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"New Mexico offers full, independent practice and prescriptive authority for licensed nurse practitioners, and was the first state in the nation to establish a curriculum for educating family nurse practitioners. This model has become an example for other states across the country, and I encourage others to look for new and innovative ways to help nursing professionals further improve preventative care and treatment."

–**Susana Martinez**, Governor of New Mexico

The Case for Removing Barriers to APRN Practice

The 2010 Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health* took a bold stand. It called for the removal of practice barriers—laws, regulations, and policies that prevent advanced practice registered nurses (APRNs) from providing the full scope of health care services they are educated and certified to provide.

In the six years since, the Federal Trade Commission, National Governors Association, AARP, Robert Wood Johnson Foundation, American Enterprise Institute, American Hospital Association, The Heritage Foundation, and others have added their voices to the call, and several states have removed or eased restrictions based on the report's recommendation.

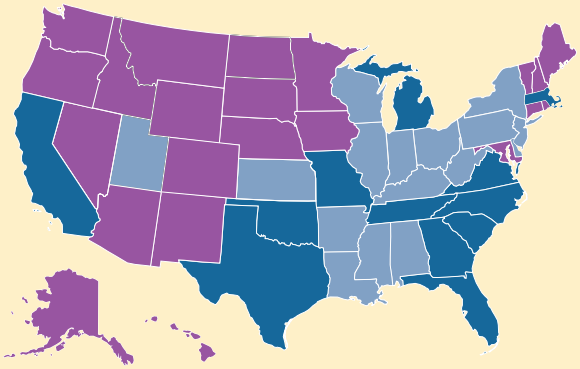
But in communities across the nation, patients still encounter delays in treatment, difficulty locating primary care and other services, and trouble finding practitioners who accept Medicaid reimbursement. These gaps result—at least in part—from state, federal, and institutional restrictions that limit how APRNs may practice, and from federal and private insurance policies that govern payment for their services.

These practice barriers persist despite a growing body of research indicating that the quality of APRN care in states that give APRNs full practice authority is comparable to the care they deliver in states that require some form of physician oversight—unnecessarily restricting the public's access to affordable, high-quality care.

This brief will acquaint readers with the debates surrounding the regulation of APRN practice, the patchwork of laws and regulations that restrict patients' access to APRN services, and the human and economic toll that accompanies these practice restrictions. A separate two-page insert provides a primer on APRN practice.

Figure 1. Restrictions on Nurse Practitioners Vary by State

Nurse Practitioner State Practice Environment, Dec. 2016



- **Full Practice** (authority to evaluate patients; diagnose, order, and interpret diagnostic tests; initiate and manage treatments, including prescribing medications)
- **Reduced Practice** (at least one element of NP practice is restricted)
- **Restricted Practice** (at least one element of NP practice is restricted and supervision by another health profession is required)

Practice rules for the other APRN roles—certified registered nurse anesthetists, clinical nurse specialists, and certified nurse-midwives—and their authority to prescribe medications also vary by state.

Source: American Association of Nurse Practitioners

The Case for Removing Barriers to APRN Practice

Executive Summary

Introduction

In 2010 the Institute of Medicine issued a report, *The Future of Nursing: Leading Change, Advancing Health*, that called for the removal of laws, regulations, and policies that prevent advanced practice registered nurses (APRNs) from providing the full scope of health care services they are educated, trained, and, in most cases, professionally certified to provide. Since then, several states have lifted restrictions on APRN practice, but work remains to be done. Despite research showing comparable quality of patient care in states where APRNs have full practice authority, (that is, the ability to practice to the full extent of their education, training, and certification), barriers to practice persist in many places, and patients continue to experience gaps in care caused at least in part by those limits.

Clearing Up Misperceptions (see p. 2)

Much of the public is uninformed or misinformed about what APRNs do. This lack of information can cloud decision-making about regulatory policy. There are four APRN roles: nurse practitioner (NP), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), and certified nurse-midwife (CNM). All are registered nurses (RNs) with master's or doctoral degrees who are certified to provide specific types of care for particular populations. While their scopes of practice can overlap with those of physicians, APRNs do not practice medicine; they practice nursing. They seek the opportunity to practice to the full extent of their education and training within their professional scopes of nursing practice.

See *A Primer on Advanced Practice Registered Nurse (APRN) Practice* for details.

Barriers to APRN Practice (see p. 3)

State practice acts, institutional rules, and federal statutes and regulations from the Centers for Medicare and Medicaid Services (CMS) prevent APRNs from practicing to the full extent of their education and training. These barriers reduce access to care, create disruptions in care, increase the cost of care, and undermine efforts to improve the quality of care. They affect the four APRN roles in a variety of ways.

Nurse Practitioner (NP). State supervision mandates may include requiring monthly face-to-face visits with a supervising physician, and restrictions on APRNs' authority to prescribe medications and medical equipment; CMS rules limit the services APRNs may provide in skilled nursing facilities. Such restrictions reduce both NP and physician time for patient care, put undue cost burdens on NPs, and create gaps in care for patients, especially in rural areas.

- An NP and her supervising physician providing primary care in underserved areas of Texas must take several hours away from patients each month to comply with state law (see p. 4).
- In Vermont, CMS regulations that require physicians to do the admission assessments for skilled nursing care create extra costs, delays, stress, and potentially dangerous information gaps for patients whose primary care providers are NPs (see p. 4).

Certified Registered Nurse Anesthetist (CRNA). In some states, state laws and/or CMS regulations require physician supervision of CRNA anesthesia services.

- A rural hospital in Colorado welcomed its state's decision to opt out of the CMS requirement that physicians supervise CRNAs working in hospitals and ambulatory surgery centers (see p. 5).
- Although CMS has explicitly authorized direct payment to CRNAs for pain management services, some Medicare Administrative Contractors deny payment to CRNAs for these services (see p. 5).

Clinical Nurse Specialist (CNS). Some states do not recognize CNSs as APRNs. This limits CNSs to the scope of practice designated for RNs, prohibiting them from prescribing medications or ordering lab work and durable medical equipment.

- A Pennsylvania CNS has made impressive strides in addressing heart failure, but state practice barriers limit her ability to build on those improvements and reduce the costs of care at the hospital where she works (see p. 6).

Certified Nurse-Midwife (CNM). The availability of CNMs is constrained by mandatory collaborative agreements between CNMs and physicians, the refusal of some hospitals to grant privileges, reduced reimbursement from some private payers, and a lack of access to affordable liability insurance.

- In Georgia, a collaborative group practice of obstetrician-gynecologists and CNMs has radically improved birth outcomes for rural women, but state practice restrictions discourage many of the state's CNMs from practicing midwifery (see p. 6).

The Costs of Collaborative Practice Agreements (see p. 7)

The name collaborative practice agreement (CPA) may give policymakers the false impression that CPAs mandate collaboration in the care of individual patients. They do not. Instead CPAs spell out the restrictions that will govern an APRN's practice and the terms—which can vary substantially—under which the collaborating physician will interact with the APRN.

Many states require APRNs to enter into a CPA with a physician in order to practice. The stated purpose of requiring CPAs is to protect the public, but there is no evidence to show that CPAs serve this function. Meanwhile, these legal agreements impose significant costs on providers and patients.

