MODULE TWO: ADVANCING SCOPE OF PRACTICE TO INCLUDE ABORTION CARE

Module Two explains how professional practice is regulated for CNMs, NPs, and PAs, specifically in a specialty-practice area such as abortion care. We describe the roles of state licensing boards as well as national and state professional organizations in defining, enforcing, and advancing health professional practice—and how their activities apply to abortion care.

As you read Sections III, IV, and V, consider these questions:

1. What is the relationship between state legislatures and state licensing boards?
2. What is the role of state licensing boards in defining, enforcing and advancing professional scope of practice?
3. How do state practice acts and professional standards provide for or create barriers to safe, effective care?
4. How do CNM/NP/PAs demonstrate and maintain continued clinical and professional competence?
5. How can you effectively influence the state regulatory agency that governs your practice?
6. How has your state board addressed politically charged issues regarding scope of practice in the past?
7. What is the role of, as well as your obligations to, your professional organizations? Does the organization have leaders who you see as mentors or who have experience or interest in the reproductive health field?
8. Are there provider restrictions to any or all aspects of abortion care in your state?
9. How might abortion care become normalized into CNM, NP or PA scope of practice? What barriers to this goal do you identify?
10. Were you trained in abortion care in your APC educational program or your postgraduate training? How might you obtain the training you need to integrate abortion care into your practice?

SECTION III.
APC PRACTICE REGULATION: ROLES OF LEGISLATURES, LICENSING BOARDS, AND PROFESSIONAL ORGANIZATIONS

OBJECTIVES:

1. Explain state abortion laws and their relationship to APC scope of practice regulation.
2. Identify the general credentialing framework for APCs.
3. Describe authority-based and evidence-based approaches for defining APC scope of practice.
4. Identify the authority of state legislatures and licensing boards to regulate APC practice.
5. Discuss the role of the APC professions in defining and advancing scope of practice.

Section III examines who defines APC scope of practice, explaining the roles of state and national professional organizations, state legislatures, and licensing boards, as well as key factors APCs should understand about each of these groups. First, though, we look at state abortion laws and their relationship to APC scope of practice regulation.

A. STATE ABORTION LAWS AND APCS

Abortion laws, many of which were enacted before the statutory recognition of advanced practice clinicians roles and the development of newer and simpler abortion technologies, create confusion for clinicians who want to offer abortion care. After the 1973 *Roe v. Wade* Supreme Court decision legalizing abortion, many states enacted physician-only laws presumably to protect women from unsafe, untrained, and unlicensed abortion providers. Unfortunately, these laws have become a de facto restrictive legacy to the evolution of APC scope of practice for two reasons: (1) hesitation by some health professionals and reproductive rights organizations to address the issue of women's access to abortion care from all qualified women's health care providers, and (2) uncertainty whether these laws apply to demonstrably "safe and competent" providers who are not physicians.

Even in states where APCs have a broad scope of practice including prescriptive authority, they must abide by abortion-specific limitations that prevent them from offering either aspiration or medication abortion services. For example, although in Arizona, PAs have broad physician-delegated authority to diagnose, treat, prescribe, and perform minor surgery, a statute specifically prohibits them from providing abortions (Ariz. Rev. Stat. § 32-2501.11 (2007)). Similarly, in Ohio, PAs' prescriptive authority specifically excludes abortion-inducing medications (Ohio Rev. Code § 4730.02 (2009)).

However, in a number of states, including those with physician-only laws, APCs with additional training are providing medication and, in some cases, aspiration abortions as a result of Attorney General opinions, regulatory clarifications, and other mechanisms (Joffe & Yanow, 2004; Advancing New Standards in Reproductive Health, 2007). This demonstrates that even in states where abortion is restricted by law to licensed physicians, nonlegislative strategies have provided APCs with opportunities to incorporate abortion services into their practices. (See Section IV.D and IV-E for an overview of these statutory and regulatory examples.)

These state-specific abortion laws must be considered within the context of nursing, midwifery and physician assistant practice acts which also vary from state to state. Although

the state regulation of CNM, NP and PA practice will be discussed generally in Section III-C through III-E, it is beyond the scope of the *APC Toolkit* to provide detailed description of each state's practice acts regulating advanced practice nursing roles (e.g., NPs and CNMs) and PAs. Fortunately, there are regularly updated reference documents which provide current state-by-state information on CNM, NP and PA practice regulation including state practice acts and legislative changes to scope of practice. See Figure III-1 for a description of these references.

FIGURE III.1

State laws & regulations governing NP, CNM and PA practice: Where to find information

Since there is no federal law governing the scope of practice, it is necessary to go to each state licensing board to access the specific practice act and rules and regulations for CNMs, NPs and PAs. Fortunately, there are now websites and published documents which summarize and update these state practice laws and regulations along with pertinent government and policy information related to proposed legislation and scope of practice changes for each state and the District of Columbia (DC).

Nurse Practitioners

Since 1988, Linda Pearson, former editor of the Nurse Practitioner Journal, has summarized NP legislation and related health care issues, including a recap and update of each state's nurse practice act and related rules and regulations. Now the *Pearson Report* is available in both print and electronic formats with a condensed version of each state/DC report appearing annually in the January/February issue of *The American Journal for Nurse Practitioners*. The complete version of each state/DC report is available on the NP Communications website (www.webnp.net) which includes specific details on NP scope of practice changes, statewide NP associations and schools, organized opposition to NP legislative or regulatory changes, the number of National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank filings, and the ranking of the state's NP regulation and consumer choice environment (Pearson, 2009). Dr. Pearson encourages anyone to provide her with updates by emailing her at lindapearson@comcast.net.

Nurse-Midwives

The *Pearson Report* includes some information about the regulation of CNMs. The ACNM also provides information on state laws and regulations specific to CNMs. A handbook that summarizes state laws and regulations affecting CNMs is available online to ACNM members only. Topics include the identity of the regulatory board, scope of practice, prescriptive authority, tort reform, breastfeeding and other statutory provisions governing the practice of midwifery. The ACNM website also provides public access to state/DC summaries of CNM practice regulation and key statistics (http://www.midwife.org/state_legislation.cfm). ACNM annual reports (available online) highlight state advocacy efforts related to CNM practice and regulation. The most recent published report (2007) describes, activities in 17 states, including the passage of legislation in seven states advancing CNM scope of practice (http://www.midwife.org/siteFiles/about/2007_annnual_Report.pdf).

