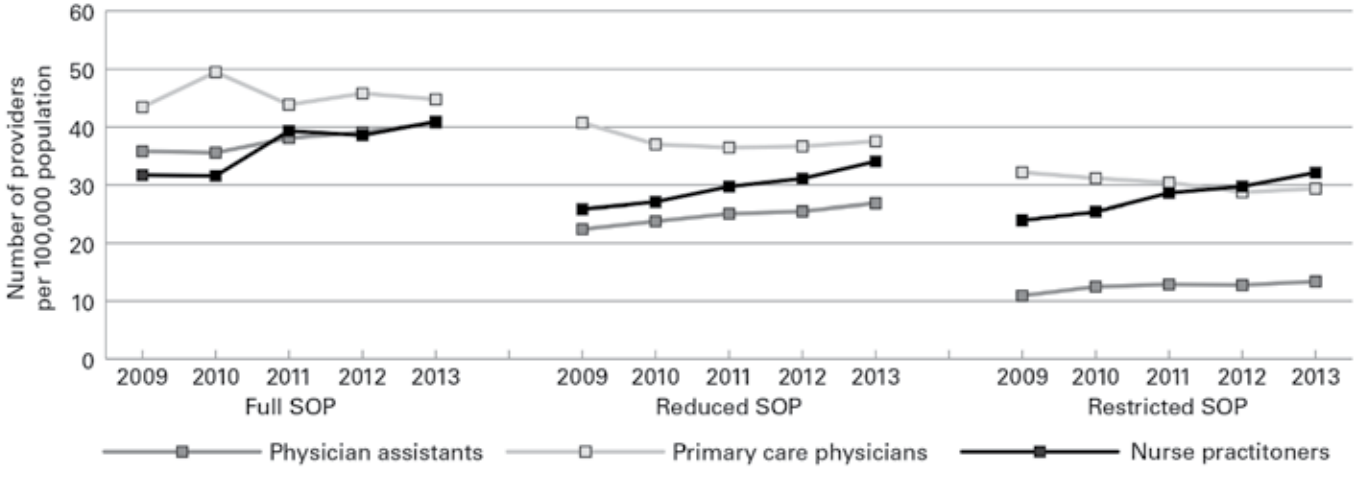
Trends in NP supply in rural and primary care HPSA counties are shown in Figure 3. As observed, NP supply was higher in rural and primary care HPSA counties in states with full SOP regulation than in states with reduced or restricted SOP regulation; however, the growth of NP supply appeared similar among states by three types of SOP regulation. To investigate whether the observed differences were statistically significant, we examined the effects of SOP regulation, year, and the interaction between SOP regulation and year using a hierarchical mixed-effects model while controlling for selected covariates. To avoid multicollinearity, we only included three county population characteristics: percent of elderly, percent of black or Hispanic residents, and percent of nonelderly individuals at or below FPL 138%. Other covariates included primary care physician supply, PA supply, capital input indicators, annual number of NP graduates, state-level average wages for NPs, health maintenance organization penetration rate, and census region. The analysis results confirm the observed differences (Table 2). Compared with counties in states with full SOP regulations, counties in states with reduced or restricted SOP regulation had statistically significantly lower NP supply in baseline year 2009; however, the growth rate in NP supply was not statistically significantly different, as shown by the interaction effect between SOP regulation and year.

## Discussion

Our analyses revealed a trend toward greater numbers of NPs per 100,000 population in rural and primary care HPSA counties during the study period. Further, NP supply in rural and primary care HPSA counties was associated with state SOP regulation: supply was the highest in states with full SOP regulation, intermediate in states with reduced SOP, and lowest in states with restricted SOP regulation.