- Physicians often charge APRNs for collaborative services. The cost of CPAs is unregulated and can be onerous, amounting to thousands or even tens of thousands of dollars a year (see p. 7).
- Many physicians hesitate to enter into collaborative agreements for fear of incurring additional liability (see p. 7).
- Laws that limit the distance (for example, 50 miles or less) permitted between APRNs and their collaborating physicians discourage APRNs from opening practices in rural areas where they are most needed (see p. 7).
- The termination of a collaborative agreement when a physician moves, retires, or suddenly leaves practice can create gaps in care. When this occurred in Massachusetts, patients resorted to hospital-based emergency care (see p. 7).
- Insufficient availability of collaborating physicians limits the opportunity to scale up proven interventions that use APRNs to improve quality and reduce costs. A CMS-funded project in Missouri is experiencing these growing pains (see p. 8).
- States with restrictive APRN practice acts may also incur a workforce penalty, since states with fewer restrictions appear to be more successful in attracting APRNs to work there (see p. 8).

A Legislative Compromise (see p. 8)

Transition-to-practice periods (TPPs), currently in place in ten states, represent a political compromise. TPPs allow new APRNs to apply for full practice authority after practicing for a given number of years and/or a minimum number of hours under the supervision of a physician, or in some cases, an experienced APRN. Although there is no evidence to support delaying entry into full practice for all APRNs, some nurses welcome the idea of creating true transition-to-practice programs for newly certified NPs. These programs would be guided by more experienced APRNs and be educational, rather than legal, in nature.

Veterans Administration Changes Regulation of APRN Practice (see p. 9)

To improve access to care at the Department of Veterans Affairs (VA) Veterans Health Administration, VA issued a final rule at the end of 2016 that would grant APRNs in three of the four roles (NP, CNM, and CNS) full practice authority when acting within the scope of their VA employment, regardless of state restrictions. VA noted that the decision to exclude nurse anesthetists "does not stem from the CRNAs' inability to practice to the full extent of their professional competence, but rather from VA's lack of access problems in the area of anesthesiology."

Other Recent Breakthroughs (see p. 10)

Since 2010 nine states have granted their NPs full practice authority. As of March 1, 2017, 22 states and the District of Columbia allow NPs full practice authority. At least 12 states are currently considering legislation to remove practice barriers for one or more APRN roles. The National Council of State Boards of Nursing provides model legislation based on the APRN Consensus Model to facilitate this process.

Endorsements from the Federal Trade Commission, National Governors Association, AARP, American Enterprise Institute, American Hospital Association, Robert Wood Johnson Foundation, The Heritage Foundation, and others have also lent weight to the arguments in favor of removing APRN practice barriers. So has a growing body of research suggesting full practice authority for APRNs may reduce costs and improve access to care.

Remaining Challenges (see p. 10)

Practice barriers persist—not just in laws and regulations but also in institutions' decisions about who will practice within their walls and insurers' decisions about who will be paid for delivering which services. The IOM *Future of Nursing* report identified steps that Congress, state legislatures, and federal agencies could take to remove APRN practice barriers. These recommendations remain relevant today.

Clearing Up Misperceptions

On May 25, 2016, the U.S. Department of Veterans Affairs (VA) issued a proposed rule that would allow advanced practice registered nurses (APRNs) "full practice authority," that is, the ability to provide—anywhere in the United States—the full range of services they are educated and certified to deliver.

The proposed rule broke new ground by preempting those state laws that restrict what APRNs may do without physician supervision. In *The Hill*, an online publication covering federal news, veteran Michael Watson, DNP, FNP-BC, U.S. Navy reservist, declared, "[A]ll the proposal does is free APRNs to do the job we were educated and trained to do, in exactly the same way we already do it as active-duty members of the military."

Photo: U.S. Army by SGT Kalie Jones

A certified registered nurse anesthetist (CRNA) deployed with the U.S. Army in Iraq provides anesthesia for a patient in preparation for surgery.

Yet the regulation—conceived as a means to extend more timely care to veterans by increasing access to APRNs within the VA system—generated public statements from prominent organizations, including the Robert Wood Johnson Foundation, AARP, American Medical Association, and American Society of Anesthesiologists, as well as an unprecedented 220,000 comments from individuals, both for and against.

Why did this proposed regulatory change provoke such strong responses?

Historical tensions between portions of the organized medical and nursing communities are partly to blame, but much of the public is also uninformed or misinformed about who APRNs are and what they do. The term "nurse" is broadly applied to certified nurses' aides, licensed practical or vocational nurses, registered nurses (RNs), and APRNs, yet each type of "nurse" has vastly different education, certification, and licensure requirements. This creates confusion and can make it difficult to appreciate what distinguishes APRNs from other nurses.

Advanced Practice Nursing 101

APRNs make up an estimated 5-10 percent of the nursing workforce. These highly skilled clinicians are licensed RNs with master's or doctoral degrees, and they are certified to provide various types of care (for example, primary, mental health, or anesthesia) for distinct populations (such as children, adults, or people with cancer). (See *A Primer on Advanced Practice Registered Nurse (APRN) Practice* for details.)

APRN professional scopes of practice—the services they are educated and certified to provide to which groups of patients and in what settings—both overlap and complement those of their physician colleagues. Both types of providers examine patients, diagnose and treat illnesses, prescribe medications, and promote their patients' health. APRNs are not prepared to provide all health care services to all people—nor do they aspire to. They are seeking to remove the legal, regulatory, and institutional barriers that hamper their ability to provide the care that falls within their scopes of practice.

Myth No. 1

Opponents of full practice authority say it would allow APRNs to practice medicine without supervision despite having received far fewer hours of formal education than physicians receive.

What Policymakers Need to Know

It's true that it takes fewer years of formal education to become an APRN than to become a physician, but APRNs are not practicing medicine. They are practicing nursing. Even though many of their services overlap with those of physicians, APRNs do not routinely perform surgery, diagnose rare diseases, manage high-risk pregnancies, or engage in a host of other complex medical interventions. APRNs are appropriately educated to provide the scope of services for which they are licensed and certified, and, like other health professionals, they make referrals to their physician colleagues and other clinicians when their patients' needs fall outside their scope or competence.

What Recent Research Shows

To date, most scope-of-practice research has focused on NPs. This growing body of scholarship suggests that removing restrictions on NP practice has the potential to reduce costs and improve access to care without compromising quality.

- A study of NP-delivered care in health centers suggests that "NP care is comparable to physician care in most ways and that the quality of NP-delivered care does not significantly vary by states' NP independence status."
  Kurtzman ET, Barnow BS, Johnson JE, Simmens SJ, Infeld DL, Mullan F. Does the regulatory environment affect nurse practitioners' patterns of practice or quality of care in health centers? *Health Services Research*. 2017; 52(1pt2): 437-458.
- A 2015 study of Medicare data provides new evidence that care for beneficiaries managed by NPs costs less than care for similar beneficiaries managed by physicians.
  Perloff J, DesRoches CM, Buerhaus P. Comparing the cost of care provided to Medicare beneficiaries assigned to primary care nurse practitioners and physicians. *Health Services Research*. 2016; 51(4).
- A working paper on wages, employment, costs, and quality suggests that "[M]ore restrictive state licensing practices [for NPs] increase the costs of medical care, change wages and employment patterns, and do not appear to influence health care quality as measured by changes in the infant mortality rate and in malpractice insurance premiums."
  Kleiner MM, Marier A, Park KW, Wing C. *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service.* National Bureau of Economic Research. NBER Working Paper No. 19906; 2014.
- A systematic review of the impact of state NP scope-of-practice regulations on health care delivery concludes "[R]emoving restrictions on NP scope-of-practice regulations could be a viable and effective strategy to increase primary care capacity."
  Xue Y, Ye Z, Brewer C, Spetz J. Impact of state nurse practitioner scope-of-practice regulation on health care delivery: Systematic review. *Nursing Outlook*. 2016; 64(1): 71–85.

