



Questions from the APNA/ISPN LACE Taskforce Interactive Session

October 25, 2010

Questions about the proposal from the APNA/ISPN Taskforce

- 1. In the proposed model, would a psych CNS who is currently practicing become an NP?**

No, in order to become an NP, one would need to meet eligibility requirements to take the NP exam and then take and pass the exam.

- 2. If there is only PMH-NP, what title will the Adult NP have?**

Titles are determined by state legislature. The proposed title in the Consensus Model for all advanced practice nurses is APRN.

- 3. Can't we just grandfather everyone in as NPs? Doctors don't have these issues.**

No, in order for a CNS to become an NP, one would need to meet eligibility requirements to sit for the NP exam. MDs don't have this issue because they have one role and one path to licensure. The Consensus Model represents an effort for nursing to have greater consistency in licensure, accreditation, certification and education.

- 4. If someone is a CNS who took the 3 Ps (patho, pharm, physical assessment), what is the path to become an NP?**

If a CNS would like to become an NP, the person should contact a nursing program that offers a post-master's PMH-NP certificate and inquire about requirements for the NP program. In most cases, a gap analysis is done to compare courses/clinical hours taken in the student's past CNS program with courses required in the NP program to determine the gaps (the courses and clinical hours that need to be completed).

- 5. Would a psych CNS be qualified to teach in a psych NP program?**

Theoretically, yes, but individual schools set their own requirements for faculty status. The current National Task Force (NTF) states that NP programs need to

be directed by NPs. This does not necessarily mean that each PMH NP program needs to be directed by an NP. NTF criteria can be met if there is an NP who directs all of the NP programs at the school. PMH CNSs are qualified to teach in PMH NP programs because the content in these programs have been essentially similar.

6. When there is talk about numbers of clinical hours, does that mean hours in order to take the exam or hours to graduate from NP programs?

At this time, when we talk about clinical hours, the hours needed to sit for a certification exam must be taken within a graduate program. Thus, the hours needed to graduate are equal to or greater than the hours needed to take the certification exam.

7. What recommendations do you have for nurses who graduated from child and adolescent CNS programs, but need to sit for the exam?

We would recommend that you take the child/adolescent CNS exam.

8. We are currently preparing people to be beginning practitioners. How do we add all this content without adding more courses and cost?

There are current programs that have lifespan content and clinical. The courses and hours vary from program to program. It will be the task of PMH nursing to determine essential content.

9. Other NP programs focus on a specific age group in order to gain in-depth knowledge and practice experience. The PMH-NP dilutes and weakens our knowledge compared to our NP peers.

There are other examples of lifespan education. For example, family nurse practitioners and nurse anesthetists are educated across the lifespan.

10. As we move toward a more broad-based preparation for PMHNP students, how do you think we can develop a consensus about “how much is enough” re: expertise across the lifespan at entry level? What do you anticipate the length of the new educational programs will be? Do you think that will affect the number of students who choose psych?

These are good questions and working through them will need to be the next step in the process. One fact that may work in our favor is the movement of all advanced practice programs to the DNP. But, there needs to be more discussion about essential content.

11. Do you think you can adequately test basic skills as a PMH NP with one certification exam? For example, would specific child and adolescent skills be a small subset of questions on the exam?

Most APRNs currently take one exam, so one exam for psych would not be unusual. In terms of content, the exam would need to be psychometrically sound and legally defensible and will test basic knowledge, not expert knowledge.

12. An ANCC friend said they are definitely dropping the CNS exam based upon your (the task force) recommendation. Is that true?

No, we have asked ANCC not to discontinue any exams at this point. We are still gathering input from stakeholders before the APNA BOD and ISPN BOD make their final decision about recommendations for the future. We have been and continue to be in close dialogue with ANCC.

There is some discussion about the future viability of the child/adolescent CNS exam, but that is based upon the low number of new candidates taking the exam each year; low numbers of individuals taking an exam potentially impact the reliability and validity of that exam.

13. Why not all be CNSs? Have we not adopted and embraced the medical model as the primary focus is now prescriptive?

The task force proposal was based upon the following: the task force felt that the NP role was more widely recognized than the CNS; the trend in PMH education and certification is toward the NP, with an increase in newly certified NPs and a reduction in newly certified CNSs; and the task force strongly asserted that psychotherapy skills remain part of PMH NP education (and be the 4th P).

14. For the inpatient population, institutions can bill for NP care. Will they be willing to pay NPs to provide inpatient staff education?

That would be dependent upon the institution.

15. In my area, NPs are paid less than CNSs. What can be done?

Salaries vary from geographic area to geographic area, but because of restraint of trade issues, APNA does not get involved in salary issues. APNA is also not a collective bargaining organization.

16. How do the recommendations blend with the recent IOM recommendations and health care reform?

Given the fact that the NP is more widely recognized as the advanced practice nursing direct care provider, the task force believes that the proposed role will be beneficial to PMH nurses in the future.