FIGURE 1

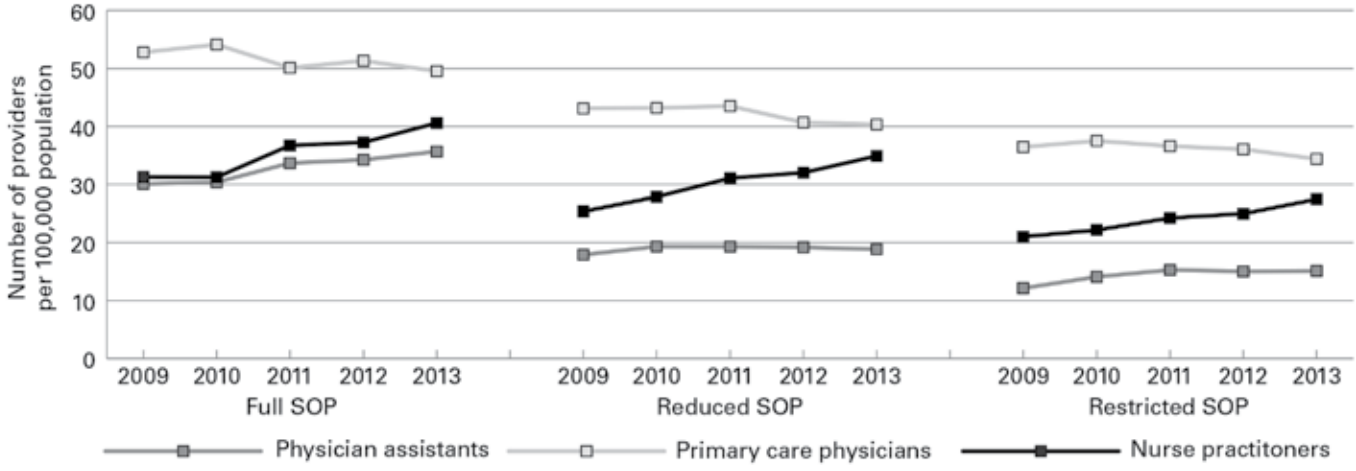
**Trends in Nurse Practitioner Supply, Primary Care Physician Supply, and Physician Assistant Supply in Rural Counties by Type of State SOP Regulation, 2009–2013**




*Note.* SOP = scope of practice.

FIGURE 2

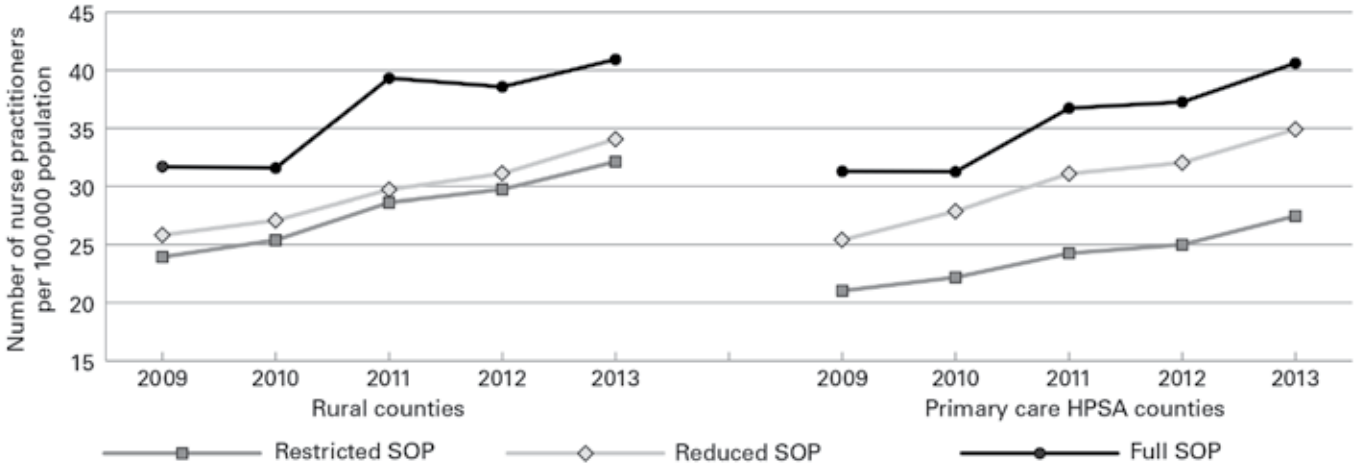
**Trends in Nurse Practitioner Supply, Primary Care Physician Supply, and Physician Assistant Supply in Primary Care HPSA Counties by Type of State SOP Regulation, 2009–2013**




*Note.* HPSA = health professional shortage area; SOP = scope of practice.

FIGURE 3

**Trends in Nurse Practitioner Supply in Rural and Primary Care HPSA Counties by Type of State SOP Regulation, 2009–2013**




*Note.* HPSA = health professional shortage area; SOP = scope of practice.