Barriers to APRN Practice

State restrictions on APRN practice vary, from pro forma physician oversight of APRN prescribing to periodic onsite physician supervision. These relationships, often spelled out in "collaborative practice agreements," can be burdensome and costly, and finding "collaborating" physicians can be a challenge (see p. 7). These mandates may also give policymakers and the public the false impression that physicians oversee APRN decision-making.

"It was clear to me that policymakers thought physicians were signing off on every prescription NPs were writing," says NP Mary Chesney, PhD, APRN, FAAN, clinical professor at the University of Minnesota, who advocated for recent changes to restrictive APRN practice laws in her state. "They didn't realize that a collaborative practice agreement as defined in our state was just a formal document listing which categories of drugs the NP was able to prescribe."

Meanwhile, Chesney and others point out that true APRN/physician collaboration is already a standard feature of patient care. Communication and referrals occur between the appropriate clinicians at the appropriate times based on their clinical judgment—not because of legal mandates or restrictions on reimbursement, but because all health professionals are bound by professional codes of conduct to serve their patients' needs.

In most states the Board of Nursing (BON) regulates nursing practice, but four states have "joint regulation." This means that the state Board of Medicine (BOM) also has a say in regulating nursing practice. Even in states where the nursing profession regulates itself—as is the case with most health professions—the BON and BOM often collaborate in writing nursing practice rules, a process known as "joint promulgation."

"Joint regulation raises a fundamental issue: whether one profession should be subject to regulation by another profession," says Lewis and Clark College Law School visiting professor Barbara Safriet, JD, LLM. "As for joint promulgation, we've seen examples where this delayed implementation of laws related to APRN practice for several years."

Variation Among State Regulations

Across the country, a patchwork of regulations dictating the circumstances under which APRNs may practice has created inconsistencies in access to high-quality, cost-effective health care. The map on page 1 (see Figure 1) reflects the practice environment for NPs alone, but maps of the practice environments of the three other APRN roles show similar variation. Differing laws and regulations governing whether APRNs may write prescriptions—and for which drugs—complicate the picture. In addition, institutional policies, federal rules governing Medicare and Medicaid reimbursement, and decisions by private insurance carriers limit the ways in which APRNs may serve their patients.

While these restrictions ostensibly aim to protect consumers, research consistently shows that granting full practice authority to APRNs does not create a tier of "second-rate" care, as opponents have argued.

Photo: Will Kirk/homewoodphoto.jhu.edu

As expert clinicians, clinical nurse specialists (CNSs) often collaborate with nurses throughout hospitals to improve quality and safety within health systems.

"It is worth noting that there has not been an uptick in malpractice claims or safety and quality problems in states that have granted APRNs full practice authority," says Chesney. "Instead people have greater access to care, and that care is effective and efficient."

For More Information

Phillips S. 29th Annual APRN Legislative Update. *The Nurse Practitioner*. 2017; 41(1).

Summers L, Bickford C. *Nursing's Leading Edges: Specialization, Credentialing, and Certification of RNs and APRNs*. American Nurses Association; 2017.

Safriet BJ. Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care. In: Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. National Academies Press; 2010: Appendix H.

Photo: Mark Hoffman, © 2015 *Journal Sentinel Inc.*, reproduced with permission

Photo: © Sarah Glover

Nurse practitioners (NPs) work in hospitals and a wide variety of outpatient settings, and they have been instrumental in making primary care and other services available in the community. The NP at left is based in a clinic housed in a YMCA in a low-income neighborhood of Milwaukee. The NP at right frequently makes house calls as part of the transitional care she provides recently hospitalized patients.

Wide Variation; Common Threads

Practice barriers vary widely, and they are contingent on an APRN's role, employment setting, and state. The following pages profile a few of the practice barriers that affect APRNs. These examples do not represent the total array of barriers that prevent APRNs from practicing to the full extent of their education and certification. Nevertheless, these profiles highlight some common threads and illustrate the ways in which practice barriers:

- reduce access to care,
- create disruptions in care,
- increase the cost of care, and
- undermine efforts to improve the quality of care.

How Practice Barriers Differ by APRN Role

State Law Puts Thriving Practice at Risk

- **Role:** Nurse Practitioner (NP)
- **Location:** Texas
- **Barrier:** Requirement that a physician provide written authorization for an APRN to diagnose patients or prescribe medications

Before Holly Jeffreys, DNP, APRN, FNP-BC, opened the Family Care Clinic of Panhandle in 2009, many of the area's residents had gone three years or more without receiving health care. Even before the town of 2,600 lost its health clinic in 2006, access to care was sporadic. Area residents would sometimes show up for scheduled visits only to find that their providers had been pulled to work at the hospital an hour away.

When Jeffreys opened her clinic, 22 patients arrived on the first day; by the end of the week, she'd cared for more than 100 people. "Some were patients with diabetes, high blood pressure, and cholesterol issues, and the last time they had had meds was three years earlier," Jeffreys says.

The Family Care Clinic of Panhandle now manages the care of more than 11,000 patients. Yet rather than facilitating the efforts of qualified practitioners such as Jeffreys, Texas law creates obstacles that make it difficult for NPs to establish primary care practices. Texas is one of 12 states that still require supervision, delegation or team management by a physician in order for NPs to provide patient care. While a 2013 law somewhat eased supervisory requirements—physicians, for instance, are no longer required to be within 75 miles of the NPs they supervise—collaborating NPs and physicians are required by law to have monthly face-to-face visits until they have worked together for three years. After that, visits must occur quarterly and may be conducted via videoconferencing, if desired.

In practice, these requirements keep both Jeffreys and her supervising physician from maximizing the time they spend on patient care. The physician is based in Amarillo—a federally designated primary care shortage area—but has to take a half-day off each month to travel to Panhandle for face-to-face reviews, since he hasn't worked with all the NPs in the practice for the required three years.

"We wouldn't anticipate a grocery store opening in a rural or underserved area if they had to get an arrangement from Safeway every year in order to operate, yet that's what we're asking nurse practitioners to do when we link their ability to provide care, and patients' ability to obtain services, to another provider."

–**Tay Kopanos**, DNP, FNP, Vice-President of State Affairs, American Academy of Nurse Practitioners

Jeffreys also has to pay him for his time, adding to the financial stress she faces as a small business owner. Jeffreys' regular overhead includes the salaries of 15 employees. If her supervising physician decided to end their arrangement, or was suddenly unable to practice, Jeffreys would have to immediately stop seeing patients. Her expenses, of course, would not immediately cease, nor would the community's need for care.