Physician Assistants

The first edition of *Physician Assistants: State Laws and Regulations* was published by the AAPA in 1982 and now is available online at http://www.aapa.org/gandp/StateLawsandRegulations.htm. This state-by-state compendium provides summaries of more than two dozen key provisions of each state's statute and regulations complete with legal citations (http://www.aapa.org/gandp/state-law-summaries.html). The states are presented in alphabetical order, with each law followed by its regulations which provide the most complete picture of the requirements and conditions for PA practice. The AAPA website also lists each state PA regulatory agency with addresses, phone numbers, and Web links, available at www.aapa.org/gandp/statereg.html. Also provided is a chart that presents an overview of PA licensure or state certification requirements (http://www.aapa.org/gandp/sumchart.html).

If a physician-only statute in your state prohibits you from providing abortion care, you can still play an active role in providing reproductive health services to the women in your community!

Become part of a network of health professionals that advocates for improved reproductive health services including access to early abortion care.

Participate in efforts to support current abortion care providers including those physicians in primary care and specialty practice.

Become competent to provide the most comprehensive pregnancy options counseling available, and educate women about both medication and aspiration abortion.

Train to provide ultrasound, laminaria placement, postabortion exams, medication abortion counseling or provision, miscarriage management, and uterine aspiration in cases of failed or incomplete medication abortion.

B. CREDENTIALING FRAMEWORK FOR APCS

Generally, CNMs and NPs are credentialed first as registered nurses and then as advanced practice nurses (in the CNM or NP role), whereas PAs have only one credentialing mechanism. APCs may be educated and also credentialed for practice with a population (e.g., primary care, women's health) and/or a specialty (e.g., abortion care) focus.

The credentialing process is based on a set of *essential elements* that aligns government authority with regulatory and professional responsibilities. These essential elements of professional regulation and credentialing include the following:

- **Scope, standards, competencies, and ethical codes of practice and professional performance** are essential documents developed by the profession to provide a basis for education and practice regulation.
- **Education** is the professional's formal preparation in graduate degree–granting or postgraduate certificate programs.
- **Accreditation** is formal review and approval by a recognized agency of educational degree or professional certification programs.
- **Legal scope of practice** is defined in state laws and regulations.
- **Licensure** is the granting to an individual of authority to practice within a state.
- **Certification** (or *second licensure* in some states) is formal recognition of the knowledge, skills, and experience the individual demonstrates by meeting the standards the profession identifies.

While there is no uniform federal law that grants a professional license to practice, there are commonalities across states and each of the health professions. State legislatures and state licensing boards exercise legal authority in defining, enforcing, and advancing scope of practice for APCs. NP, CNM, and PA educators and professional organizations play a critical role in complementing state legislative and regulatory authority. State licensing boards rely on the professional organizations to assess and define professional practice, standards of practice (including ethical standards), and basic and advanced competencies that are the foundation for safe and effective care. State licensing boards may then codify these foundational elements for safe practice.

State licensing boards also look to state health-professional education and training programs to identify how practice standards and competencies are situated within the curriculum and clinical training. Furthermore, most state licensing boards have processes for determining how to incorporate practice advancement into existing regulations.

In all cases, the individual practitioner is accountable to the patient and the profession to practice according to legal/professional ethical standards and to adhere to professional performance criteria established and enforced by the regulatory and professional bodies.

C. GENERAL LEGAL AND REGULATORY REQUIREMENTS

Professional licensees in each state are governed by their respective practice acts and other statutes applicable to them, as well as by licensing board rules, orders, policies, advisory opinions, and procedures.[9] In addition, generally applicable (mostly procedural) statutes such as state Administrative Procedure acts and Open Meetings laws and Government-in-the-Sunshine laws

[9] For links to states' licensing boards and their practice statutes, rules, procedures, decisions, and opinions, see the Federation of State Medical Boards' and the National Council of State Boards of Nursing's websites at http://www.fsmb.org and http://www.ncsbn.org, respectively. Because federal laws affecting abortion services mostly concern eligibility for patient coverage or provider payment and not APCs' authority to provide such services, they are not included in this analysis. See also Figure III.1 Section III.A of this document.

also affect the ways in which licensees and boards interact.[10] As is the case for any other health or medical service a licensed professional might provide, APCs providing abortion and reproductive services must understand and comply with the legal requirements, both substantive and procedural, set forth in multiple intertwined legal standards, acts, and pronouncements.

All health care professionals are legally accountable for actions they take in the course of their practice. This accountability is enforced principally through the legal mechanisms of licensure, state practice acts, and related legislative and regulatory initiatives, all of which explicitly codify the profession's obligation to act in the best interests of society. Nurse practice acts grant nurses and advanced practice nurses (such as NPs and CNMs) the authority to practice—and also grant regulatory boards the authority to sanction those who violate the norms of the profession and act in a manner that threatens public safety. PAs are similarly regulated by state PA practice acts.

D. UNDERSTANDING SCOPE OF PRACTICE

In an ideal world, statutory definitions of professional practice would be consistent with and build upon a profession's definition of its practice base, yet be general enough to encompass the dynamic nature of an evolving scope of practice. Such a consistent yet flexible definition would serve society both by enhancing the geographic mobility of providers and by promoting access by all states' residents to the full range of services nurses, NPs, CNMs, and PAs provide. Unfortunately, this consistency does not yet exist, as the wide variation in state practice authority, as well as abortion practice restrictions for CNMs, NPs, and PAs, shows. This lack of consistency in statutory definitions is one more reason it is so important for APCs to understand both their state's current scope of practice provisions and strategies for advancing their scope to encompass evolving competencies.

All APCs are familiar with the essential concept of professional scope of practice. However, a quick review[11] will help reinforce its relevance to sustaining and promoting the availability of safe reproductive health services, including abortion.