It is promising that NP supply grew in rural and primary care HPSA counties, the most in-need geographic areas for access to care. These trends are consistent with the current and projected increases in the overall NP workforce. According to the HRSA's analysis, the NP workforce will be the fastest growing primary care workforce between 2013 and 2025, and it is the only primary care profession projected to have a surplus in each state (U.S. Department of Health and Human Services, Health Resources and Services Administration, & National Center for Health Workforce Analysis, 2016). In contrast, estimates indicate a national shortage of 23,640 primary care physicians, which will manifest in most states (U.S. Department of Health and Human Services et al., 2016). As shown in our analysis, the number of primary care physicians per 100,000 population declined and the number of PAs per 100,000 increased moderately in underserved areas between 2009 and 2013. The trend toward growing NP supply in rural and primary care HPSAs signifies the important role of NPs in expanding access to care in these underserved areas.

Furthermore, our analysis indicates that states with full SOP regulation had the highest NP supply in rural and primary care HPSA counties compared with states with reduced or restricted SOP regulation. This finding is consistent with a prior study that reported higher NP supply in rural counties in states with full SOP regulation using a cross-section design that incorporated local travel patterns (Graves et al., 2016). To our knowledge,

this study is the first to demonstrate a link between NP supply in primary care HPSAs and state SOP regulation. These findings support the notion that NPs' propensity to practice in rural and primary care HPSAs can be hampered by requirements for physician collaboration or supervision under reduced or restricted SOP regulation (Yee, Boukus, Cross, & Samuel, 2013). The shortage of primary care physicians in rural and primary care HPSAs can be a challenge for NPs looking for a physician willing to enter into a collaborative agreement or to provide supervision.

Although NP supply in rural and primary care HPSA counties was the highest in states with full SOP regulation, we found that growth of NP supply over time was similar across states by type of SOP regulation. Several explanations exist for this finding. First, only five states changed SOP regulation from reduced to full SOP regulation during the study period. Changes in SOP may require more than a few years to have an impact on NP supply. Second, it is likely that other factors such as organizational policies play a role in slowing the impact of SOP change on NP supply (Westat, 2015). Third, it reflects limitations in the capacity of local health systems to accommodate growth in NP care in the short term. Fourth, NPs may face greater challenges in establishing and maintaining a nurse managed health center or nurse-led clinic in rural and other underserved areas regardless of SOP regulation (Esperat, Hanson-Turton, Richardson, Tyree Debisette, & Rupinta, 2012).

These findings on the association of state SOP legislation and the availability of NPs to provide care to vulnerable populations in rural and primary care HPSAs are instructive. Improving access to care in rural and primary care HPSAs is a top priority of the national and state health care agenda (Office of Disease Prevention and Health Promotion, 2017). Our study demonstrates that expanding state SOP regulation was associated with higher NP supply in underserved counties; state SOP regulation plays a role in maximizing capacity of the NP workforce serving in rural and primary care HPSA counties, which could thus increase patient access to care.

Substantial federal and state efforts, such as investment in federally qualified health centers and rural health clinics and expansion of Medicaid programs, have targeted underserved populations with the aim of improving medical infrastructure and financial access to care. Although expanded financial coverage is a necessary step to relieve medical financial burden, an adequate supply of primary care providers in underserved areas is essential to ensure timely access to care. Research indicates that Medicaid expansion increased financial coverage, but it was also associated with longer waiting times for appointments, an indicator of poor access to care (Miller & Wherry, 2017). In fact, workforce challenges are one of the key barriers for community health centers to serve patients in their full capacity. The National Association of Community Health Centers reported that health centers could serve 2 million more patients if all clinical vacancies were filled (National Association of Community Health Centers, 2016). Community health centers were twice as likely to hire NPs and PAs as other primary care settings (National Association of Community Health Centers, 2013). Care provided by NPs in community health centers complemented care by physicians in regard to patient panel and clinical services, and NPs were more likely to serve as a primary care provider in rural health centers than in urban health centers (Morgan, Everett, & Hing, 2015).

The need to improve access to care in rural and primary care HPSA counties in states with reduced or restricted SOP regulation is striking. Our data showed that these states had a total of 3.8 million people residing in rural counties and 94.5 million in primary care HPSA counties. Further, rural and primary care HPSA counties in these states had a much higher percent of minority and low socioeconomic residents than those in states with full SOP regulation. Expanding SOP regulation might benefit the vast number of vulnerable residents in these underserved areas and has the potential to produce a substantial improvement in patient access to care.

