About a year ago, there was a question that came in through our information line. It was an email from a nurse practitioner and this is what she asked. "I am a primary care nurse practitioner, I've been offered a position as a hospitalist in a medical facility. I have much experience in the acute care environment as a registered nurse. Am I within my scope of practice if I accept this position?"

By the way, we only have 29 acute care facilities in the state and a good portion of them are critical access hospitals. Interesting question. When I read that, I thought, "Why is that even a question?" So, brought it to the practice committee, and we spent some time stepping back and reviewing why is this a question, talking about this, who is this person?

And then, we realized, out of the seven of us or out of the seven board members, each board member knew at least five or six family nurse practitioners who were possibly working in the acute care environment as hospitalists or in the ICU.

So, that was the scope of the problem initially. We realized that if anything were to be done such as discipline, it could cause an access-to-care problem in the state immediately. They decided on a phased-in communication and education project.

And they decided not to seek out discipline of these individuals, but absolutely, if a complaint were filed, that they would review their scope of practice complaints per the NPA. So, I'd like to walk you through our communication plan.

The first piece was, it was my responsibility to explain to all the board members, because we do have one public member, and we had an LPN who were not fully understanding of the consensus model of the history behind APRN graduate education foundational. So, I explained that, and we came up with some possible solutions.

Since we only have four powers, regulate and make the rules, license, discipline, and the education piece, we had four possible solutions. The board voted and decided that they would not open their own complaints at this time against those individuals who were practicing as hospitalists. However, they would like to create what amounted to a lengthy communication project with the community, with the licensees, stakeholders, ee, discipline, and thkend thowd

They are highly qualified and capable. And the two top is that employers did not understand the four APRN roles or population foci, and that was where the rubber meets the road. APRNs are passionate.

I put this here because when we started with the focus group invites, people wanted to know about it, they talked about it, there was a flurry of conversation in this state that would get back to me. So, that

was specific to Wyoming, what Wyoming APRNs need to know about population foci. We've published that in the WNR. And then, we resubmitted, redistributed the advisory opinion on population foci, which was created in 2007.

And when I did that, I did point out that it was created in 2007, and it's remained the same since. The employers' information phase. So, previous to this, the information was sent, more or less, to the APRNs themselves, and now, in the fall, we started reaching out to the employers.

And that, again, is where the rubber, kind of, met the road. Employers thought that the APRN model was comparable to the physician's assistants or medical model. As a matter of fact, I've never met one employer who did not know this about their education.

The goal was to ensure that they were clear on the education model without causing a panic among leaders or their APRNs. We started with a memorandum to all the acute care facilities who employed APRNs.

And I believe, most of them, there might have been 1 or 2 out of the 29 that, at that time, didn't employ APRNs, but that has changed since. After that memo went out, the president of the hospital association asked to come into the office and talk to us.

He stayed about two hours. He was asked by his people to get some further explanation. I met with him for the first two hours and explained this, he was very accepting. Like I said, we used positive words, positive affirmations. We know that everybody wants to be compliant, we really do.

He came back two times after that, more information, he would go and help. He ended up being an excellent collaborator and helped us. After talking to his people, they requested that we create a webinar on how to credential your APRNs, they wanted to learn more, they wanted to have something they could share.

They invited me to staff meetings to talk to everybody. They invited me immediately over to the local hospital. As soon as they got the letter, they said, "Would you come and do a presentation?" The association also sent out their own newsletter article, which I wrote for them, which mirrored the memorandum. So, we were always on the same page. And the pièce de résistance was the court case that I gave the CEOs of the hospital.

I might not pronounce it right, I kind of got a cross between Dolly Parton and Al Pacino accent, it's Billeaudeau versus Opelousas General Hospital. And it was, I believe, 2016 precedent out of Louisiana, which stated that acute care facilities are responsible for properly credentialing their providers.

That got everybody's attention. So, knowledge. The University of Wyoming was founded in 1886 when Wyoming was still a territory. It opened its doors to 42 students and 5 faculty members. And befitting the University of The Equality State, both students and faculty included women from the first day, so that's 1886.

And that is Pistol Pete, one of our mascots. And the horse that...oh, I forgot the horse's name. Piston Pete. Ability. So, how did WSBN support the ability to change enhancing compliance with the Nurse

course, is no, any physician, we cannot send a contract waiving our rights under the Nurse Practice Act, waiving our responsibilities under the Nurse Practice Act.