Scope of practice has been described as:

- "defined spheres of activity within which various types of health care providers are authorized to practice," (Safriet, 2002, p. 303)
- "those health care services a …health care practitioner is authorized to perform by virtue of professional license, registration, or certification," (Federation of State Medical Boards, 2005, p. 4)
- the "[d]efinition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field," (Federation of State Medical Boards, 2005, p. 19) and
- "establish[ing] which professionals may provide which health care services, in which settings, and under which guidelines or parameters." (Dower, Christian, & O'Neil, 2007, p. 1)

In less formal terms, scope of practice addresses the questions of "who can do what for whom in what clinical setting and under what circumstances." Answers to these questions also determine the ancillary but important issue of who can get paid for providing services.

APCs as members of their state professional organizations must continually monitor legislative proposals relevant to their practice regulations and authority. This requires attention to activities related to their particular regulatory board or practice act. It also involves monitoring bills or legislative committee actions in related areas, such as the Pharmacy Act (for prescriptive authority), the Medical Practice Act (for physician supervision or "collaboration" requirements and other constraints), and the Departments of Health or Health Services and the Insurance Commissioner (for conditions of payment for services or requirements for the range of services provided in hospitals or community health clinics).

[10] Copies of these statutes are available online at the website of each state's Attorney General or Secretary of State. In addition, almost all states publish "Guides to Understanding" the Open Meetings laws or Administrative Procedures acts. These publications are invaluable aids in mastering the often-confusing procedural niceties of administrative process.

[11] For more comprehensive analyses of scope of practice, see Safriet (2002, 1992); Dower, Christian, & O'Neil (2007); and Christian, Dower, & O'Neil (2007).

Whether viewed in sophisticated or common-sense ways, scope of practice underpins the entire framework of our health provider licensing system. That is, state governments,[12] acting to protect and promote the public health, assess the education, training, and abilities of various provider groups and then signal to the public through licensure that these providers have been deemed competent and are authorized to provide a relatively defined range of health services in a safe and effective manner.

Understanding scope of practice as the central organizing principle of our regulatory scheme lets us appreciate the history of its political and professional evolution in each state—and its continuing importance for APCs.

Defining Scope of Practice under an Authority-Based Scheme

Physicians were the first health care providers to secure licensure in all the states, and their legislatively recognized scope of practice—the "practice of medicine"—swept the entire human condition into their exclusive domain. The almost unlimited range of physicians' authority to practice is reflected in the following typical Medical Practice Act provisions:

> **Definition of the practice of medicine:** A person is practicing medicine if he/she does one or more of the following:
>
> 1. offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
> 2. administers or prescribes drugs or medicinal preparation to be used by any other person;
> 3. severs or penetrates the tissue of human beings. (Washington Revised Code §18.71.011)

This all-encompassing medical scope of practice, combined with physicians' simultaneously obtained authority to supervise, direct, and delegate to all other kinds of health care providers, preempted the practices of other health professionals and clinicians. This forced subsequent legislatively recognized health care providers, such as APCs and others, to settle for narrowly confined scopes of practice "carved out" from the universe of the practice of medicine. Even then, physician supervision or referral was usually required.

This authority-based scheme continues to affect scope of practice today, in decidedly asymmetrical ways. For example, as research and innovation expand effective treatment modalities, physicians are able to provide those treatments without having to seek revision in their legal scope of practice.[13] In contrast, health care providers such as APCs not only must acquire the

[12] Although the federal government arguably could directly regulate individual providers, including their basic licensure, it has continued to honor the historic role of the states in carrying out these functions. Also, it should be noted that federal health care facilities (including those run by the U.S. military, the Department of Veterans' Affairs, and the Indian Health Service) set the scopes of practice for health care professionals practicing in their facilities. These scopes of practice may deviate somewhat from (usually they are more expansive than) the practice laws of the state in which these professionals practice.

[13] Interestingly, with increased medical specialization and heightened reliance on specialty "certification" as a prerequisite for institutional privileges/credentialing as well as for payment eligibility, medical organizations themselves have begun to emphasize that a physician's "ability," rather than professional certification or specialty status, should determine scope of practice, at least as far as physicians' clinical privileges. For example, note the following from a listing on the American Academy of Family Physicians website of policy statements on "Family Physicians Scope of Practice":

> "It is the position of the American Academy of Family Physicians (AAFP) that clinical privileges should be based on the individual physician's documented training and/or experience, demonstrated abilities and current competence, and not on the physician's specialty" (AAFP, 2009).

The American Medical Association (AMA) holds a similar position. Regarding clinical privileges, the 1993 *AMA Policy Compendium* states,

> "The accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training and experience, and demonstrated current competence." It also states that "[i]n implementing these criteria, each facility should formulate and apply reasonable non-discriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose" (AMA, 1993).

AAFP strongly believes that all medical staff members should realize that there is overlap between specialties and that no one department has exclusive "rights" to privileges. (http://www.aafp.org/online/en/home/policy/policies/c/colonoscopypositionpaper.html)

knowledge and ability to provide these new interventions but also must confirm that these tasks are within their scope of practice as it is currently defined. If not, these providers must engage in the time-consuming process of legislative or administrative modification of their scope.

Legislators, licensing boards, and professional organizations are well aware of the legislative and regulatory dynamics reference to this "historical" definition of physician scope of practice unleashed. Each effort to revise a particular profession's scope of practice to more accurately reflect ever-increasing clinical abilities is met with the argument of historic authority—that is, "This is medicine, and therefore only physicians can do it." Of course, given the undifferentiated, universal, and timeless scope of practice legally authorized in medical practice acts,[14] the "This is medicine" portion of the argument isn't inaccurate. However, the second prong of the argument ("…and therefore only physicians can do it") is both inaccurate and irrelevant to the question of who is competent to do what.

Defining Scope of Practice under an Evidence-Based Scheme

Fortunately for health care providers, and for the public they serve, the tide is turning slowly but inevitably toward emphasizing evolving ability and competence rather than static, historic grants of exclusive authority. This laudable and necessary shift in approach to scope of practice is succinctly set forth in a 2006 monograph entitled *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations* (hereinafter referred to as *Scope Changes*) (Association of Social Work Boards [ASWB] et al., 2006). Though not binding, the document provides information and guidance to health policy decision makers. Several aspects of *Scope Changes* are noteworthy for APCs and others interested in facilitating access to safe and effective care for their patients.