### Limitations

Results from our study should be interpreted in the context of the following limitations. First, our study did not establish a causal relationship between state SOP regulation and NP supply and can only inform a statistical association. However, our study employed a longitudinal study design that generated findings with stronger inference than a cross-sectional design. Second, we were unable to differentiate various types of NP specialization due to lack of data; it would be preferable to include only primary care NPs in the analysis. This limitation is likely minimal, as specialty medical services are less available in rural and primary care HPSA counties (Rosenthal, Zaslavsky, & Newhouse, 2005). Third, the National Provider Identifier Registry, from which data on NPs and PAs were extracted, may not include a small proportion of NPs who were practicing but not registered (U.S. Department of Health and Human Services, Health Resources and Services Administration, & National Center for Health Workforce Analysis, 2014). This might have led to a slight underestimation of the number of NPs.

## Implications for Nursing Regulation

The landmark report Changes In Healthcare Professions' Scope of Practice: Legislative Considerations that was produced by the National Council of State Boards of Nursing in collaboration with five other health care regulatory organizations,

identified improved access to health care as a major goal in providing guidance for legislative and regulatory agencies regarding changes in the SOP of health care professions (National Council of State Boards of Nursing, 2009).

Our study provides information for boards of nursing on the availability of NPs serving vulnerable populations residing in rural and primary care HPSA counties. Particularly, we presented this evidence in the context of primary care physicians and PAs. In light of exacerbating primary care physician shortages in those areas with a high concentration of socioeconomically disadvantaged individuals, the availability of NPs in caring for these vulnerable populations is central to the debate regarding strategies to expand access to care in these underserved areas. Furthermore, our study provides evidence indicating that the expansion of state SOP regulation can help increase NP supply in rural and primary care HPSA counties. Such information is key to strategically guide state regulatory policy on NP practice within the broader context of health care provider workforce trends.

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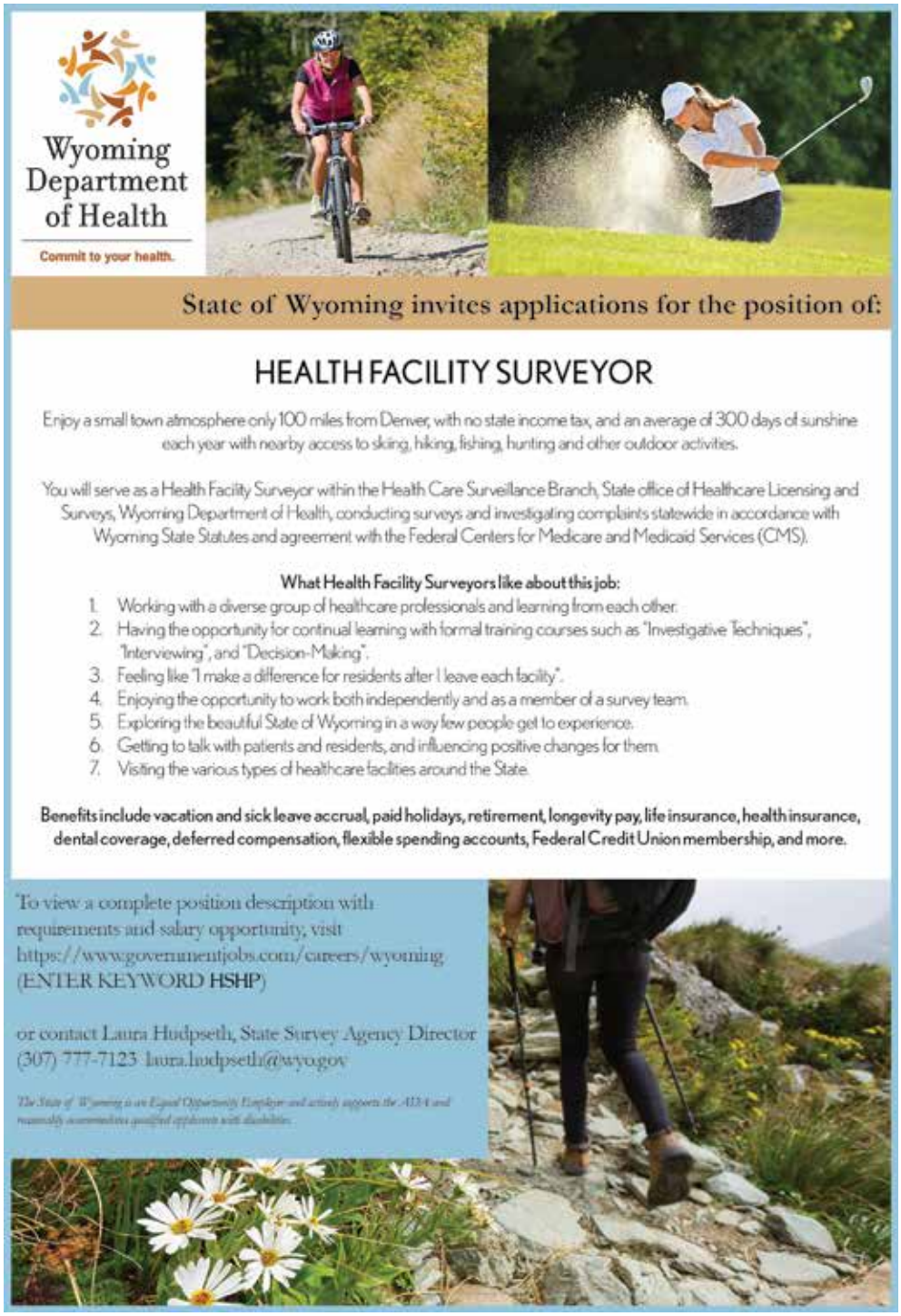