Federal Regulations Create Confusion, Inefficiency in Skilled Nursing Facilities

- **Role:** Nurse Practitioner (NP)
- **Location:** Vermont
- **Barrier:** Medicare stipulation that only physicians—not NPs—may certify patients' need for skilled nursing care and conduct patient intake assessments and every other routine visit

Michele Wade, MSN/Ed, APRN, AGNP-C, an NP at Rutland Health & Rehab in Vermont, spends far more time than she'd like explaining regulations to residents and families.

"I recently fielded a call from a new resident's family that was extremely upset that a physician they did not know did an admission assessment on their 90+-year-old mother and billed for a nursing home visit," Wade says. Under Center for Medicare and Medicaid Services (CMS) guidelines, physicians are the only providers allowed to conduct the comprehensive admission assessments required for Medicare-covered skilled nursing care. As a result, the woman's long-time primary care provider—an NP—was effectively barred from helping the family during this time of transition.

These circumstances create inefficiencies, Wade says, with the potential to delay care and put patients at risk. She recently noticed differences between the medication list provided by another new resident and the one provided by the admitting hospital. She called the patient's primary care provider—an NP in private practice—and learned that the patient required medication for both bipolar disorder and diabetes, two conditions that weren't even mentioned in the hospital discharge notes. The NPs straightened out the patient's medication and care plan during the call; then a few days later, a physician who did not know the patient conducted the required admission assessment, signed the medication regimen, and was paid for both, even though the NPs had already reconciled the medications.

Barriers written into CMS guidelines may also inadvertently inhibit systemwide improvements in care. Research shows that including NPs on long-term care teams reduces hospitalizations, increases resident and family satisfaction with the quality of care, and may reduce costs by minimizing the unwanted use of treatments at the end of life. Yet nursing homes shy away from hiring these providers because NPs employed by nursing homes cannot legally certify patients for Medicare coverage or conduct mandatory assessments—even though similarly employed physicians can.

For More Information
Centers for Medicare and Medicaid Services, *MLN Matters®* Article SE1308 (2013)

How Practice Barriers Differ by APRN Role *continued*

An Essential Provider in Rural America

- **Role:** Certified Registered Nurse Anesthetist (CRNA)
- **Location:** Colorado
- **Barriers:** Physician supervision requirement for anesthesia services in some settings; denial of some CRNA claims for pain management services

Like anesthesiologists, CRNAs provide both pain management services and anesthesia, including during relatively rare and difficult surgeries. In some settings, anesthesiologists oversee CRNAs who deliver direct patient care. In other settings—especially in underserved areas—CRNAs provide high-quality, cost-effective care without physician oversight. The American Association of Nurse Anesthetists estimates that CRNAs delivered 43 million anesthetics in 2016 alone.

"Rural hospitals depend on CRNAs. They are absolutely essential. The use of CRNAs prevents patients from putting off care until a situation becomes life-threatening."

–**Brock Slabach**, MPH, FACHE, Senior Vice President, National Rural Hospital Association

In 2001 CMS allowed states where CRNAs had full practice authority to opt out of the CMS requirement that physicians supervise CRNAs working in hospitals and ambulatory surgery centers. The reason, regulators wrote, was a lack of "compelling scientific evidence that an across-the-board federal physician supervision requirement for CRNAs leads to better outcomes."

By 2016 17 states had wholly or partially opted out of the CMS supervision requirement. A 2010 study examined the first 14 states that opted out and found that the risk of anesthesia deaths or complications in those states did not increase.

Surgeons at Delta County Memorial Hospital welcomed the governor of Colorado's decision in 2010 to let rural and critical access hospitals opt out of the Medicare supervision requirement. Before the opt-out, says CEO Jason Cleckler, RN, BSN, Memorial's six CRNAs reported to surgeons who provided little if any supervision. "The surgeons were relieved when the opt-out happened," he says. "Now the CRNAs and the surgeons simply collaborate."

Myth No. 2

Opponents of full prescriptive authority for APRNs say it would put patients at risk for drug addiction.

What Policymakers Need to Know

A recent analysis of a study by the Centers for Disease Control and Prevention found that "states with independent APRN prescribing laws prescribed significantly fewer opioid [sic] and benzodiazepines," two classes of drugs linked to painkiller overdose deaths.

For More Information

Schirle L, McCabe BE. State variation in opioid and benzodiazepine prescriptions between independent and nonindependent advanced practice registered nurse prescribing states. *Nursing Outlook*. 2016; 64(1): 86-93.

The 49-bed rural hospital provides essential trauma surgery for a large rural community when auto, hunting, and farm accidents occur. Without the availability of CRNAs, some patients would need to travel two-and-a-half hours to the nearest city for surgical care or to deliver a baby.

Nationwide, CRNAs deliver about two-thirds of the anesthesia services in rural hospitals and are disproportionately located in cities and counties with median incomes far below the national average. The National Rural Hospital Association has stated that removing the physician supervision requirement for CRNAs is consistent with giving patients access to high-quality, cost-effective care.

An Underused Resource for Chronic Pain

CRNAs are authorized to evaluate, manage, and treat chronic pain without physician supervision in 28 states, and since 2013 CMS has explicitly stated that Medicare may pay CRNAs directly for pain management services. Yet a 2014 federal report found that Medicare Administrative Contractors (MACs)—intermediaries upon whom CMS relies to pay claims—have not implemented the CMS CRNA payment rule consistently. By denying CRNA claims for pain management services, the report stated, MACs may have inappropriately limited Medicare beneficiaries' access to care.

A 2015 National Institutes of Health study estimated that 50 million U.S. adults suffer from chronic pain. CRNAs learn to manage chronic pain in the course of their education, and since 2015, they have been able to earn an additional, voluntary credential in non-surgical pain management.

"There are a huge number of underserved people out there," says Lisa Pearson, CRNA, NSPM-C, DAAPM, owner of the Metamorphosis Pain Clinics in Colorado Springs and Cañon City. "I see a lot of Medicare and Medicaid patients. Many family practice physicians are not open to new patients, and do not have the time to implement all of the new opioid-related recommendations, so there is a big access issue. When I opened my clinic in Colorado Springs, I received 350 referrals in the first month. I'm still averaging over 50 a week."

An analysis of Medicare claims for pain procedures from 2009 to 2012 found that services provided by CRNAs accounted for less than one-half of 1 percent of these claims. Pain physicians billed for 40 percent of procedures, and physicians without certification in pain management billed for the majority of pain procedures.

Myth No. 3

Opponents of full prescriptive authority for APRNs say that involving physicians in APRN prescribing protects patients.

What Policymakers Need to Know

No state requires APRNs to consult with a physician *before* writing prescriptions for individual patients. In states that require physician supervision of APRN prescribing, it takes two forms: determining which classes of drugs an APRN may prescribe, and reviewing a subset of an APRN's patient charts *after* prescriptions are written.