First, a unique process was used to develop *Scope Changes*. Its authors describe the publication as "a collaborative project developed by representatives of the [associations of] regulatory boards of the following health care professions: medicine, nursing, occupational therapy, pharmacy, physical therapy and social work" (p. 5). Second, the drafters rejected the static, historic-authority perspective and its resulting turf battles and opted instead to focus on patient safety. The resulting framework "rests on the premise that the only factors relevant to scope of practice decision-making are those designed to ensure that all licensed practitioners be capable of providing competent care" (p. 15).

To put to rest the most common arguments inherent in the "first-in-time, first-in-right" historic-authority approach, the document explicitly sets forth several basic assumptions informing the group's framework for scope of practice decision making:

1. Public protection, rather than professional self-interest, should have top priority in scope of practice decisions; this promotes the public's access to safe and competent providers.
2. Changes in scope of practice are inherent in our current health care system, as knowledge and capabilities are ever evolving.
3. Collaboration between health care providers should be the professional norm, not a selectively-imposed statutory requirement only for some.
4. Overlap among professions is necessary. No one profession actually owns a skill or activity in and of itself.
5. Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service. (ASWB et al., 2006, pp. 8–10)

In short, demonstrated clinical ability and competence are to be the touchstones guiding legal authority for health professional scope of practice.

[14] Even though physicians' legally defined scope of practice remains exceedingly inclusive and authorizes them to perform virtually any kind of medical or health intervention, most physicians do not and would not engage in such unfettered practice. A combination of extralegal constraints, including common sense, professional judgment, professional ethics, institutional credentialing systems, voluntary accreditation standards, and malpractice insurance provisions, reinforces self-restraint to keep physicians from practicing beyond the boundaries of their abilities.

Assessing Changes in Scope of Practice

Finally, with patient safety as the goal and clinical ability as the metric, *Scope Changes* articulates four areas of inquiry relevant to assessing changes in scope of practice. These include:

1. **Historical basis:** How do the history, theory, and evolution of the profession and its practice support the requested change?
2. **Education and training:** Do entry-level training programs provide the knowledge base and skill sets necessary for providers to acquire new skills? Do postprofessional training programs and/or competence assessment tools indicate that the advanced skill can be performed safely?
3. **Evidentiary base:** What clinical evidence and research, standards of care, risk data, and other benchmarking data are available to support the inclusion of new skills or techniques in the safe practice of these providers?
4. **Regulatory environment:** Is the licensing board authorized and prepared to resolve any regulatory issues resulting from the proposed change, including identifying standards of practice and training, as well as assessment mechanisms for competence? (ASWB et al., 2006, pp. 11–13)

The authors of the monograph conclude that if the analysis of these factors demonstrates a strong basis for redefining a particular scope of practice, the request should be approved, since doing so would promote public access to quality care.

This evolution in scope of practice assessment from an authority-based perspective to one of evidence-based ability bodes well for APCs in their desire to better meet the needs of their patients by providing a model to safe and effective reproductive health care services, including abortion.

E. WHO DETERMINES SCOPE OF PRACTICE?

Many factors and processes interact to shape the legally recognized scope of practice of APCs. There is significant variation among the states (and sometimes even within the same state) in the legal authority for health care providers' professional services. Regardless of these differences, however, there is a common framework for the development and implementation of scope of practice policy. To best serve their patients and their profession, as well as to protect their own professional integrity and license, APCs must understand the actors and processes involved in the legal determination of scope of practice.

The Common Legal Framework: State Practice Acts and Licensing Boards

For each group of licensed health care providers, the basis of regulation resides the practice act. This statute, enacted by the state legislature, determines that, to protect the public, only those who meet specified requirements, usually including successful completion of educational programs and a professionally relevant and validated examination resulting in licensure, can perform certain services or functions. The practice act sets out the rights and responsibilities of licensees and, in varying degrees of specificity, states what those license holders are authorized to do in their professional roles.

In addition, the practice act establishes an administrative agency (such as the Board of Nursing or PA Practice Committee of the Board of Medicine) comprised principally of practitioners and educators from the regulated profession, as well as public members, and gives it a variety of powers: to determine who meets the qualifications for licensure; to gather, analyze, and disseminate information on the licensed profession's practice; to ensure licensees' compliance with requirements and standards; and importantly, to implement the legislature's intent by adopting and enforcing rules and regulations designed to further that intent.

The role of these boards in policy development, especially in the area of scope of practice, is extensive and, in many ways, inevitable. Almost no practice act can specify

Although the title of the board, the exact responsibilities, and the specific duties may vary, each state has a regulatory board responsible for implementing legislative statutes governing the practice of CNMs, NPs and PAs. Traditionally, these boards are staffed by a combination of clinicians and non-clinicians whose goal is to protect the safety of the public by implementing licensure regulations that describe the minimum requirements for the practice of CNMs, NPs or PAs. The board keeps a list of all the practitioners who have meet these requirements for licensure and serves as the disciplinary arm to deal with practitioners who do not follow the rules. As such, the licensing boards are not necessarily the advocate for the CNM, NP or PA. They cannot set up special rules to help practitioners or defend them in actions against employers or physicians, and its members are not lobbied like members of the legislature. (Edmunds, 2006)

in advance each and every permutation of professional practice, especially given the rapid evolution of clinical knowledge and techniques and the concomitant expansion in educational curricula. As a result, licensing boards must constantly "update" their interpretations and applications of practice act provisions and policies. They do this through a variety of means, including issuing Advisory Opinions and Policy Statements and promulgating rules and regulations that establish more detailed rights and responsibilities than those typically found in the original practice act. In addition, in carrying out their enforcement functions in individual adjudications or disciplinary actions, licensing boards must grapple with the interpretation and application of policy to new and unique facts and circumstances. Their decisions affect not just the licensee involved, but also the entire profession through development of precedent. Finally, boards often are in the best position to identify the need for revisions to the practice act itself, and they can recommend proposals for statutory modifications to the legislature.

