



March 14, 2006

Donna M. Dorsey, MS, RN, FAAN, President
National Council of State Boards of Nursing
111 East Wacker Drive, Suite 2900
Chicago, Illinois 60601

Dear Ms. Dorsey,

As organizations with a common and vested interest in advancing excellence in education, certification, and practice of Pediatric Nurse Practitioners as Advanced Practice Registered Nurses (APRNs), we are writing to strongly and steadfastly voice our opposition to the establishment of generic, lifespan education and licensure of APRNs as described in the draft of the National Council of State Boards of Nursing's "Vision Paper: The Future Regulation of Advanced Practice in Nursing". Rather, we support certain tenets of the NCSBN's 2002 position paper, *Regulation of Advanced Practice Nursing*, particularly the statements:

- Combined with advanced practice graduate nursing education, professional certification examinations should be used as one qualification for licensure...
- Licensure should be granted only if the concentration in the APRN education program and the area of the certification exam are congruent
- Movement should be toward consistent educational requirements, titling and uniform use of terminology to improve public protection...
- APRN licensure should be in relatively broad categories of practice, such as Adult NP...
- Prescriptive authority should be within the scope of the license to practice...
- APRNs are responsible for practice that reflects the state of the science and the evidence-based guidelines that form the standard of care

Our opposition to the Vision Paper centers around the statements found on page 1 and expanded upon later in the document, "*Nurse Practitioners will complete a broad-based educational program across the lifespan, populations, and settings and then take a licensure examination, and complete a residency.....Nurse Practitioners can become specialists, such as a pediatric nurse practitioner or a geriatric nurse practitioner, by attaining competency in the specialty area.*" Several key issues are raised through these statements:

1. Broad-based education "*across the lifespan, populations, and settings*" occurs at the baccalaureate level. At the graduate level, specialty education occurs. There is insufficient time within 2-year graduate programs to prepare NPs across the lifespan and

then at the specialty level. Extending programs to meet an NCSBN goal of simplified licensure while achieving the desired outcome of specialists in advanced practice nursing would be inefficient, and too costly, both for programs and students.

The 2002 NCSBN statement in bullet 4 above declaring that APRN practice should be licensed at the specialty level is preferable.

2. How the “*nurse practitioner can become a specialist by attaining competency in the specialty area*”, the core of PNP education currently, is not explained in light of the lifespan proposal. Apparently it occurs within the residency.

Advanced pediatrics health care, the state of the science, body of knowledge, and evidence-based practice guidelines are established already to meet provider and consumer needs. This body of knowledge should neither be denied nor discounted in importance to practice. As stated earlier, 2 year programs of study with supervised clinical practice in the specialty are necessary to prepare specialists.

3. A generic APRN licensure examination could not possibly test the unique specialty knowledge required to provide care safely to children, a highly vulnerable population, with several complex developmental stages within the specialty. Newborns are not the same as adolescents. To assume that testing at the generic lifespan level would assure competency and safety for the public is a misguided wish.
4. Residency expectations are not spelled out clearly in the document. One must assume that either educational programs and institutions will need to implement new residency programs in the specialties such as occurs in medical education, or that residencies by informal arrangements between new clinicians and employers will arise with inevitably variable outcomes.
5. Another statement of the Vision paper, “*Regulators must not license narrowly prepared APRNs because to do so would place an unacceptable limitation on the APRN’s scope and practice resulting in a compromise in public safety*” seems to assume that NPs will not function at the specialty level in the future. PNPs, both in acute care and primary care, are very clear about their scope of practice limits. They prefer in-depth specialty practice to more superficial breadth across populations and ages. The level of specialty preparation is appropriate for licensure, sub-specialization does not need to be regulated since sub-specialists would have already achieved specialty status.
6. Integrating knowledge about health care of children with care of all citizens for the required generic testing level of practice essentially discounts the health care needs of our nation’s 78 million children. Nurse practitioners in other specialties such as gerontology can speak out similarly for their specialty populations’ health care needs. Nursing needs to be and is prepared to be more than a one-size-fits-all profession.

7. Licensure examination by the state BONs raises significant concerns. How can such Boards with their governor-appointed memberships which may or may not even include APRNs, and many activities related to all levels of nursing practice expect to design, implement, and evaluate licensure examinations for APRNs that will exceed the work of experienced educators, certification boards, and accrediting agencies, with many years of experience working with APRNs specifically and guarantee safe APRN practice for the public? It seems preferable to use the expertise of appropriate nursing bodies in an interrelated, cooperative, fashion.

For more than 35 years regulators have worked together with voluntary accreditation and certification organizations to create public/private partnerships incorporating quality education and clinical practice standards to recognize and regulate PNP practice. This partnership between regulators, certifiers, educators and clinical experts has served the nursing profession and the public well. This partnership is hallmarked by the cooperation that continues among the AFPNP, NAPNAP and the PNCB. Educated through more than 100 PNP programs at top universities throughout the country, today more than 10,000 Certified Pediatric Nurse Practitioners (CPNPs™) provide for the health care needs of children and families in all 50 states and US territories and almost 7,000 are members of their professional association. History will attest that the quality of care provided by PNP is linked to the mutual missions of AFPNP, NAPNAP, and PNCB.

We understand there is much confusion among members of state Boards of Nursing (BONs) and stand ready to provide consistent information and support to state BONs and the public. In fact, several of the points listed below were sent to all state BONs in 2005 as part of our efforts to assist members understanding of these complex issues.

As the public continues to benefit from PNP care, we voice our support for the current interactive public private model integrating quality education and certification as core components of PNP practice recognition and regulation. This dynamic model has been a time tested success. Progress to assure the public that certification exams are psychometrically sound and legally defensible has been robust. Accreditation of certification organizations, cooperation in the establishment of standards and competencies, and quality improvements illustrate this success and will assist state Board of Nursing in their review, specifically:

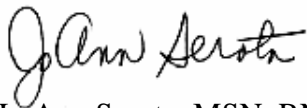
- Full accreditation of NP programs has been achieved through the accreditation processes of the CCNE and NLNAC. The NP certification organizations have achieved and maintained national accreditation.
- The Criteria for Evaluation of Nurse Practitioner Programs, as developed by the National Task Force on Quality Nurse Practitioner Education, were revised and strengthened. National consensus on the requirements for faculty, program curriculum, integration of core and specialty knowledge, and clinical preparation of competent nurse practitioners was reached and incorporated into the criteria. The Criteria for Evaluation of NP Programs has been endorsed by the NCSBN, as well as incorporated in the CCNE and NLNAC accreditation processes.

- In partnership with the Department of Health and Human Services, National Organization of Nurse Practitioner Faculties (NONPF) and the American Association of Colleges of Nursing (AACN), the NP certification organizations and others developed national specialty competencies in primary care specialty areas for nurse practitioners including acute care, adult, family, gerontological, pediatric, psychiatric-mental health and women's health.
- Through the Alliance for Accreditation's APN Consensus Panel meetings, discussion continues in an effort to reach consensus on the definition of advanced practice nursing and the development of mechanisms for recognition of new advanced practice roles and specialties.

With the strengths of this model apparent, we are very concerned about recent discussion regarding the development of non-specialty based, generic testing for NPs and other advanced practice nurses as well as various positions expressed in the Vision Paper.

Thank you for your response.

Sincerely,



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