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# YOU ASK... WE ANSWER!

**Jennifer L. Burns, MJ, MSN, RN-BC, NEA-BC, PHNA-BC**
**Practice and Education Consultant**

## Q Are Nurse Practitioners cost effective, especially in acute care settings?

**A** The AANP states, "comparable savings are associated with NP compensation. In 1981, the hourly cost of an NP was one-third to one-half that of a physician (OTA). The difference in compensation has remained unchanged for 30 years. In 2010, when the median total compensation for primary care physicians ranged from $208,658 (family) to $219,500 (internal medicine) (American Medical Group Association, 2010), the mean full-time NP's total salary was $97,345, across all types of practice (American Academy of Nurse Practitioners [AANP], 2010). A study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs and total labor costs per visit were both lower in practices where NPs and physician assistants (PAs) were used to a greater extent (Roblin, Howard, Becker, Adams, and Roberts, 2004). When productivity measures, salaries, and costs of education are considered, NPs are cost effective providers of health services." NPs are especially valuable in acute care environments because, unlike physician assistants, NPs do not require physician supervision or collaboration in Wyoming under the Nurse Practice Act and can be utilized to the full scope of their practice.

## Q Can an APRN work in any setting?

**A** The setting is not specific to the care of the patients, however the population foci (type of patients) must be adhered to, as defined in the Wyoming Nurse Practice Act and by national standards and defined certification of the individual APRN.

## Q How can I, as an Employer, support the APRNs who work for me?

**A** Employers are keenly aware of the benefits of having APRNs on their provider teams. Many evidence based studies show APRNs provide unique emphasis on the health and well-being of the whole person. With a focus on health promotion, disease prevention, and health education and counseling, NPs guide patients in making smarter health and lifestyle choices, which in turn lower patients' out-of-pocket costs. Data shows patients with NPs as their primary care provider often have fewer emergency room visits, shorter hospital stays and lower medication costs. As an employer, work with your credentialing team to develop job descriptions that allow our APRNs to practice to the full extent of their education. Support APRNs who want to return to graduate school by offering tuition reimbursement and flexible hours to complete clinical rotations. Develop a shared governance policy and culture by having APRNs on your leadership teams. Support APRNs with peer to peer opportunities. Stay abreast of national trends and the role APRNs play in filling voids in access to health care in our state. Reach out to the Wyoming State Board of Nursing for advice and assistance, we are here to support! 307-777-6127.

# BOARD TALK

## BOARD MEETINGS

A seven (7) member Board appointed by the Governor, the Wyoming State Board of Nursing (WSBN) consists of five (5) registered nurses, one (1) licensed practical nurse and one (1) consumer member. Meetings are open to the public. Agendas are posted on the Board's website.

