

**Consensus Model for APRN Regulation:
Licensure, Accreditation, Certification & Education**

July 7, 2008

**Completed through the work of the APRN Consensus Work Group & the
National Council of State Boards of Nursing APRN Advisory Committee**

The APRN Consensus Work Group and the APRN Joint Dialogue Group members would like to recognize the significant contribution to the development of this report made by Jean Johnson, PhD, RN-C, FAAN, Senior Associate Dean, Health Sciences, George Washington School of Medicine and Health Sciences. Consensus could not have been reached without her experienced and dedicated facilitation of these two national, multi-organizational groups.

LIST OF ENDORSING ORGANIZATIONS

This Final Report of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee has been disseminated to participating organizations. The names of endorsing organizations will be added periodically.

The following organizations have endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (July 2008).

Posted January 2009

Academy of Medical-Surgical Nurses (AMSN)
American Academy of Nurse Practitioners (AANP)
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing (AACN)
American Association of Critical-Care Nurses (AACN)
American Association of Critical-Care Nurses Certification Corporation
American Association of Legal Nurse Consultants (AALNC)
American Board of Nursing Specialties (ABNS)
American College of Nurse-Midwives (ACNM)
American College of Nurse Practitioners (ACNP)
American Holistic Nurses Association (AHNA)
American Nurses Association (ANA)
American Nurses Credentialing Center (ANCC)
American Psychiatric Nurses Association (APNA)
Arkansas State Board of Nursing
Association of Faculties of Pediatric Nurse Practitioners (AFPNP)
Commission on Collegiate Nursing Education (CCNE)
Dermatology Nurses Association (DNA)
Dermatology Nursing Certification Board (DNCB)
Emergency Nurses Association (ENA)
Gerontological Advanced Practice Nurses Association (GAPNA)
Hospice and Palliative Nurses Association (HPNA)
National Association of Clinical Nurse Specialists (NACNS)
National Association of Orthopedic Nurses (NAON)
National Association of Pediatric Nurse Practitioners (NAPNAP)
National Board for Certification of Hospice and Palliative Nurses (NBCHPN)
National Certification Corporation (NCC)
National Council of State Boards of Nursing (NCSBN)
National Gerontological Nursing Association (NGNA)
National League for Nursing (NLN)
National League for Nursing Accrediting Commission, Inc. (NLNAC)
National Organization of Nurse Practitioner Faculties (NONPF)
Nurse Practitioners in Women's Health (NPWH)
Nurses Organization of Veterans Affairs (NOVA)
Oncology Nursing Certification Corporation (ONCC)
Oncology Nursing Society (ONS)
Orthopedic Nurses Certification Board (ONCB)

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Pediatric Nursing Certification Board (PNCB)

Wound, Ostomy and Continence Nurses Society (WOCN)

Wound, Ostomy and Continence Nursing Certification Board (WOCNCB)

INTRODUCTION

Advanced Practice Registered Nurses (APRNs) have expanded in numbers and capabilities over the past several decades with APRNs being highly valued and an integral part of the health care system. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs need to be effectively aligned in order to continue to ensure patient safety while expanding patient access to APRNs.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but shares the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards-governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

Many nurses with advanced graduate nursing preparation practice in roles and specialties e.g., informatics, public health, education, or administration) that are essential to advance the health of the public but do not focus on direct care to individuals and, therefore, their practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the four current APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education. Although extremely important to the nursing profession and to the delivery of safe, high quality patient care, these other advanced, graduate nursing roles, which do not focus on direct patient care, are not roles for Advanced Practice Registered Nurses (APRN) and are not the subject or focus of the Regulatory Model presented in this paper.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations included in this document. In a few instances, when agreement was not unanimous a 66% majority was used to determine the final recommendation. However, extensive dialogue and transparency in the decision-making process is reflected in each recommendation. The background of each group can be found on pages 13-16 and individual and organizational participants in each group in Appendices C-H.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Overview of APRN Model of Regulation

The APRN Model of Regulation described will be the model of the future. It is recognized that current regulation of APRNs does not reflect all of the components described in this paper and will evolve incrementally over time. A proposed timeline for implementation is presented at the end of the paper.