How Practice Barriers Differ by APRN Role *continued*

State Practice Barriers Limit Performance Improvement

- **Role:** Clinical Nurse Specialist (CNS)
- **Location:** Pennsylvania
- **Barrier:** No state recognition of CNSs as APRNs

Heart failure is a prevalent—and expensive—problem, costing the United States more than $30 billion annually in health care dollars and lost productivity. In Harrisburg, Pa., the clinical nurse specialist at PinnacleHealth Heart Failure Center is leading an interdisciplinary program for heart failure patients that has lowered their all-cause readmission rate by almost one-third and reduced the all-cause heart failure mortality within 30 days of discharge from 10.8 to 2.8 percent.

Performance improvements and cost savings from the heart failure program could be even greater, but Pennsylvania is one of nine states that still do not recognize CNSs as APRNs. This means Pinnacle's CNSs have the same legal scope of practice as other RNs. They may not prescribe medications or order consultations, lab work, or durable medical equipment such as walkers—unlike APRNs in states with less restrictive practice laws.

"To order blood work, I needed to develop a nursing protocol and justify the need in front of a panel of physicians," says Kim Fowler, MSN, RN, CNS-BC, heart failure program manager. Similarly, if a patient's heart rate is elevated, Fowler can only suggest a dosage change; she cannot prescribe it, although her education, training, and experience have prepared her to do so. As a result, two or more health professionals are needed to complete tasks that could be completed by one, unintentionally creating expensive redundancies within the health care system.

"It's a waste of people's time to work around these restrictions," Fowler says. "I think it's certainly slowed care."

Collaboration Requirement Limits Access to Maternity Care

- **Role:** Certified Nurse-Midwife (CNM)
- **Location:** Georgia
- **Barriers:** APRNs may not practice without a collaborative agreement with a physician; lack of hospital privileges

Georgia's maternal mortality rate is among the worst in the country, in large part because rural women frequently lack access to qualified maternity care. In 2012 the maternal mortality rate in rural Georgia was 24.3 per 100,000 births compared to 16.5 per 100,000 births in other parts of the state. Rural hospitals have been closing for years, and many counties do not have a single obstetrician-gynecologist (ob-gyn) or CNM.

It's a common problem, affecting 40 percent of U.S. counties. By 2030 the American College of Obstetricians and Gynecologists (ACOG) predicts an 18 percent shortage of ob-gyns. Yet qualified providers sit on the sidelines, stymied by practice restrictions that make it difficult to provide much-needed care.

In Georgia, more than one-third of CNMs do not provide prenatal or birth care, due to difficulty finding physician collaborators as required by state law and hospitals willing to accept CNMs as birth providers. Instead, these CNMs provide basic primary care or fill out paperwork in insurance claims offices, prisons, schools, and home health agencies.

The Midwifery Practice at Athens Regional Medical Center is an exception. More than 40 years ago one of the local obstetric groups approached the hospital about setting up a midwifery practice where CNMs could provide prenatal care and attend vaginal births. At the time, no obstetricians in the area accepted Medicaid, so many women were showing up at the emergency department in labor, with little to no history of prenatal care.

Today the practice's CNMs care for women from more than 30 counties, and they also provide weekly prenatal appointments at satellite clinics. Their collaborating ob-gyns consult on high-risk cases, provide obstetric back-up, and perform C-sections and instrumental deliveries as needed. As a result of the comprehensive care provided at this interprofessional clinic, the preterm-birth and infant-mortality rates for Athens Midwifery are half those of the surrounding Clarke County.

Removing practice barriers—in Georgia and elsewhere—would allow other CNMs to establish similar practices in underserved areas. According to a study published in the *Journal of Midwifery and Women's Health*, states that allow autonomous midwifery practice have more midwives attending births at rural hospitals than states with more restrictive scopes of practice. A study by the Georgia Maternal and Infant Health Research Group suggests the same could happen in Georgia, as 54 percent of surveyed CNM students said they were likely to accept a job in a shortage area.

Photo: Andy Cross/The Denver Post via Getty Images

A certified nurse-midwife (CNM) examines a pregnant teen while her mother watches. In addition to providing prenatal care and managing low-risk labor and delivery, CNMs attend to family planning and women's health issues.

"ACOG is committed to ensuring women receive safe and effective care, and we work closely with the American College of Nurse-Midwives to achieve this goal. Too many women, most often in rural areas, face challenges finding an ob-gyn for routine obstetric and/or gynecologic care. Working together with nurse-midwives is an excellent way to bridge the gap between the supply of ob-gyns and the demand for women's health care services."

–**Hal Lawrence**, MD, Executive Vice President, American College of Obstetricians and Gynecologists (ACOG)

The Costs of Collaborative Practice Agreements

Despite their name, legally mandated collaborative practice agreements (CPAs) do not require that physicians and APRNs collaborate or consult in the care of individual patients. Instead, CPAs usually specify which classes of drugs an APRN may prescribe and lay out the terms under which physicians will interact with their collaborating providers. These terms often indicate when and where a physician will review a subset of an APRN's patient charts, and how the physician will be compensated for these activities.

While these agreements, which vary from state to state, may appear well intentioned, there is no evidence that they serve their avowed purpose of protecting the public (see *What Recent Research Shows*, p. 2). Rather CPAs impose significant costs—on both patients and providers.

The Cost of Doing Business

Barbara C. Phillips, MN, NP, FAANP, runs a website and consulting service for NPs and other APRNs in private practice and regularly fields questions on setting up CPAs. As far as Phillips knows, reimbursement for collaboration is totally unregulated, forcing APRNs who choose to be in business for themselves to pay what the market will bear. In rural areas, where fewer physicians are available to serve as collaborators, these fees can be especially onerous.

"I worked with an NP who opened a practice in Virginia and was struggling because her collaborator was charging her $5,000 a month," Phillips reports. "That's not sustainable." A recent commentary by the Texas Public Policy Foundation, a nonprofit research institute, cited one such contract that cost twice that figure.

In 2009 and 2014, testimony before the Nebraska legislature revealed wide variation among the financial arrangements spelled out in CPAs. One NP paid her collaborator by covering in the emergency department on weekends, while another NP reported paying her collaborator $15,000 a year.

The Cost to Physicians

While physicians and APRNs in private practice must carry their own liability insurance and are generally only responsible for the care of the patients they treat, many physicians are reluctant to enter into CPAs for fear of incurring additional liability. According to attorney Carolyn Buppert, JD, physician malpractice liability and insurance premiums are unlikely to increase because a physician enters a collaborative relationship with an NP, and NPs are less likely than physicians to be sued. Nevertheless, under some circumstances, physicians could have cause for concern.

Writing in *The Journal for Nurse Practitioners* in 2016, Buppert noted emerging trends in how courts view physician liability when a collaborating APRN's patient is harmed. "[I]f a state requires specific actions of collaborators, such as chart review over a specified time frame, then a physician who *did not do that work* may be held liable." [emphasis added]

Buppert, who specializes in legal and reimbursement issues for physicians and NPs, lists three strategies that physicians could employ to avoid liability: decline to enter into collaborative agreements, actually collaborate in patient care, or lobby for the abolition of collaboration requirements.

A 2017 study supports this last recommendation. It found that in the absence of tort reform, enacting scope-of-practice laws to require less physician supervision of NP practices is associated with a 31 percent reduction of physician malpractice rates, "more than double the reduction associated with enacting a cap on noneconomic damages."