## BOARD MEETING DATES

| | |
|---|---|
| *January 8-9, 2019* | *Cheyenne** |
| *February 12, 2019* | *Teleconference* |
| *March 6, 2019* | *Teleconference* |
| *April 15-17, 2019* | *Cheyenne** |

**anticipate live streaming*

## STATE HOLIDAYS — WSBN'S OFFICE IS CLOSED:

*Tuesday, January 1st, 2019 . . . . . New Year's Day*

*Monday, January 21st, 2019 . . . . . Martin Luther King Day*

*Monday, February 18th, 2019 . . . . . President's Day*

## EXECUTIVE DIRECTOR

Cynthia LaBonde, MN, RN

## PRACTICE & EDUCATION CONSULTANT, ASSIST. TO THE EXECUTIVE DIRECTOR

Jennifer Burns, MJ, MSN, RN-BC, NE-BC, PHNA-BC

## LICENSING SUPERVISOR

Lisa Hastings

## LICENSING SPECIALIST

Raymie Bingman & Stephanie Martin

## FISCAL & HUMAN RESOURCES (HR) COORDINATOR

Cindy Stillahn

## COMPLIANCE AND DISCIPLINE (C&D) MANAGER

Victoria Pike, J.D., RN

## LEGAL ASSISTANT

Joey Clure

## OFFICE SUPPORT SPECIALIST II

Caitlin Casner

## WSBN OFFICE HOURS

WSBN's office hours are 7:30 am–4:30 pm.

## COME TALK TO THE BOARD

During each regularly scheduled meeting at WSBN, Board members hold a Public Forum for people to talk to them on nursing-related issues.

If you want to speak during the Public Forum, check the meeting agenda for the date and time it will be held. If multiple individuals wish to address the Board, time is divided equally among those who wish to speak.

For more detailed information regarding the Public Forum, please contact the Office Support Specialist at the Board office. The contact number is (307) 777-3425.

## WE'LL COME TALK TO YOU

Board staff will come speak to your organization on a range of nursing-related topics, including nursing education, continuing education, licensure and discipline processes as well as the Nurse Practice Act (NPA).

## YOU'RE IN GOOD COMPANY!

Active Wyoming Licenses/certificates as of October 2018

CNA: 4192 APRN: 738 LPN: 814 RN: 7810 Multistate Licenses: 965

## BOARD COMMITTEES

Ad-Hoc Committee for APRN Practice in conjunction with the Wyoming Council for Advanced Practice Nurses (WYCAPN) and still recruiting members.

WSBN is advised by and appoints members to five standing committees. These include the Application Review Committee (ARC), Discipline Committee (DC), Legislative Committee (LC), Practice Committee (PC) and the Education Committee (EC).

Further information on the committee's charge as well as meeting dates may be found on WSBNs website at: https://nursing-online.state.wy.us/Default.aspx?page=68

## MOVING?

The law requires you to inform the Board when you have a change in your contact information. The easiest and fastest way for you to update your information is to email our office at wsbn-info-licensing@wyo.gov. You may also call the office at 307-777-7601, or mail a letter to the Wyoming State Board of Nursing, 130 Hobbs Ave, Ste B, Cheyenne, WY 82002. Please remember to provide your name, license/certificate number, former and current addresses.

## WSBN ACCOMPLISHMENTS

Congratulations to Joey Clure, promoted to Legal Assistant of the WSBN Compliance & Discipline Department! Cynthia LaBonde Executive Director of WSBN and Area I Director for National Council of State Boards of Nursing and Jennifer Burns Practice and Education Consultant of WSBN will attend the National APRN Forum in April. The National APRN Forum brings together APRNs and other stakeholders from all states to discuss trending issues related to practice, consensus, and regulation.

## CNA SKILLS/WRITTEN EXAM TESTING AND SCHEDULING INFORMATION:

Prometric is recruiting for testing sites in Gillette, Powell, Cody and Worland and skills evaluators throughout the state. Please call 443-455-6286 for more information.

# Disciplinary Actions September 16–December 15, 2018

The full statutory citation for disciplinary actions can be found on the WSBN website at https://nursing-online.state.wy.us. Each individual nurse is responsible for reporting any actual or suspected violations of the Nurse Practice Act. To submit a report, use the online complaint form or to receive additional information, contact Compliance & Discipline at 307-777-5281, Wyoming State Board of Nursing, 130 Hobbs Ave, Suite B, Cheyenne, Wyoming, 82002.