In this APRN model of regulation there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs¹, are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a pre-approval, pre-accreditation, or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited² and their graduates must be eligible for national certification used for state licensure.

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes. APRN certification programs will be accredited by a national certification accrediting body³. APRN certification programs will require a continued competency mechanism.

Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they cannot be licensed solely within a specialty area. *In addition, specialties can provide depth in one's practice within the established population foci.* Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e., nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations.

¹ Degree granting programs include master's and doctoral programs. Post-graduate programs include both post-master's and post-doctoral certificate education programs.

² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

³ The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

In addition, a mechanism that enhances the communication and transparency among APRN licensure, accreditation, certification and education bodies (LACE) will be developed and supported.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for **all** APRNs is that a significant component of the education and practice focuses on direct care of individuals;
4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**

7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

The Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and

system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

Titling

The title Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.⁴ This title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles. An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

⁴ Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term *advanced public health nursing* however, may be used to identify nurses practicing in this advanced specialty area of nursing.

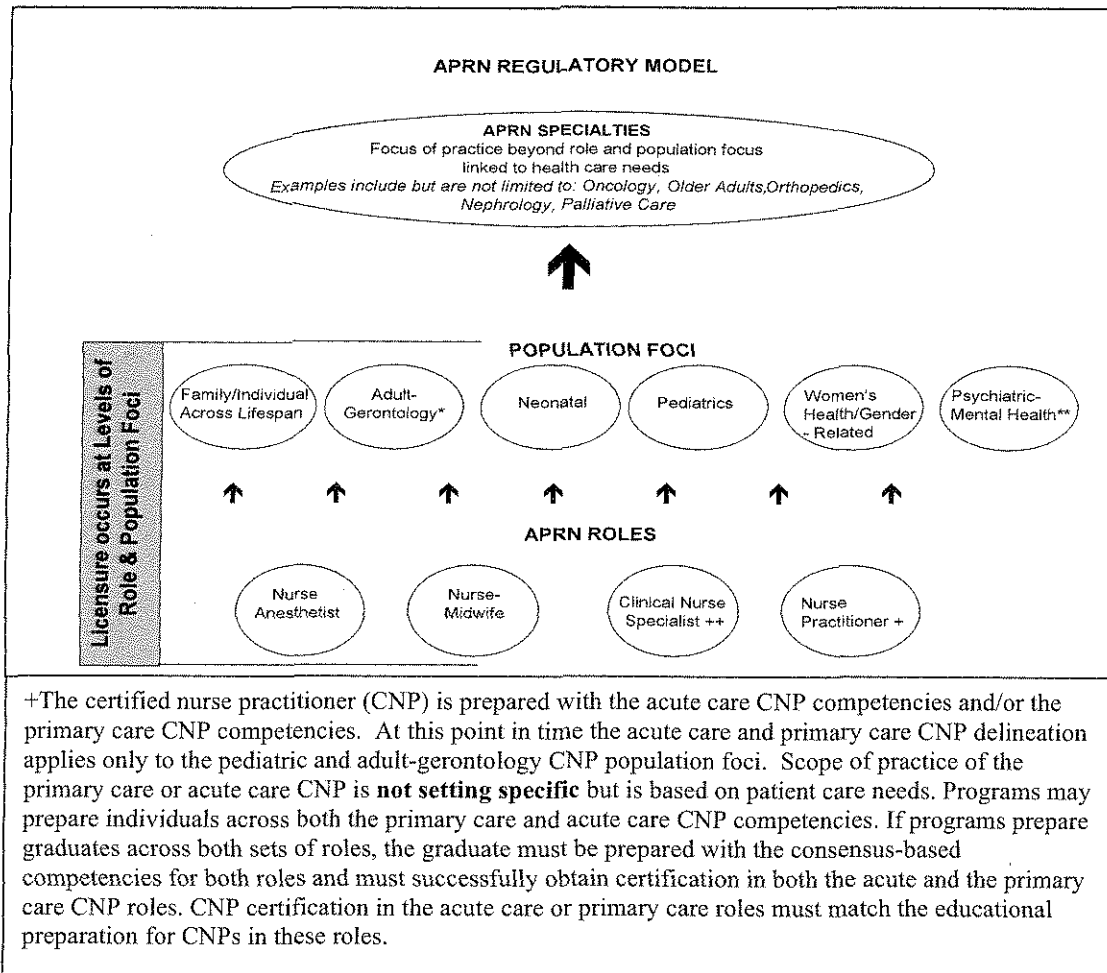


Diagram 1: APRN Regulatory Model

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

++ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation, or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- include at a minimum, three separate comprehensive *graduate-level* courses (the APRN Core) in:
 - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
 - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
 - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre-approval, pre-accreditation, or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to ensure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse, or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.

An APRN specialty

- preparation cannot replace educational preparation in the role or one of the six population foci;
- preparation can not expand one's scope of practice beyond the role or population focus
- addresses a subset of the population-focus;
- title may not be used in lieu of the licensing title, which includes the role or role/population; and
- is developed, recognized, and monitored by the profession.

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the role practice as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations, etc.).