Licensing boards, especially Boards of Nursing responsible for NPs and CNMs, are constantly evaluating and assessing scope of practice issues. APCs and their professional associations must be active participants in these determinations.

Rulemaking is the most obvious method boards use to act on their authority to articulate and adopt policy. Usually, rulemaking is done in accordance with the state's Administrative Procedures Act, which generally requires public notice of the proposed rule and an opportunity for comment, either in a public hearing or through the submission of written testimony. Once it has evaluated the comments, the board either adopts the rule in its original or a modified form or decides not to finalize the proposal. In either case, it is important for APCs, individually and collectively through professional organizations, to analyze the policy issues involved and share their informed opinions on how the proposed rule would affect the public's access to safe and effective reproductive health care services.

Most nursing boards have other mechanisms directly focused on scope of practice development and interpretation. These include standing committees on advanced practice and scope of practice. These committees conduct ongoing assessments and evaluations of parameters for advancing educational and clinical practice. On their own initiative, on referral from the board, or by petition from an individual practitioner, these committees issue Practice Statements, Opinions, or Recommendations to the full board addressing whether a skill, procedure, or technique is within the authorized scope of practice of a licensed provider group. In taking these actions, nursing boards evaluate existing statutory and administrative policies, research and clinical studies, professionally developed standards of care, educational and training curricula, and experiences from other states, all with the goal of determining whether the new skills or techniques can be effectively and safely included in a provider's practice. As individuals or (more commonly) through their professional organizations, advanced practice nurses can play an important role in these processes, including providing testimony and documentation on factors relevant to demonstrating clinical ability and competence.

Medical boards governing PA practice may also have separate PA committees. In California the Medical Board includes a Physician Assistant Committee that provides limited guidance on scope of practice questions through answers to Frequently Asked Questions and Information Bulletins. In addition to the restrictions on scope of practice provided under state statutes and regulations, scope of practice determinations for PAs are often left to individual supervisory physicians who work with PAs to develop PA duties and delegation agreements. In some states, such as Montana, the supervision agreements developed by the supervisory physician and the PA must be submitted to the state's medical board (Mont. Code Ann. § 37-20-301(1)(c)(2007). In addition to the filing requirement of the PA supervision agreement to the Montana Board of Medical Examiners; Mont. Code Ann. § 37-20-301(2) and (3), the PA is required to have a signed "duties and delegation agreement" that must be kept by the PA and made available as requested. Individual PAs advocate for themselves by working with their supervising physicians to develop scope of practice and delegation agreements that allow them to provide the full

Continuous engagement with the relevant board (nursing, medical, PA, or midwifery) is vital to protecting and promoting professionally appropriate practice scopes. Although a proceeding on a specific practice issue may draw focused APC attention, engaging in ongoing dialogue with board members and staff to keep them updated on developing clinical abilities and the need for continual realignment of ability-based regulatory authorization is critical. This "early and often" relationship with licensing boards is an essential activity of state professional organizations.

range of services that are within the PA's competency and training and the supervising physician's area of specialization.

Please refer to Figure IV.3 in Section IV.F where we suggest effective strategies for working with licensing boards. In this section we describe how individual APCs and their professional organizations are most effective in informing regulatory boards.

One final scope of practice policy venue deserves special note: the adjudicatory or disciplinary proceeding, including investigation of outside complaints of alleged scope of practice violations. In carrying out their responsibility to ensure a licensee's compliance with legal practice requirements, boards can initiate disciplinary or adjudicatory proceedings directed at an individual provider. These proceedings are usually triggered by information gathered by board staff or by the receipt of a complaint (sometimes anonymous) from a member of the public or another health care provider. The process begins with informal information gathering by board staff or investigators. Depending on the results of this investigation, the proceeding can be concluded at this stage with a finding of no violation or a decision that a violation did occur, with the board and the practitioner agreeing to a set of penalties or corrective actions. If there is a finding of a likely violation and no mutually agreeable resolution, then the case can proceed to a formal adjudicatory hearing before the board, with a panoply of procedural rights and requirements specified by both the state Administrative Procedures Act and the board's own procedural rules.

Several issues integral to these disciplinary proceedings are noteworthy. First, the resolution of these cases often involves issues of "first impression." That is, the board is asked to interpret and apply the practice act and board policies to a unique set of circumstances that the legislature probably did not specifically anticipate when it wrote the act. The board must base its determination on the best fit between legislative intent, the authority granted to the board, and the facts and issues before it. Often, scope of practice issues are central to these cases. The board must analyze whether the individual provider's decision to perform the task(s) in question was supported by appropriate training and education and whether the provider demonstrated competence, both of which would place the task within the provider's scope of practice. Decisions like these have salience, not just for the individual involved, but also for the broad professional cohort. The board's determination of "within" or "not within" the scope of practice will have precedent-setting influence in delineating scope of practice policy.

The adjudicatory nature of these licensing board proceedings is markedly different from that of other policy-making processes. In rulemaking and the development of Practice Statements, for example, public and professional input of many kinds is permitted, and often encouraged. In adjudications, however, requirements of due process and fairness dictate that the board base its decision only on the information and evidence appropriately introduced by parties at the hearing. This generally precludes board receipt of communications outside the formal proceedings (ex parte contact). This emphasizes how important it is for individual APCs and their professional organizations to provide policy input on an issue before any disciplinary proceedings arise. It also reinforces that any assistance in demonstrating the competence basis for an inclusive interpretation of scope of practice must be filtered through the individual practitioner involved in the proceeding and her/his attorney for the board to consider it. If the clinician whose scope of practice is challenged has not been active in or in contact with state and national professional organizations, she/he may not receive the valuable assistance that peers and associations can offer.