**Letter of Reprimands - 2**
**Summary Suspensions - 3**
**Revocations - 1**
**Suspensions - 3**
**Denials - 0**
**Voluntary Surrenders - 6**
**Conditional Licenses - 4**
**Reinstatements - 3**

# Licensure Statistics September–December, 2018

The full statutory citation for licensing requirements can be found on the WSBN website at https://nursing-online.state.wy.us. To submit an application, use the online forms appropriate to your discipline. For additional information, contact Licensing at 307-777-7616, Wyoming State Board of Nursing, 130 Hobbs Ave, Suite B, Cheyenne, Wyoming, 82002. The following are numbers of applications processed in each discipline for the last two quarters:

**CNA by Exam - 145**
**CNA by Endorsement - 37**
**CNA by Recertification - 18**
**LPN by Exam - 45**
**LPN by Endorsement - 3**
**LPN by Relicensure - 0**
**RN by Exam - 103**
**RN by Endorsement - 99**
**RN by Relicensure - 9**
**APRN by Exam - 4**
**APRN by Endorsement - 17**
**APRN by Relicensure - 1**

Welcome to our new Certified Nurse Aide testing vendor, Prometrics.
If you are interested in becoming a test site or nurse aide evaluator, please visit www.prometric.com

**Multistate licenses approved to date: 965!**

# WSBN Transitioning to a NEW Licensing Management System

WSBN will launch a NEW licensing management system on January 28, 2019. The new system is called ORBS, which stands for "Optimal Regulatory Board System."

ORBS is a confidential and secure, cloud-based system for digital processes, which provides modules for licensing, discipline and education program management. ORBS will reduce operational processes and has seamless integration with other nursing regulatory systems like, Nursys and NCLEX Administration.

After January 28, 2019, applicants and licensees/certificate holders will be required to create an on-line profile from which they can:

- manage their initial and renewal applications
- submit requests to Board staff
- receive alerts/reminders from Board staff, and
- check their licensure status

OF SPECIAL NOTE:

- Paper applications will NOT be accepted after January 11th, 2019, and
- Credit/debit card payment will be the only form of payment accepted through the ORBS System.

If you have any questions regarding our new paperless system, call our licensing department at 307-777-7601.

# Legal Nurse Consultant Role

Legal nurse consulting is the critical analysis of clinically related issues by a licensed Registered Nurse through evaluation biased upon medical facts and testimony of witness and the rendering of informed opinions related to the delivery of nursing and other healthcare services and outcomes, and the nature and cause of injuries based upon that review looking for breach for the standard of care. The nurse requires a strong educational and experiential foundation to be qualified to assess adherence to standards and guidelines of practice as applied to nursing practice .

A legal nurse consultant will perform the following in developing an opinion:

- Determine the health care facilities standards of care for patient care
- Determine statute of limitations applications to the case
- Determining if there have been breaches to care which have caused harm
- Participate in client interviews
- Identify, organize and analyze pertinent medical records
- Prepare a chronology, timeline or other summaries of documentation in medical records
- Conduct medical literature searches and assist in other research
- Identify applicable standards of care in medical malpractice cases
- Identify, screen and facilitate review by expert witnesses
- Evaluate medication administration
- Evaluate charting
- Evaluate case strengths and weaknesses
- Draft or analyze medical portions of legal documents
- Evaluate causation and damages issues
- Educate attorneys and clients regarding relevant medical issues
- Identify plaintiff's future medical needs and associated costs
- Participate in case management and case strategy discussions
- Attend independent medical exams
- Serve as a nurse expert witness
- Perform cost of care estimates for long-term care treatment and catastrophic case management scenarios
- Locate or prepare demonstrative evidence for trial
- Assist with preparation for and support during deposition, trial or ADR

If a nurse is considering assisting an attorney in chart investigation, there are several courses which help the nurse to understand more completely what the role entails. Board certification is available to legal nurse consultants through the Legal Nurse Consultant Certified (LNCC®) program. Similar to clinical nursing certification, LNCC® certification demonstrates that the RN has met experience and education requirements and has passed the certification examination.