Questions about the Consensus Model for APRN Regulation

- 1. How will the Consensus Model be implemented so that it does not negatively impact currently practicing CNSs or NPs? I am concerned some State Boards of Nursing will jump the gun and refuse sooner rather than later to re-issue Advanced practice licenses to those who are CNS and not NP. I want to continue providing psychotherapy and not prescribe. Do I need to go back to school to get the NP courses to do what I have been doing for the past 15 years?**

Within the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education there is a “grandfathering clause” that is expected to prevent the Consensus Model from impacting practicing APRNs. The following is quoted from the Consensus Model:

Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure. However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- Current, active practice in the advanced role and population focus area,*
- Current active, national certification or recertification, as applicable, in the advanced role and population focus area,*
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and*
- Compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure).*

Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) All new graduates applying for APRN licensure must meet the requirements outlined in this regulatory model (Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, Education)

If you have not read the Consensus Model, we recommend that you read it. It is posted on the APNA website (www.apna.org).

2. Does the Consensus Model include other nursing specialties, such as peds, adult, etc.?

Yes, the other populations are pediatrics, neonatal, adult/gero, family/individual across the lifespan, and women's health/gender-related.

3. The APRN Consensus Model did not eliminate the adult NP or pediatric NP roles so why did we recommend doing this for psych?

In the Consensus Model, lifespan PMH education would lead to entry-level advanced practice licensure. The proposed model would provide all new PMH NPs with broad-based education and would enable consistent licensure from state-to-state. In the future, with certification tied to licensure, if one were certified as an adult PMH NP or child NP, seeing an individual outside those age parameters would mean that the practitioner is operating outside his or her scope of practice and could potentially jeopardize his or her advanced practice license. The paucity of mental health providers in many areas of the country makes it important that PMH APRNs be licensed to treat individuals across the lifespan. The task force recognized the need or desire for increased specialization in areas such as child psychiatric nursing. Educators and practitioners will need to work together to offer specializations that meet the mental health needs of subpopulations.

4. What will you be doing to make state/commonwealth laws re: scope of practice consistent from state to state?

The National Council of State Boards of Nursing (NCSBN) has proposed model legislative language and each state board of nursing has voted in favor of this model language. However, state laws still could potentially vary from state to state. One goal of the Consensus Model is consistency in legislation from state to state, but enacting this goal will require psychiatric nurses to be involved at the state level.

5. What will the requirements be for supervision? Credentials?

The Consensus Model and the NCSBN model legislative language recommend independent practice in all of the states, but achieving this will require active involvement of PMH nurses at the state level. The task force proposed that PMH-NP be the future certification for advanced practice psychiatric nursing.

6. Under the Consensus Model, would "specialty" areas include areas such as child, geriatric, primary care behavior consultant and "subspecialty" be areas like, acute care child/adolescent?

Within the Consensus Model, advanced practice nurses need to be educated in a role and a population. APRN licensure would be at this level. The LACE task force has proposed that the role be NP and the population would be lifespan PMH education. The Consensus Model does include options for specialization, over and above that required for licensure. Specialty areas could include child, geriatrics or other areas of continued specialization. In the Consensus Model, the term “subspecialty” is not used.

7. I would like to know why ANCC does not offer one exam for PMH NP and CNS.

The Consensus Model distinguishes the NP and CNS role as two separate roles. Thus, there was not support among the states for one exam to test the two roles. Also, given the Consensus Model, ANCC decided to not launch a “combined” exam.

Questions about the DNP

1. How does the Consensus Model relate to the DNP? Will the DNP become entry into practice?

The American Association of Colleges of Nursing (AACN) has mandated that all advanced practice programs be at the DNP level by 2015. However, this mandate is separate from the Consensus Model. Exactly how programs integrate lifespan PMH NP programs into their DNP programs will be up to individual programs. However, each program will need to meet AACN Essentials for DNP Education.

2. What happens to those NPs that do not go back to obtain a DNP by 2015?

The DNP mandate only applies to future students and will not impact current APRNs.

Comments from LACE meeting

1. This is a very important move toward unity—which will only strengthen our role as PMH NPs
2. BRAVO! I would like to be on the task force for the next phase—Kirste; xxxxx@xxx.com. Currently Adult CNS and getting certified in child. I am tired of telling people that a CNS is “like an NP but different: The public understands the term NP.
3. While nursing is working its way through this...the PAs are scooping us with their psych certification exam.

4. I am a full time study in an NP Psych program. It seems with all the goals that a practicing NP needs to achieve in his or her practice at graduation that the programs that are in existence are too short and do not include all courses or enough clinical hours to meet those goals. I feel the programs need to be longer and more in-depth.
5. How do you propose and allow for clinical hours throughout the lifespan? I believe a residency program would work and I would love to work on this. Kelley
6. APNA has a Grad Ed Council—how can this council assist the work of the LACE task force so that we don't work at cross purposes, especially regarding substantial changes in the APRN PMH curriculum for the future? Carole and Ginny.
7. I think the number of hours/credits is prohibitive for recruiting NPs in PMH. This PNP is not going to be successful.