The Role of the Professions in Defining Scope of Practice

National NP, CNM, and PA organizations have developed documents and policies related to philosophy of practice, practice boundaries, standards of practice and education, competencies

for entry into practice and excellence, ethical codes, practice guidelines, educational program accreditation, and practice policies such as institutional privileging, collaborative practice agreements, and so forth. These professional policies and documents establish criteria by which professional organizations credential clinicians. These criteria are also adopted by boards and other regulatory bodies from state to state to monitor and regulate clinical practice, deem it safe or unsafe, and discipline clinicians. Specialty practice (e.g., abortion care as a component of women's primary care or reproductive health) standards and clinical care guidelines build upon these foundational elements.

At the education level, academic programs that prepare APCs use these practice standards and competencies as the basis for curriculum development and program accreditation. Most national organizations also have state chapters and practice committees that play an important role in the implementation, review, and revision of regulatory and credentialing documents. Because professional regulation is implemented at the state level through licensing boards and legislative action, members of state practice organizations and committees must provide essential formal and informal expertise to these boards and agencies.

Advanced practice nursing organizations, nurse-midwifery organizations, and PA organizations along with professional organizations representing women's health practice have established a number of essential documents, policies, and mechanisms to assure clinical competence, safety, and quality care.

For more information on these professional organizations and their functions, see the Appendix:

- **Table A.1** describes APC professional organizations—who they are and their role in credentialing and defining scope of practice.
- **Table A.2** outlines the credentialing functions of nursing, midwifery, and PA organizations as they relate to patient and public safety: education standards, program requirements, and educational accreditation agencies; scope of practice delineation by role (e.g., CNM, NP, and PA) and by population (e.g., women's health, primary care); professional practice policies and documents (e.g., philosophy, standards, core competencies, clinical guidelines, and ethical codes); and professional certification programs.
- **Table A.3** lists websites for all these professional organizations.

F. HOW INDIVIDUAL APCS CAN PARTICIPATE IN SCOPE OF PRACTICE DETERMINATIONS

Participation in our professional organizations is a responsibility for all health professionals. If the professions fail to provide leadership in developing, maintaining, and advancing professional standards and responsibilities, then licensing boards and legislatures will take the lead.

What Professional Organizations Do for Individual NPs, CNMs, and PAs

Although the essential practice documents of each professional role are developed at the national level, each of the professional organizations representing APCs has regional or state chapters.

State nursing organizations are professional organizations which can be organized as labor unions and are often affiliated with the American Nurses Association. They provide a variety of services to their members, including lobbying at the state legislature, representing the profession before government agencies, providing continuing education for nurses, and disseminating information and updates about national and state professional issues. State nursing organizations also review and implement standards of practice and education, and in many states they provide collective bargaining services. State nursing organizations also encompass an active community of peers that can effect change and respond to challenges in politics, practice, and labor as well as advocate for nursing and quality health care. State nursing organizations affiliated with the American Nurses Association (ANA) represent advanced

Given the great number of bills proposed in state legislatures each year, state or national professional associations are better positioned than are individual APCs to gather and monitor this range of information. To be privy to this information and play a role in what is happening legislatively, APCs need to affiliate themselves with a professional organization active at the state level. Individuals and associations must remember that "early and often" contact with legislators is preferable to an "only in a crisis" approach. That is, APCs—individually and through their state professional organizations—need to continuously educate legislators about the value of their services. They must also emphasize that their patients and the public (the legislators' constituents/voters) are best served by laws that promote the fullest utilization of providers' ever-evolving clinical abilities.

practice nursing, which includes CNMs and NPs. States may also have free-standing NP organizations or NP organizations that function as subsidiaries within the state nursing organization.

Glossary: Practice essentials are documents developed by health professional organizations (such as practice philosophy, standards, core competencies, and ethical guidelines) that are essential for competent clinical and professional practice. These "practice essentials" provide the basis for education, legal regulation, professional certification, and practice credentialing.

Similarly, state and regional chapters of the American Academy of Physician Assistants (AAPA), the American College of Nurse-Midwives (ACNM), and the American Academy of Nurse Practitioners (AANP) provide support and leadership for their members in the area of **practice essentials**.

"Do the Math!" Because CNMs, NPs and PAs represent a small fraction of the total health workforce, usually less than 10% of the licensed nurses, it is important to work with state nursing organizations. For example, in California there are almost 20,000 APCs compared with over 300,000 RNs. These state nursing organizations have experienced government relations committees and lobbyists who are knowledgeable about practice laws, regulations and they maintain formal relationships with medical and nursing regulatory boards on behalf of their profession. State PA chapters contribute to collaborative advocacy efforts by working with both state medical and nursing organizations.

Getting Involved with Your Professional Organization

Participation in your professional organization can take many forms. A passive (but certainly important) form of participation is to pay membership dues to keep your membership in good standing and support your colleagues in bringing a professional voice to scope of practice conversations at the state and national levels. See Figure III.2

Much of what all the APC organizations accomplish is due to the volunteer efforts of their members: NPs, PAs, and CNMs across the country who contribute their expertise, energy, time, and perspective to the work of these groups. Raising the profile of APCs and their critical role in the future of health care delivery is one of the important activities of these organizations. The more members who are involved in and support their professional organization, the greater the organization's professional voice and impact.

Most state nursing organizations and chapters of national CNM and PA organizations have professional practice committees that provide leadership in that area. How various state APC organizations structure their professional practice–related activities varies, but all provide guidance and support for developing and maintaining the scope, standards, and competencies of professional APC practice. Join your organization's professional practice committee if you are interested, or form a subcommittee with other APCs working in reproductive health and/or abortion care. Such a subcommittee can

- provide support to its members,
- clarify professional practice issues (e.g., care refusal, restrictive legislation or regulations),
- provide expertise to a generic practice committee within the organization, and/or
- examine the limitations of your state's NP, CNM, or PA practice acts for advancing scope of practice into abortion care and/or provision.

Working with State-Based Professional Associations: Benefits and Challenges

Most state associations are powerful forces in influencing scope of practice and political decisions affecting APCs. Because the relationship between professional associations and regulatory boards differs from state to state, understanding your state's unique circumstances will prepare you to develop strategies and messages that will be most effective in meeting your goals.

Glossary: Collective bargaining is negotiation between organized workers and their employer or employers to determine wages, hours, rules, and working conditions.