Education programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN education programs, including preparation in the APRN core, role, and population core competencies. In addition, for licensure purposes, one exam must assess the APRN core, role, and population-focused competencies. For example, a nurse anesthetist would write one certification examination, which tests the APRN core, CRNA role, and population-focused competencies, administered by the Council on Certification for Nurse Anesthetist; or a primary care family nurse practitioner would write one certification examination, which tests the APRN core, CNP role, and family population-focused competencies, administered by ANCC or AANP. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty, *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the four nationally recognized APRN roles and in one of the six population foci. Individuals must be

recognized and credentialed in one of the four APRN roles within at least one population foci. APRNs are licensed at the role/population focus level and **not** at the specialty level. However, if not intended for entry-level preparation in one of the four roles/population foci and not for regulatory purposes, education programs, using a variety of formats and methodologies, may provide licensed APRNs with the additional knowledge, skills, and abilities, to become professionally certified in the specialty area of APRN practice.

Emergence of New APRN Roles and Population-Foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. In addition, the scope of practice within the role or population focus is not entirely subsumed within one of the other roles. Careful consideration of new APRN roles or population-foci is in the best interest of the profession.

For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus. A new role or population focus should be discussed and vetted through the national licensure, accreditation, certification, education communication structure: LACE. An essential part of being recognized as a role or population-focus is that educational standards and practice competencies must exist, be consistent, and must be nationally recognized by the profession. Characteristics of the process to be used to develop nationally recognized core competencies, and education and practice standards for a newly emerging role or population-focus are:

1. national in scope
2. inclusive
3. transparent
4. accountable
5. initiated by nursing
6. consistent with national standards for licensure, accreditation, certification and education
7. evidence-based
8. consistent with regulatory principles.

To be recognized, an APRN role must meet the following criteria:

- nationally recognized education standards and core competencies for programs preparing individuals in the role;
- education programs, including graduate degree granting (master's, doctoral) and post-graduate certificate programs, are accredited by a nursing or nursing-related accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA); and
- professional nursing certification program that is psychometrically sound, legally defensible, and which meets nationally recognized accreditation standards for certification programs.⁵

⁵ The professional certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

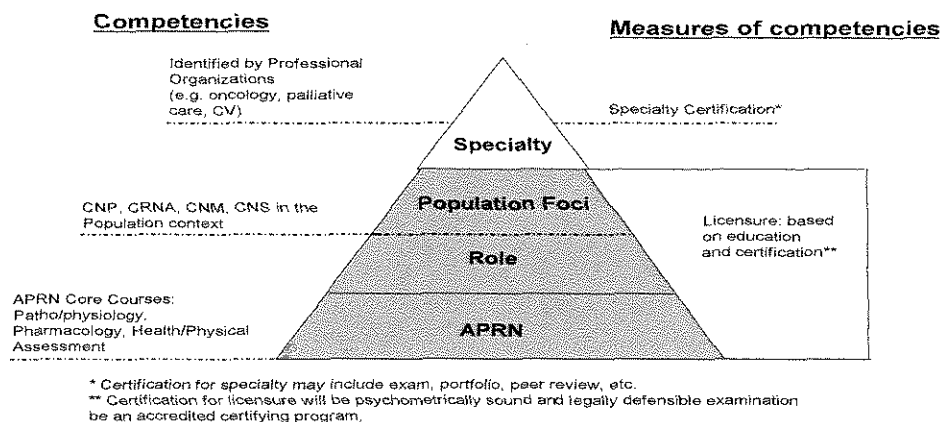


Diagram 2: Relationship Among Educational Competencies, Licensure, & Certification in the Role/Population Foci and Education and Credentialing in a Specialty