Bonnie Bath RN

# 11TH NURSING CONTINUING EDUCATION Cruise

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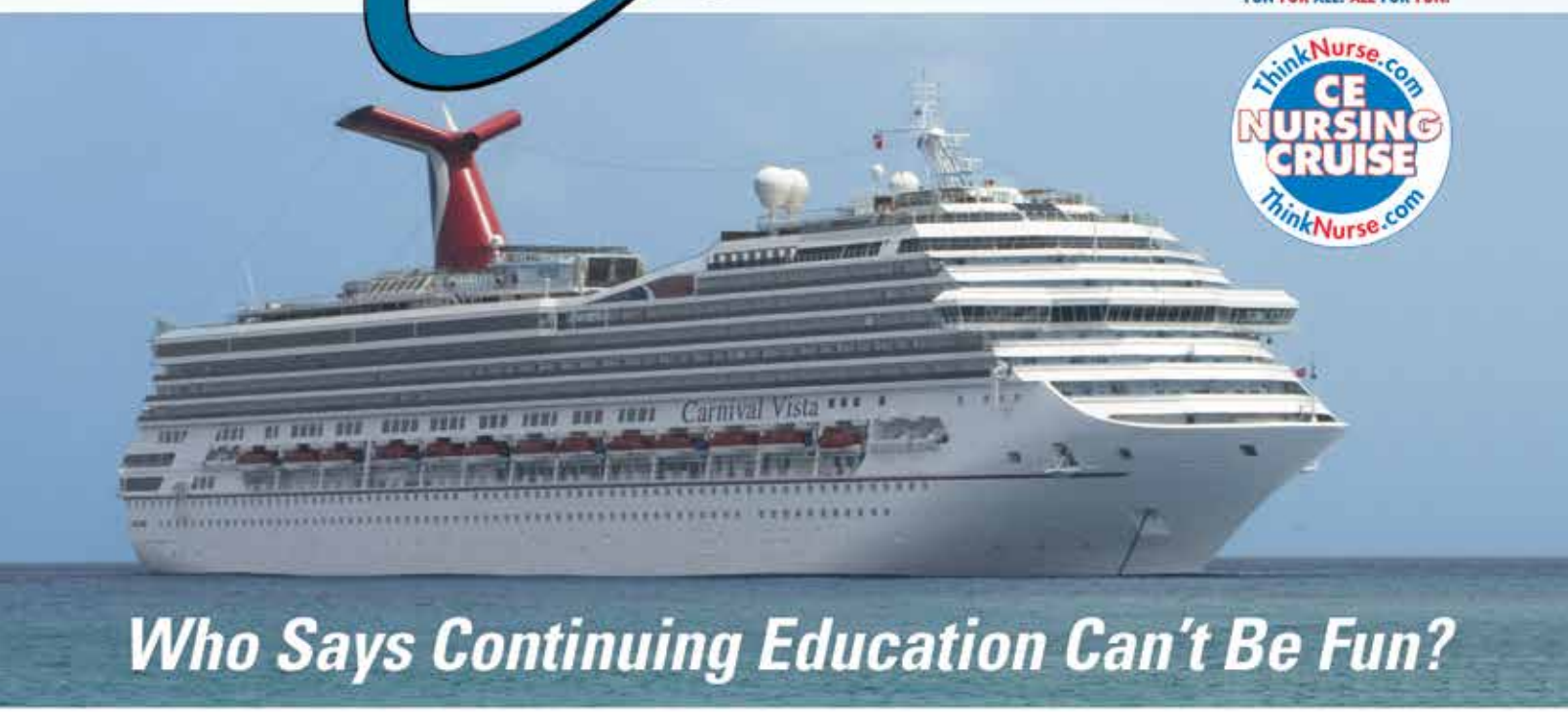


## Who Says Continuing Education Can't Be Fun?

Join ThinkNurse and Poe Travel for our 11th CE Cruise. Cruise the Caribbean on Carnival's Vista while you earn your annual CE credits and write the trip off on your taxes! Prices for this cruise and conference are based on double occupancy (bring your spouse, significant other, or friend) and start at $1,000.00p/p based on double occupancy, includes – 7 night cruise, port charges, government fees and taxes. A $250 non-refundable per-person deposit is required to secure your reservations. Please ask about our Cruise LayAway Plan!

*This activity has been submitted to the Midwest Multistate Division for approval to award nursing contact hours. The Midwest Multistate Division is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.*

| Day | Port | Arrive | Depart |
|---|---|---|---|
| Sun | Galveston, TX | | 4:00 PM |
| Mon | Fun Day At Sea | | |
| Tue | Fun Day At Sea | | |
| Wed | Mahogany Bay, Isla Roatan | 8:00 AM | 6:00 PM |
| Thu | Belize | 8:00 AM | 5:00 PM |
| Fri | Cozumel, Mexico | 8:00 AM | 4:00 PM |
| Sat | Fun Day At Sea | | |
| Sun | Galveston, TX | 8:00 AM | |

POETRAVEL

**For more information about the cruise and the curriculum please log on to our Web site at ThinkNurse.com or call Teresa Grace at Poe Travel Toll-free at 800.727.1960.**

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