Case studies throughout the United States lead us to recommend that all APCs belong to their state professional associations, but individuals may resist this recommendation for many reasons. Sue Davidson, Assistant Executive Director of Nursing Practice, Education, and Research at the Oregon Nurses Association (ONA), cites the **collective bargaining** aspect of her organization as the largest barrier to membership (S. Davidson, personal communication, September 2008). Davidson explains that although ONA (and its sister organization, Nurse Practitioners of Oregon) puts practice issues front and center, many potential members are uncomfortable with or are prohibited from participating in the bargaining aspects and therefore do not see a role for themselves in the association. Davidson believes that even when collective bargaining is not a barrier to membership, the perception of "union politics" and historical antipathy toward bargaining units create divisions within the profession and may prevent clinicians from joining their state association. In Oregon, only 29% of all licensed nurses belong to the ONA, a statistic that may undermine the association's ability to influence scope of practice conversations and decisions as effectively as it might otherwise. This low membership reflects the national trend to decreasing membership in health professional organizations.

Davidson explains that there has traditionally been a professional expectation (as codified in professional ethics codes for nursing, midwifery and PAs) that licensed professionals would belong to their state and national professional associations. She believes that while collective bargaining is the largest barrier to membership (for nurses), the decrease in membership nationwide is also largely a result of the training received during nursing education. She notes that clinician training programs focus almost entirely on clinical care, yet the majority of challenges to advanced practice nurses such as NPs and CNMs have to do with issues of professional ethics. Clinicians are often not prepared for these types of challenges and are unaware of the support that their professional associations can offer, both in proactively educating about ethical practice and in offering assistance when members are challenged.

Many APCs practicing in the field of reproductive health feel that it is the controversial nature of the specialty that makes them vulnerable. Professionals such as Davidson, however, cite the additional responsibilities, including self-regulation, that bring additional vulnerabilities and point out that beyond issues like abortion, *anyone* practicing in today's health care climate is operating in a politically charged environment. We've noted that protecting the interests of the public is the primary job of the regulatory boards; these politically appointed boards are bound by law to regulate professional practice and education and to discipline any licensed professional who violates the statutes and rules. Professional licensing boards are mandated to investigate any complaint made against an individual clinician. Clinicians who do not understand the roles and responsibilities of the licensing boards may misinterpret board action as adversarial or punitive.

Preoccupation with the daily demands of their practice or busy personal lives may keep clinicians from seeking involvement in their statewide professional community. Yet it is precisely this involvement, according to Davidson, that not only protects clinicians by bringing their collective voice to scope of practice determinations but also reinvigorates them for practice and shows them how to operate from a base of power rather than a defensive stance. Building alliances with peers and colleagues, presenting a unified voice within one's professional association, and then representing the views of that profession to the larger community of regulatory boards and legislative bodies can have tremendous impact on the priorities and strategies of those bodies, impact that cannot be replicated by those working outside a professional association. In this regard, membership and involvement in one's professional organizations is a key element of protecting and advancing scope of practice into politically charged areas of practice such as abortion care.

The anti-choice groups are ramping up their efforts to "chip away" at abortion access. We are seeing parental consent bills, bills requiring abortion providers to be obstetrician-gynecologist physicians, bills requiring waiting periods, and "middle of the night" bills introduced to restrict PA practice. We notify state (AAPA) chapters of these legislative measures to restrict PA practice and provide resources so they can respond effectively.

Ann Davis, AAPA Director of State Government Affairs, 2009

Clinicians are often not prepared for these types of challenges and are unaware of the support that their professional associations can offer, both in proactively educating about ethical practice and in offering assistance when members are challenged.

Membership in a state professional association can offer a chance to network with colleagues, to exchange ideas, strategies, and lessons learned; it gives APCs local professional support that the national specialty organizations cannot replicate. State professional associations can often recommend attorneys with expertise in administrative procedures that govern investigations into scope of practice issues. They may offer benefits, such as a certain amount of free legal assistance for members who need it, as part of their membership fee. Even more important, however, is that whatever the association's stance on abortion, clinicians will certainly find colleagues who are committed to protecting scope of practice, and these colleagues will support a clinician whom they believe to be acting within her/his scope regardless of their political feelings about a women's right to choose abortion. Messages like this can go a long way in gaining allies: "No matter how you feel about abortion, this is an issue about scope of practice. It is dangerous to let politically motivated complaints against nurses drive decisions about the best patient care."

Specialty Organizations—Important Allies with Professional-Role Organizations

Specialty organizations such as the National Abortion Federation (NAF) and Association of Reproductive Health Professionals (ARHP) are critically important in the development and maintenance of practice standards, competencies, and evidence-based clinical guidelines for reproductive health care and abortion care. However, membership in these organizations does not substitute for membership in a national (with state/regional chapters) NP, CNM, or PA organization.

FIGURE III.2

The Importance of Membership in Professional Organizations

Pulling the Load

By Susan Wysocki, RNC, NP, FAANP; President and CEO, Nurse Practitioners in Women's Health (NPWH)

The other day a nurse practitioner colleague of mine called to ask for NPWH's help in alerting our members in a state in which an NP was having her scope of practice (SoP) challenged. This NP had been providing pregnancy termination services for several years. The NP was experienced and skilled. But someone complained to the board of nursing (BoN). Even before the BoN had completed their investigation (required whenever such a complaint is made)—legislation was submitted that would create a "doctor only" law for the services that this NP was providing. The legislation passed the state senate before NPs in the state were even aware of it. Leaving aside the fact that the original issue concerned pregnancy termination services, the SoP issue would have set a precedent for "doctor-only" language for other circumstances and procedures as well.

The NP's state group rallied in support of her practice. The state chapter of the American Academy of Nurse Practitioners did the same. At NPWH, we sent out an email alert to our members in the state to send letters to state legislators asking that this bill limiting NP SoP not be passed. This particular NP needed support from all of these groups if she were to continue her practice. The problem had mushroomed beyond the BoN investigation of a scope of practice issue. The NP needed deeper and wider help and support.