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification, and education (LACE) must work together. Expectations for licensure, accreditation, certification, and education are listed below:

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses⁶;
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;
8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact;

⁶ Except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse-midwives and midwives jointly.

9. have at least one APRN representative position on the board and utilize an APRN advisory committee that includes representatives of all four APRN roles; and,
10. institute a grandfathering⁷ clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

Foundational Requirements for Accreditation of Education Programs

Accreditors will:

1. be responsible for evaluating APRN education programs including graduate degree-granting and post-graduate certificate programs.⁸
2. through their established accreditation standards and process, assess APRN education programs in light of the APRN core, role core, and population core competencies;
3. assess developing APRN education programs and tracks by reviewing them using established accreditation standards and granting pre-approval, pre-accreditation, or accreditation prior to student enrollment;
4. include an APRN on the visiting team when an APRN program/track is being reviewed; and
5. monitor APRN educational programs throughout the accreditation period by reviewing them using established accreditation standards and processes.

Foundational Requirements for Certification

Certification programs providing APRN certification used for licensure will:

1. follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure (see appendix A for the NCSBN Criteria for APRN Certification Programs);
2. assess the APRN core and role competencies across at least one population focus of practice;
3. assess specialty competencies, if appropriate, separately from the APRN core, role and population-focused competencies;
4. be accredited by a national certification accreditation body;⁹

⁷ 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

⁸ Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs.

⁹ The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

5. enforce congruence (role and population focus) between the education program and the type of certification examination;
6. provide a mechanism to ensure ongoing competence and maintenance of certification;
7. participate in ongoing relationships which make their processes transparent to boards of nursing;
8. participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Foundational Requirements for Education

APRN education programs/tracks leading to APRN licensure, including graduate degree-granting and post-graduate certificate programs will:

1. follow established educational standards and ensure attainment of the APRN core, role core and population core competencies.^{10,11}
2. be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA).¹²
3. be pre-approved, pre-accredited, or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. ensure that graduates of the program are eligible for national certification and state licensure; and
5. ensure that official documentation (e.g., transcript) specifies the role and population focus of the graduate.

Communication Strategies

A formal communication mechanism, LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities would be created. The purpose of LACE would be to provide a formal, ongoing communication mechanism that provides for transparent and aligned communication among the identified entities. The collaborative efforts between the APRN Consensus Group and the NCSBN APRN Advisory Panel, through the APRN Joint Dialogue Group have illustrated the ongoing level of communication necessary among these groups to ensure that all APRN stakeholders are involved. Several strategies including equal representation on an integrated board with

¹⁰ The APRN core competencies for all APRN nursing education programs located in schools of nursing are delineated in the American Association of Colleges of Nursing (1996) *The Essentials of Master's Education for Advanced Practice Nursing Education* or the AACN (2006) *The Essentials of Doctoral Education for Advanced Nursing Practice*. The APRN core competencies for nurse anesthesia and nurse-midwifery education programs located outside of a school of nursing are delineated by the accrediting organizations for their respective roles i.e., Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME).

¹¹ APRN programs outside of schools of nursing must prepare graduates with the APRN core which includes three separate graduate-level courses in pathophysiology/physiology, health assessment, and pharmacology.

¹² APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Accreditation Commission for Midwifery Education (ACME), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

face-to-face meetings, audio and teleconferencing, pass-protected access to agency web sites, and regular reporting mechanisms have been recommended. These strategies will build trust and enhance information sharing. Examples of issues to be addressed by the group would be: guaranteeing appropriate representation of APRN roles among accreditation site visitors, documentation of program completion by education institutions, notification of examination outcomes to educators and regulators, notification of disciplinary action toward licensees by boards of nursing.