For More Information

McMichael BJ, Safriet B, Buerhaus P. The Extraregulatory Effect of Nurse Practitioner Scope-Of-Practice Laws on Physician Malpractice Rates. *Medical Care Research and Review*. 2017.

The Cost to Patients

CPA requirements discourage APRNs from setting up practices where they may be most needed: in rural areas with limited access to care. In those states that restrict the distance that may exist between APRNs and their collaborating physicians, opening a practice in an area that is medically underserved may be almost impossible.

Even when physicians and APRNs practice side by side, the need for a CPA can have perverse consequences. In Massachusetts, a private behavioral health clinic had to suspend care for more than 1,200 patients for two months in 2013 when the sole psychiatrist on staff was abruptly terminated. While the clinic sought a physician willing to sign a CPA to cover the APRNs during the search for a new psychiatrist, 10 APRNs were barred from providing care. Many patients resorted to emergency departments to obtain medication for conditions such as ADHD, bipolar disorder, and schizophrenia.

Massachusetts mandates that within 96 hours, a physician must review any new prescription for narcotics, stimulants such as those used to treat ADHD, and other drugs with a high potential for abuse. This makes little sense to Stephanie Ahmed, DNP, FNP-BC, director for Ambulatory Nursing at Brigham and Women's Hospital in Boston, who has advocated for removing scope-of-practice barriers in her state.

"People have the impression that supervision happens in real time," she says. "The supervising physicians may not even be in the building, and there is no evidence that retrospective review of patient charts for prescriptions has ever contributed to patient safety or an improved outcome."

Continues next page

Myth No. 4

Proponents of collaborative practice agreements (CPAs) say they encourage APRNS to engage in team-based care and ensure that APRNs are supervised by more knowledgeable physicians.

What Policymakers Need to Know

Like other providers, APRNs regularly consult with specialists and other providers who can help their patients. CPAs neither mandate nor encourage APRNs and physicians to collaborate in individual patient care. In fact, in some states, any physician—regardless of specialty or knowledge of an APRN's practice area—may be eligible to enter into a CPA. For example, at rural hospitals with no anesthesiologists on staff, a CRNA might have a CPA with a surgeon. In at least one case, an NP providing primary care had to enter into a CPA with a pathologist—the only willing physician in her geographic area—to avoid disrupting her patients' care.

The Costs of Collaborative Practice Agreements *continued*

The Massachusetts Health Policy Commission, the Massachusetts Hospital Association, and large payers and employers in the state have also taken public stands in favor of removing scope-of-practice restrictions for APRNs. The state legislature continues to support the status quo.

Opportunity Cost

Nurse researchers at the Sinclair School of Nursing at the University of Missouri have achieved something remarkable—a 34 percent reduction over two years in the hospitalization of skilled nursing facility (SNF) residents—and they did it in the region of the state with the highest hospital admission rates. The CMS-funded pilot was deemed so successful that CMS not only renewed Sinclair's award, but the agency also adjusted its SNF reimbursement structure to support the effort.

These impressive results notwithstanding, the researchers say they could accomplish much more if Missouri's practice laws allowed facilities to use APRNs efficiently.

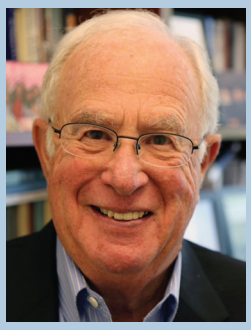
"When we started the project," says Marcia K. Flesner, PhD, RN, project coordinator, "we expected the NPs we placed in nursing homes to develop CPAs with the medical directors, but Missouri limits physicians to three collaborating APRNs, which made that impossible."

As a result, Sinclair NPs had to resort to cumbersome workarounds to achieve the initiative's direct care goals. The NPs still assessed the SNF patients, but without a CPA, they lacked the legal authority to order lab work and X-rays or to start or adjust medications. The NPs had to ask the staff nurses to relay patients' conditions to the physician in charge and wait until the physician sent orders affirming their recommended course of action, a process that could delay care for hours.

In spite of these hurdles, the project achieved the drop in hospital admissions because it also tasked the NPs with educating and mentoring direct care staff. This paid off in better patient care, but the inefficiency of the process frustrates Flesner and others. "It would be so much better if we could intervene directly on patients' behalf without taking the physicians away from their patients," she says.

A Workforce Cost?

States with restrictive APRN practice acts may also incur a workforce penalty. A 2013 study of Medicare data found that beneficiaries were 2.5 times more likely to receive primary care from an NP in states with the least restrictive regulations. The experience of states that recently removed scope-of-practice restrictions may also be instructive. Nevada, for instance, has seen an influx of APRNs moving there from states with more restrictive laws since revising its nursing practice laws in 2013.



"By preventing providers from doing the things they are educated and licensed to do, outdated scope-of-practice laws create a barrier to cost-effective care."

–Stuart Altman, PhD, Chair, Massachusetts Health Policy Commission and Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Photo: Marvin Fong/The Plain Dealer

A nurse practitioner (NP) examines a young child at a CVS MinuteClinic. NPs are the principal providers in the burgeoning retail clinic sector, which provides convenient access to care for routine health concerns at affordable prices.

Some States Adopt Phase-Out of CPAs

In a number of states, transition-to-practice periods (TPPs) have emerged as a political compromise between granting full practice authority to new APRNs and requiring ongoing physician supervision for *all* APRNs. Delaware, for instance, now allows APRNs to apply for full practice authority after two years and a minimum of 4,000 supervised practice hours; and Nebraska has replaced its CPA requirement for all NPs with a 2,000-hour TPP for *new* NPs.

Susanne Phillips, DNP, APRN, FNP-BC, clinical professor at the University of California, Irvine, tracks state legislation related to APRN practice and publishes an annual update in *The Nurse Practitioner*. She says ten states have passed "transition-to-practice" legislation since 2010, and several states plan to employ this strategy in the 2017 legislative session.

"Though we're moving to full practice authority for APRNs, many states are adopting an arbitrary number of supervised hours," says Phillips, who notes that states granting full practice authority to newly licensed and certified APRNS do not experience quality and safety problems or inferior patient outcomes. "How states determine when full practice authority can be realized depends on the political climate. Transition-to-practice periods appear to be a politically palatable alternative."

Over the past few years, some nursing leaders have proposed the creation of transition-to-practice *programs*—residency-like educational experiences guided by more senior APRNs to help new NPs become acclimated to their roles in the clinical environment. To learn more, see "Clinical residency training: Is it essential to the Doctor of Nursing Practice for nurse practitioner preparation?" in *Nursing Outlook*.

VA Rule Change: A Turning Point for Veterans' Access to Care?

To address staffing shortages and to standardize care, in 2016 the Department of Veterans Affairs (VA) proposed a change in its regulations: granting full practice authority to all APRNs working in Veterans Health Administration (VHA) facilities.

In December 2016, after months of vigorous public comment (see p. 2), VA issued a final rule allowing APRNs in three of the four advanced-practice roles (NP, CNM, and CNS) "to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians."

As a result, most of the 5,825 APRNs employed by VHA are slated to follow a single set of rules concerning basic prescriptive authority, admissions, and physician supervision—rules that previously varied by state. State law will still determine whether APRNs may prescribe and administer controlled substances.