Grandfathering. Is there a possibility that the current FMPs I have working on my hospitalist team can be grandfathered in some way? We do have a grandfather piece in our Nurse Practice Act, but it's from 1999 if you were prior to...and we have about 50 nurse practitioners and CNSs who were grandfathered in.

We actually have a nurse practitioner who does not have a master's degree, she has a bachelor's degree. What are our options? They wanted to know what can we do. At this point, when I'm asked what are our options by the hospital leaders, I give them examples, such as how about tuition reimbursement. Tuition reimbursement for your gals, and I say gals because most of them are women, who would like to go and get a postgraduate, a secondary certificate.

How about time off so they can do their clinicals? I'm trying to give them examples. And the most common question was, is this something Wyoming made up? Heard my little cheese. No, we didn't make it up, it's a national standard.

Reinforcement. How will WSBN reinforce the change in understanding and the desire to become compliant going forward? Always, always, always positive, collaborative discussions. We don't want to place the blame on anybody.

And quite frankly, I am more and more sympathetic to the APRNs who have taken a position in acute care environment because those are the jobs that are available. If you know the state of Wyoming, our larger cities are few and far between, and in between there, is a few hundred miles.

It's not like Chicago, where I can go to the next city and get a job in primary care, it's just not that way at all. I, as the P&E consultant, want to give support. I'll talk to anybody who wants to call me, I don't need your name, I'll talk to you like you're my best friend giving good advice. And that's the way, and it makes people feel better, more at ease.

Authoritative document sharing. The practice committee wrote all the communications together, and that is four people. And then, we would take that final product and run it through probably about four or five other people.

So, it was really a community effort on any piece of communication, we were scouring it for perfection. Open discussions. And my plan is to redistribute the advisory opinion prior to renewals this year. Reinforcement. A rodeo writer has to reinforce his grip, Cheyenne is home to the Cheyenne Frontier Days, a 10-

maybe we can have a acute care nurse, a hospitalist, come down and help out because we know they're going upstairs.

We know who's going upstairs, and we left it to them to figure that piece out because, you know, that medical home model because of the same problems we're having nationwide, more and more patients are coming for the small things or coming that they should probably see their physician for who's not available, right?

So, thank you. Ma'am? - [Caroline] Hi. I'm Caroline Buford, I am an attorney and former nurse practitioner, and my law practice is all about the legal issues affecting nurse practitioners. So, I get a lot of emails from nurse practitioners about scope of practice issues, women's health care, doing primary care, family nurse practitioner doing psych, etc., etc.

And also from our ends who are asked to do things that are questionably outside their scope of practice. So, I'm always looking for examples of how people have gotten into trouble, you know, as a learning situation, and I always say, "Well, you know, if you get sued, the first thing the plaintiff's attorney is going to say is, 'What's your qualification for even doing this?'"And then, I say, "And then you can give a report to the Board of Nursing."

But the thing is, I haven't come up with any cases and I have trouble finding any cases where boards of nursing have disciplined people. So, my question is, well, if anybody here knows of such case, I'd love to hear of them. And then, you mentioned one complaint. Can you just give me a general idea?

- Yes, I could. It was a nurse practitioner who was only acute...excuse me, adult-care-certified. She came from another state. I don't know if she was working through...she was working through some kind of agency. And she saw pediatric clients. And there was some kind of bad outcome to clients.

And the complaint from the parents were made to the corporation. And the corporation opened up her HR file and said, "Why are you seeing pediatric clients when you're an adult nurse practitioner?" And she said, "Well, you know, you credentialed me, you put me here.And don't tell the board."

primary that you draw your lines in a way that do not create problems for people who have been prepared to do the kinds of things they're doing. And the whole thing we focus on an awful lot, in relation to this, was that the setting was not what it was supposed to be, it was the role.

And we've been very strong about that and we hope that that will continue.

- Indeed. And thank you for that clarification, I guess. Thank you. And I did talk about blurring, and that's what we're finding, too, especially the cardiologist who has a nurse practitioner on staff, who he sends to discharge his patients. Well, they're an hour away from going home. Why could she do that? Right?

So, we are seeing that there is a lot of scenarios, but the main thing is, I think, it was a good model, I feel like it was successful, we have a little bit more work to do going forward. And we are very pro-APRN. And, you know, APRNs are the answer. We have 250,000 in the United States, our numbers have grown by 100% in just a few short years.

We've got to hopefully figure all of these details out and move forward, so I appreciate your support. And anybody who wants to get together and talk this, please give me a call. Thank you.

- Thank you, Jennifer, thank you so much.