Creating the LACE Structure and Processes

Several principles should guide the formulation of a structure including: 1) all four entities of LACE should have representation; 2) the total should allow effective discussion of and response to issues and ; 3) the structure should not be duplicative of existing structures such as the Alliance for APRN Credentialing. Consideration should be given to evolving the existing Alliance structure to meet the needs of LACE. Guidance from an organizational consultant will be useful in forming a permanent structure that will endure and support the work that needs to continue. The new structure will support fair decision-making among all relevant stakeholders. In addition, the new structure will be in place as soon as possible.

The LACE organizational structure should include representation of:

- State licensing boards, including at least one compact and one non-compact state;
- Accrediting bodies that accredit education programs of the four APRN roles;
- Certifying bodies that offer APRN certification used for regulatory purposes; and,
- Education organizations that set standards for APRN education.

Timeline for Implementation of Regulatory Model

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification, and education, certain recommendations will be implemented sequentially. However, recognizing that this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform decisions made by each of these entities as the APRN community moves to fully implement the APRN Regulatory Model. A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

HISTORICAL BACKGROUND

NCSBN APRN Committee (previously APRN Advisory Panel)

NCSBN became involved with advanced practice nursing when boards of nursing began using the results of APRN certification examinations as one of the requirements for APRN licensure. During the 1993 NCSBN annual meeting, delegates adopted a position paper on the licensure of advanced nursing practice which included model legislation language and model administrative rules for advanced nursing practice. NCSBN core competencies for certified nurse practitioners were adopted the following year.

In 1995, NCSBN was directed by the Delegate Assembly to work with APRN certifiers to make certification examinations suitable for regulatory purposes. Since then, much effort has been made toward that purpose. During the mid and late 90's, the APRN certifiers agreed to undergo accreditation and provide additional information to boards of nursing to ensure that their examinations were psychometrically sound and legally defensible (NCSBN, 1998).

During the early 2000s, the APRN Advisory Panel developed criteria for APRN certification programs and for accreditations agencies. In January 2002, the board of directors approved the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to improve the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues such as with the establishment of the annual NCSBN APRN Roundtable in the mid 1990's. In 2002, the Advisory Panel also developed a position paper describing APRN regulatory issues of concern.

In 2003, the APRN Advisory Panel began a draft APRN vision paper in an attempt to resolve APRN regulatory concerns such as the proliferation of APRN subspecialty areas. The purpose of the APRN Vision Paper was to provide direction to boards of nursing regarding APRN regulation for the next 8-10 years by identifying an ideal future APRN regulatory model. Eight recommendations were made. The draft vision paper was completed in 2006. After reviewing the draft APRN vision paper at their February 2006 board meeting, the board of directors directed that the paper be disseminated to boards of nursing and APRN stakeholders for feedback. The Vision paper also was discussed during the 2006 APRN Roundtable. The large response from boards of nursing and APRN stakeholders was varied. The APRN Advisory Panel spent the remaining part of 2006, reviewing and discussing the feedback with APRN stakeholders. (See Appendix C for the list of APRN Advisory Panel members who worked on the draft APRN Vision Paper and Appendix D for the list of organizations represented at the 2006 APRN Roundtable where the draft vision paper was presented.)

APRN Consensus Group

In March 2004, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) submitted a proposal to the Alliance for Nursing Accreditation, now named Alliance for APRN Credentialing¹³ (hereafter referred to as *the APRN Alliance*) to establish a process to develop a consensus¹⁴ statement on the credentialing of advanced practice nurses (APNs).¹⁵ The APRN Alliance¹⁶, created in 1997,

¹³ At its March 2006 meeting, the Alliance for Nursing Accreditation voted to change its name to the Alliance for APRN Credentialing which more accurately reflects its membership.

¹⁴ The goal of the APRN Work Group was unanimous agreement on all issues and recommendations. However, this was recognized as an unrealistic expectation and may delay the process; therefore, consensus was defined as a two thirds majority agreement by those members of the Work Group present at the table as organizational representatives with each participating organization having one vote.