The rule does not grant full practice authority to one APRN role: CRNA. In publishing the rule, VA noted that the decision to exclude nurse anesthetists "does not stem from the CRNAs' inability to practice to the full extent of their professional competence, but rather from VA's lack of access problems in the area of anesthesiology." The agency also took the unusual step of requesting additional comment "on whether there are access issues or other unconsidered circumstances that might warrant [CRNAs'] inclusion in a future rulemaking."

What Prompted the Rule Change?

In 2014 Congress established the Commission on Care to examine why VHA was struggling to provide timely care to veterans. The commission concluded that staffing shortages and the ineffective use of providers, including "failing to optimize use of advanced practice registered nurses (APRNs)," were significant contributors to the VA's access problems. The rule change, proposed several years earlier by a visionary chief nursing officer (see *CNF* 20), offered a solution.

Of VHA sites with clinically meaningful access delays, 94 percent indicated that increasing the number of licensed independent practitioners, such as physicians and APRNs, was "critical or very important to increasing access." The commission drew on several investigative reports, including one 2015 assessment of VA health care capabilities, which found examples where limited availability of anesthesia services had delayed care.

How Might the Rule Affect Care Delivery?

The VA's adoption of the new rule has put the nation's largest integrated health care system more in line with both the Military Health Service and the Indian Health Service, which already grant full practice authority to APRNs. According to Penny Kaye Jensen, DNP, FNP-C, FAAN, liaison for the APRN National Policy Department of Veterans Affairs, there have been no reports of quality of care issues in either of these systems. In her view, "Servicemen and women transitioning from the Department of Defense to VA should be able to receive the same level of care from APRNs in both systems."

Opponents of the rule argued that physician-led teams are optimal for care delivery and that granting APRNs full practice authority would jeopardize collaboration within VA. Jensen disagrees. "The VA is team-based and we will always be team-based so we can work together to provide high-quality care for veterans," she says. "On any given day, the best person to lead the team may differ. If I am evaluating a patient who has PTSD and suicidal ideation, the mental health NP or CNS may be the best person to lead the team. It really depends on the patient's needs."

A Turning Point for Access?

"This is a real breakthrough for nurses, and by expanding access, it will improve patient care, as well," says John Iglehart, founding editor of *Health Affairs* and national correspondent for the *New England Journal of Medicine*. "There are so many VA installations in rural spaces where access to care is a challenge across the board."

With more than 1,200 sites of care, VHA is the largest integrated health care system in the country. In the years since the United States began conducting military operations in Afghanistan and Iraq, enrollment in the VA health care system has grown significantly—from 6.8 million veterans in fiscal year 2002 to 8.9 million veterans currently—increasing VHA's need for providers of all sorts.

"The VA rule is the best thing for veterans," says Cary Pigman, M.D., FACEP, an emergency physician and lieutenant colonel in the U.S. Army Reserves who is working to remove APRN practice barriers in his home state. He represents District 55 in the Florida House of Representatives, and last year his bill making it possible for Florida NPs to prescribe controlled substances was signed into law.

"The VA rule won't solve delays in cardiovascular surgery," Pigman says, "but it will help veterans get in to see the person monitoring their diabetes and hypertension, and that's the bedrock."

For More Information

CNF 18 describes VA's Patient Aligned Care Team and the roles nurses play in this collaborative model of primary care.

"The final rule making for APRNs addresses the need to increase veterans' access to quality health care by expanding the pool of qualified health professionals authorized to provide health care services to the full extent of their education, training, and certification."
–**David J. Shulkin**, MD, Secretary of Veterans Affairs

Other Recent Breakthroughs

Against the backdrop of rising Medicaid enrollments and physician workforce shortages, state legislatures increasingly view APRNs as part of the solution to improving access to care and reducing costs in their states. Since the IOM *Future of Nursing* report was released in 2010, nine states have revised their NP practice regulations, and currently 22 states and the District of Columbia allow NPs full practice authority. As of publication, at least a dozen states are considering legislation to remove practice barriers for one or more APRN roles in 2017.

High profile endorsements from The Heritage Foundation, American Enterprise Institute, and other groups have lent support for these changes.

- In 2010 AARP concluded that statutory and regulatory barriers at the state and federal levels were "short-changing consumers" and updated its policy book to support lifting restrictions on APRN practice.
- In 2012 the National Governors Association released "The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care," which concluded that states should consider easing NP practice restrictions and modifying reimbursement policies for NPs.
- In 2013 an American Hospital Association white paper identified "current state licensing acts that restrict some practitioner's full scope of practice" as a barrier to redesigning primary care.
- In 2014 a Federal Trade Commission statement, "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses," concluded that removing barriers to APRN practice is "good for competition and American consumers."
- And in 2016 CMS proposed allowing "non-physician primary care practitioners to provide some services in the place of primary care physicians" in order to strengthen and expand PACE, one of its signature programs for frail older adults.

In tandem with these expressions of public- and private-sector support, a growing body of research (see p. 2) has emerged. So too has a regulatory framework that states can use to modernize their APRN practice statutes. The APRN Consensus Model, jointly produced by APRN organizations and the National Council of State Boards of Nursing, encompasses licensure, accreditation, certification, and education. It can be used to create greater uniformity among state regulations.

These developments, and the VA's 2016 decision to grant full practice authority to three of four APRN roles within the VHA workforce (see p. 9), may signal additional progress on the horizon.

Remaining Challenges

While opportunities abound to capitalize on the changes that have occurred at VHA and in individual states, across the nation practice barriers persist—not just in laws and regulations but in institutions' decisions about who will practice within their walls and insurers' decisions about who will be paid for delivering which services.

"Legislation is only the first step," says the University of Minnesota's Mary Chesney. Since her state granted APRNs full practice authority in 2015, she says some large health systems have yet to expand APRN privileges by adjusting the level of oversight to match the requirements of the current law. Chesney thinks employers that are slow to embrace change may lose out in the long run.

"The systems that will fare the best as we move to value-based payment," she believes, "are the ones that use folks to the full extent of their expertise—that use NPs for primary care and chronic care; CNMs for healthy pregnancies; and physicians for acute care management, high-risk pregnancy, and complex chronic disease."

The IOM *Future of Nursing* report targeted three groups to advance its recommendation to remove APRN practice barriers:

- Congress, to revise federally funded programs to remove barriers to reimbursement for services provided by APRNs within their full scope of professional practice, and to use federal nursing education funds to encourage states to permit full APRN practice authority.
- State legislatures, to reform their practice regulations to conform to the APRN Consensus Model.
- Federal agencies, to use their authority to encourage payers, institutions, and states with restrictive practice acts to amend their rules to increase access to APRN services.

Although the report's recommendations remain as relevant today as they were in 2010, they were written shortly after the passage of the Affordable Care Act. With the possibility that the law may be repealed, the context for future efforts will almost certainly change, bringing challenges—and opportunities—that are difficult to predict. Nevertheless, a strong body of research and the experience of health systems and consumers across the United States suggest that removing barriers to APRN practice will remain an effective and overdue strategy for increasing the public's access to timely, high-quality health services while controlling health care costs.