The irony is that the NP under investigation was not a member of any of the groups that supported her. In fact, she was not a member of any state or national NP organization. But these organizations were there for her. Think about why they supported her. They did so because other NPs had been paying their membership dues and supporting these organizations and their goals. Member dues pay for the phone and fax lines that alerted NPs across the state. Member dues allow NPWH to send out email alerts within minutes of receiving the call.

In this particular NP's case, NPWH did help because the issue could potentially affect every NP in that state, including members of NPWH. Legislation to decrease any NP's scope of practice could become a new strategy for limiting procedures that NPs are qualified to perform.

Membership is your insurance if your scope of practice is ever threatened. Membership is your insurance that when you call, someone will answer the phone (because their salary and the phone bill have been paid). Membership is your insurance if someone other than you is challenged or you are simply in the line of fire.

Source: Previously published in Women's Health Care for NPs, 7(2), 6, 33; 2008 by NP Communications.

Despite the strong case for membership in one's professional association, additional barriers should be noted. For some, finances are the issue. APCs who provide abortion care may feel forced to choose between belonging to their professional association or to associations that specifically serve abortion providers (and they may also have to decide between attendance at professional conferences and clinical training opportunities). For those working in small clinics, this financial barrier, albeit an important professional investment, can feel insurmountable. Still others express reluctance to join their professional association because they feel ostracized for their pro-choice stance or their commitment to providing abortion care. All of these are valid concerns that clinicians should address with their professional associations and colleagues.

Building relationships with members of your state professional association before there is a scope of practice challenge (rather than waiting to act until a crisis presents itself) can increase communication and goodwill. We have been surprised to learn that, in some cases, while the pro-choice groups feel that the professional associations are inaccessible, the professional associations believe they cannot take a pro-choice stance because their membership would not support it. Clinicians working in family planning settings and abortion clinics may be ideal catalysts for bringing these parties together in conversation.

G. GETTING TO KNOW YOUR PROFESSIONAL COMMUNITY

Here are some proactive approaches for clinicians who want to become familiar with their professional community and take advantage of the learning opportunities that exist there:

- Read your professional practice act. Know how your scope of practice is defined in statute and regulations, including the rules (if any) for how your scope of practice can be advanced.
- Get to know the members of your licensing board: check out their profiles on the board's website and/or attend a board meeting. Identify board members who understand scope of practice regulation, and reach out to them *before* a crisis occurs. See section IV-E for additional strategies for working with state regulatory boards.
- Participate in practice development or maintenance where you work—for example, in institutional professional practice committees.
- Attend a meeting of your state professional association, and offer yourself as a resource to those who have questions about reproductive health.
- Form a practice group to apply your professional code of ethics or conduct to ethical issues in reproductive health and abortion care that are relevant to your practice.
- Seek membership on practice-related advisory councils associated with primary care or women's health. These councils may be at the level of a professional practice organization, the state department of health, the state/county public health system, or a state licensing board.
- Request a private meeting with the association's leadership to talk about your practice and the issues that are most important to you.
- Attend statewide conferences, and submit proposals for workshops focused on the evidence for maintaining access to abortion. Use evidence in *Toolkit* Section I-II as a template.
- Seek appointment to advisory committees and task forces that provide input to your state licensing board or to national councils representing state licensing boards.
- Offer testimony at state and national hearings on the subjects of proposed regulatory changes, prescriptive authority, or reimbursement schemes.
- Respond to invitations to review, edit, or provide feedback on circulated drafts of professional and regulatory policies that directly affect APC education and practice.
- Use your professional role in the service of your communities: on the PTA, in neighborhood associations, and in other volunteer roles that interest you.

Advocacy Activities with Professional Organizations: Pro-choice & Pro-professional Positions

Engage professional organizations in the adoption of position papers or resolutions on the role of nurses and PAs in preventing unintended pregnancies and protecting reproductive rights. For example, reproductive rights activists working with nurses in New York drafted a resolution titled "The role of nurses in patient education on birth control and reproductive health" that was subsequently passed at the New York State Nurses Association Annual Convention in October of 2004. The resolution read as follows: "...resolved, that the New York Nurses Association collaborate with other interested organizations to develop and disseminate educational materials on the provision of comprehensive pregnancy prevention methods and abortion procedures, and on the history of the role of nurses in providing this essential care to women." (New York State Nurses Association, 2004).

SUMMARY

- APCs must become familiar with the essential government actors—state legislatures and state licensing boards—who are responsible for developing and enforcing regulations governing their practice, including scope of practice determinations.
- Involvement of and input from both APC professional organizations and individual APCs at various stages in the regulatory process is critical.
- State licensing boards rely on the professional organizations to assess and define professional practice, standards of practice, and basic and advanced competencies that are the foundation for safe and effective care. These boards also look to state health-professional education and training programs to identify how practice standards and competencies are situated within the curriculum and clinical training.
- One of the important responsibilities of APC professional organizations is to align the essential elements necessary for APC legal scope of practice and credentialing (licensure and certification of competency) with evolving practice.
- Scope of practice is a central issue for APCs and their national and state professional organizations. Working with other reproductive rights advocacy and policy groups, individual APCs and their organizations must continue to situate early pregnancy termination procedures within the scope of health care services APCs can capably provide for their patients.
- Disciplinary proceedings and scope of practice investigations target individual clinicians. To protect against such inquiries, APCs and their professional organizations must provide regulators with policy input demonstrating APC ability/competence and supporting an inclusive interpretation of scope of practice before these challenges occur.
- APCs who have not been active in, or in contact with, their state and national organizations may not receive the professional assistance those organizations can offer should their scope be challenged. This is detrimental to both the individual and the profession as a whole.
- Working with your professional organization provides political support when facing challenges from anti-abortion groups but also challenges from organized medicine to limit APC scope of practice.

A Tip for Administrators and Advocates:

Actions you can take:

- Become familiar with how scope of practice is regulated for CNMs, NPs and PAs in your state.
- Support APCs in your organization to become involved in their professional organizations.
- Work with APC organizations to craft common messages in response to anti-abortion attacks on APC scope of practice.
- Offer to help APCs in your organization research the use of state-specific mechanisms for changing health professional statutes and regulations such as state administrative law procedures.

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