¹⁵ The term advanced practice nurse (APN) was initially used by the Work Group and is used in this section of the report to accurately reflect the background discussion. However, the Work group reached consensus that the term advanced practice registered nurse (APRN) should be adopted for use in subsequent discussions and documents.

was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. A number of differing views on how APN practice is defined, what constitutes specialization versus subspecialization, and the appropriate credentialing requirements that would authorize practice had emerged over the past several years.

An invitation to participate in a national APN consensus process was sent to 50 organizations that were identified as having an interest in advanced practice nursing (see Appendix F). Thirty-two organizations participated in the APN Consensus Conference in Washington, D.C. June 2004. The focus of the one-day meeting was to initiate an in-depth examination of issues related to APN definition, specialization, sub-specialization, and regulation, which includes accreditation, education, certification, and licensure¹⁷. Based on recommendations generated in the June 2004 APN Consensus Conference, the Alliance formed a smaller work group made up of designees from 23 organizations with broad representation of APN certification, licensure, education, accreditation, and practice. The charge to the work group was to develop a statement that addresses the issues, delineated during the APN Consensus Conference with the goal of envisioning a future model for APNs. The Alliance APN Consensus Work Group (hereafter referred to as *the Work Group*) convened for 16 days of intensive discussion between October 2004 and July 2007 (see Appendix H for a list of organizations represented on the APN Work Group).

In December 2004, the American Nurses Association (ANA) and AACN co-hosted an APN stakeholder meeting to address those issues identified at the June 2004 APN Consensus meeting. Attendees agreed to ask the APN Work Group to continue to craft a consensus statement that would include recommendations regarding APN regulation, specialization, and subspecialization. It also was agreed that organizations in attendance who had not participated in the June 2004 APN Consensus meeting would be included in the APN Consensus Group and that this larger group would reconvene at a future date to discuss the recommendations of the APN Work Group.

Following the December 2004 APN Consensus meeting, the Work Group continued to work diligently to reach consensus on the issues surrounding APRN education, practice, accreditation, certification, and licensure, and to create a future consensus-based model for APRN regulation. Subsequent APRN Consensus Group meetings were held in September 2005 and June 2006. All organizations who participated in the APRN Consensus Group are listed in Appendix G.

¹⁶ Organizational members of the Alliance for APRN Credentialing : American Academy of Nurse Practitioners Certification Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, National Organization of Nurse Practitioner Faculties

¹⁷ The term regulation refers to the four prongs of regulation: licensure, accreditation, certification and education.

APRN Joint Dialogue Group

In April, 2006, the APRN Advisory Panel met with the APRN Consensus Work Group to discuss APRN issues described in the NCSBN draft vision paper. The APRN Consensus Work Group requested and was provided with feedback from the APRN Advisory Panel regarding the APRN Consensus Group Report. Both groups agreed to continue to dialogue.

As the APRN Advisory Panel and APRN Consensus Work Group continued their work in parallel fashion, concerns regarding the need for each group's work not to conflict with the other were expressed. A subgroup of seven people from the APRN Consensus Work Group and seven individuals from the APRN Advisory Panel were convened in January, 2007. The group called itself the APRN Joint Dialogue Group (see Appendix E) and the agenda consisted of discussing areas of agreement and disagreement between the two groups. The goal of the subgroup meetings was anticipated to be two papers that did not conflict, but rather complemented each other. However, as the APRN Joint Dialogue Group continued to meet, much progress was made regarding areas of agreement; it was determined that rather than two papers being disseminated, one joint paper would be developed, which reflected the work of both groups. This document is the product of the work of the APRN Joint Dialogue Group and through the consensus-based work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification, and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

CONCLUSION

The recommendations offered in this paper present an APRN regulatory model as a collaborative effort among APRN educators, accreditors, certifiers, and licensure bodies. The essential elements of APRN regulation are identified as licensure, accreditation, certification, and education. The recommendations reflect a need and desire to collaborate among regulatory bodies to achieve a sound model and continued communication with the goal of increasing the clarity and uniformity of APRN regulation.

The goals of the consensus processes were to:

- strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- develop a vision for APRN regulation, including education, accreditation, certification, and licensure;