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A Primer on Advanced Practice Registered Nurse (APRN) Practice

Who are APRNs?	What do APRNs do?
Nurse Practitioners (NPs)	Take health histories; conduct physical exams; diagnose and treat acute and chronic illnesses; provide immunizations, health education, and counseling; prescribe and manage medications and therapies; order and interpret diagnostic tests. *Settings: outpatient practices, health centers, retail clinics, schools, hospitals, homes.*
Clinical Nurse Specialists (CNSs)	Serve as expert clinicians, consultants, researchers, and educators; address health system issues to improve quality and safety. *Settings: health systems, hospitals, other clinical sites.*
Certified Registered Nurse Anesthetists (CRNAs)	Administer anesthesia and related care for surgical, therapeutic, diagnostic, and obstetrical procedures; provide pain management. *Settings: hospitals, outpatient surgical centers, dental offices.*
Certified Nurse-Midwives (CNMs)	Provide primary care; gynecological exams; family planning services; management of low-risk labor and delivery; prenatal, neonatal, and postpartum care. *Settings: hospitals, birth centers, community health centers, homes.*

Sources: Adapted from Institute of Medicine, *Future of Nursing: Leading Change, Advancing Health* (2010); APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee, *APRN Consensus Model* (2008)

How many are there?

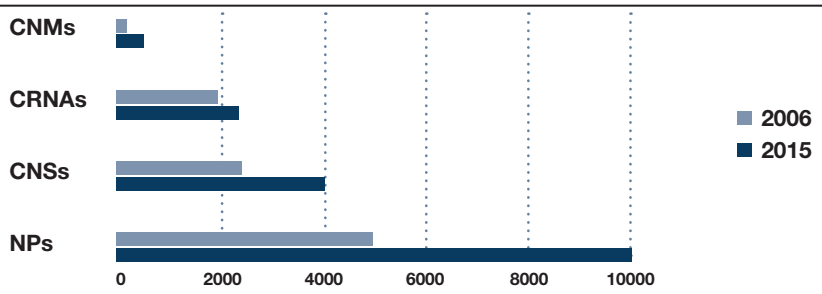
By Role

NPs	222,000
CNSs	69,000
CRNAs	48,000
CNMs	11,000

Sources: American Association of Nurse Practitioners (2016), National Association of Clinical Nurse Specialists (2015), National Board of Certification and Recertification of Nurse Anesthetists (2016), American Midwifery Certification Board (2015)

*NACNS estimate of RNs who have the education and credentials to practice as a clinical nurse specialist

Graduation Trends – A Growing Workforce



Sources: American Midwifery Certification Board, National Board of Certification and Recertification of Nurse Anesthetists, American Association of Colleges of Nursing, National Organization of Nurse Practitioner Faculties

How do nurses prepare for advanced practice?

Undergraduate education	Earn a baccalaureate nursing degree.			
Licensure	Obtain and maintain licensure as a registered nurse. Achieved by graduating from a nursing program approved by a state board of nursing, passing a national standardized exam (NCLEX-RN), and meeting additional state board of nursing requirements.			
Graduate education	Earn a master's degree or practice doctorate from an accredited program, with advanced course work and clinical education in physical/health assessment, pharmacology, pathophysiology, and the topics below.			
	NPs	**CNSs**	**CRNAs**	**CNMs**
	Health promotion, disease prevention, disease management; topics related to the population served.	Topics related to the population served and within the CNS spheres of influence: patient/client care, nursing practice, and health care organization.	Anesthesia. Note: CRNA students must complete at least one year of critical care nursing prior to enrolling.	Midwifery, care of newborns, primary and reproductive health care for women, and treatment of sexually transmitted diseases in male partners.
Graduate-level clinical training	A minimum of 500 faculty-supervised clinical hours (1,000 recommended for a practice doctorate).	A minimum of 500 faculty-supervised clinical hours (1,000 for a practice doctorate).	A minimum of 2,000 hours and 600 cases across designated categories.	As many hours as needed to attain core competencies.
Certification	National standardized exam linked to APRN role and population served. (Certification exams exist for some, but not all, CNS specialties.)			
Post-certification professional development	Clinical practice and continuing education hours required for periodic recertification. Specific requirements vary by role, population focus, specialty, and credentialing body and, in some cases, include reexamination.			

Sources: American Association of Colleges of Nursing, National Association of Clinical Nurse Specialists, National Board of Certification and Recertification of Nurse Anesthetists, Accrediting Commission for Midwifery, National Task Force on Quality Nurse Practitioner Education, Council on Accreditation

Glossary of Terms

Professional scope of practice: The services a fully qualified health professional is educated, trained, and, in most cases, nationally certified to provide.

Legal scope of practice: The services a fully qualified health professional is legally permitted through licensure and regulation to provide and the restrictions placed on providing those services.

Licensure: The legal authority to engage in professional practice.

Certification: An independent accrediting body's determination that a member of the profession has the knowledge and skills for APRN practice.

Full practice authority: The authority to diagnose and treat patients without supervision by or mandated collaboration with other health professionals. When professionals have full practice authority, no gap exists between what they are educated and licensed to provide (professional scope of practice) and what state practice acts allow them to provide (legal scope of practice).

Practice restrictions: The laws, regulations, institutional rules, and insurer policies that constrain health professionals from freely providing the full scope of services they are educated, licensed, and certified to provide.

Full prescriptive authority: The authority to prescribe all classes of drugs, including controlled substances, and medical devices and equipment without supervision by or mandated collaboration with other health professionals.

Prescriptive authority restrictions: The laws, regulations, institutional rules, and insurer policies that govern which classes of drugs a health professional may prescribe and whether or not a physician must oversee that professional's prescribing practices. Also, the restrictions that apply to prescribing medical equipment and devices.

APRN Consensus Model: Model regulatory language—jointly developed by APRN organizations—that encompasses licensure, accreditation, certification, and education of all APRNs. The model assists states in updating statutes and regulations to enable full practice authority for APRNs.

Supervision, team management, delegation: A spectrum of supervisory relationships that establish physician oversight of APRN care delivery. *Direct supervision* requires that a physician be present onsite to assist in care if called upon. *Team management* sometimes implies that the APRN will be part of a physician-led team. *General supervision* typically indicates remote physician oversight of APRN services. Authority for APRN practice and prescribing may also be conveyed through *delegation* by a physician or via a *collaborative practice agreement.*

Collaborative practice agreements: State-mandated contracts describing the ways in which a physician will supervise an APRN, most often by 1) specifying which classes of drugs the APRN may prescribe, and 2) periodically reviewing a set percentage of patient charts. In many states APRNs may not legally practice without a CPA. Despite their name, CPAs do not mandate actual collaboration in caring for patients.

Collaborative practice: A variety of practice arrangements in which health professionals collaborate—through joint practice, consultation, or referral—in the care of patients.

Autonomous practice: The ability to provide patient care services without supervision by or mandated collaboration with other health professionals.

Transition-to-practice period: A legally defined period of time after entry into practice before an APRN obtains full practice and prescriptive authority.

Credentialing: The process by which a hospital, health care organization, or insurer determines a health professional's qualifications to provide and/or be reimbursed for health care services.

Privileging: The process by which a hospital or other health care organization authorizes a health professional to provide specific services, such as admitting patients or ordering diagnostic tests.