

Removal of Legal Barriers to the Practice of Advanced Practice Registered Nurses

Eileen C. Kugler, Linda D. Burhans, Julia L. George

A recent report from the Institute of Medicine of the National Academies (IOM) calls for states to amend regulations on the practice of advanced practice registered nurses (APRNs). This article reviews the roles of APRNs, the IOM recommendations, and efforts by national and state stakeholders to remove legal barriers to APRN practice.

Advanced practice registered nurse (APRN) professional classifications include certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs) (Table 1). These classifications are regulated in a variety of ways in North Carolina. In fact, state statutes, administrative codes, and other regulations governing the practice of APRNs vary greatly across the United States. For example, NPs are afforded autonomous practice in 23 states, as well as Washington, D.C. The boards of nursing in these states have sole regulatory authority in scope of practice, without statutory or regulatory requirements for physician involvement (ie, mandated collaboration, direction, or supervision). Twenty states require physician collaboration, even though the boards of nursing in the states have sole regulatory authority. Three other states in which boards of nursing have sole regulatory authority require physician supervision. Finally, in the 4 remaining states, including North Carolina, NPs are jointly regulated by the board of nursing and the board of medicine [1]. In addition, the regulation of prescriptive authority for APRNs is complicated and varies between the states, with some requiring various levels of physician involvement and others allowing independence in this function. Requirements for physician involvement in APRN practice (ie, supervision or collaboration) usually include various types of agreements between APRNs and physicians, with stipulated content, as well as mandated meetings, on-site time by physicians, chart reviews, and restrictions in the numbers of APRNs a physician may supervise. These requirements prevent APRNs from practicing to the full extent of their qualifications, limit access to care, and restrict consumer choice [2].

O'Grady [3], in her work on APRNs and patient safety and quality, maintains that the current regulatory environment for APRNs includes numerous problems that may promote poor quality of care or impair patient safety. She

states that the "high degree of variation across the States for APN regulation has spotlighted the need to ensure that regulation serves the public, promotes public safety, and does not present unnecessary barriers to patients' access to care" [3]. Recently, this sentiment has become a resounding refrain, as several bodies have advocated for changes in regulatory requirements to allow APRNs to function to the full extent of their educational preparation, competencies, and experience [1-5]. Perhaps the most notable summons to unshackle APRN practice is found in a report on the future of nursing recently published by the Institute of Medicine of the National Academies (IOM) [4]. Recommendation 1 in the report calls for the removal of scope-of-practice barriers and advocates for APRNs to "be able to practice to the full extent of their education and training" [4p278]. The report further calls on Congress, state legislatures, the Centers for Medicare and Medicaid Services, the national Office of Personnel Management, the Federal Trade Commission, and the Antitrust Division of the Department of Justice to take specific actions within their jurisdictions to help ensure that the recommendation is implemented. The IOM committee, which was funded by the Robert Wood Johnson Foundation and conducted their study of the future of nursing over a 2-year period, "sees its recommendations as the building blocks required to expand innovative models of care, as well as to improve the quality, accessibility, and value of care, through nursing" [4p278].

To bring this discussion to the state level, the APRN regulatory landscape in North Carolina can be compared to a patchwork quilt. Each of the 4 APRN roles is regulated in a different manner. NPs are jointly regulated by the North Carolina Board of Nursing and the North Carolina Medical Board and are required to have physician supervision. CRNAs are regulated by the board of nursing, with no requirement for physician supervision. CNMs are regulated by the Midwifery Joint Committee, with independent statutory authority; however, CNMs are required to have physician supervision. Last, CNSs are not regulated and do not

Electronically published September 23, 2011.

Address correspondence to Ms. Eileen C. Kugler, North Carolina Board of Nursing, 4516 Lake Boone Trl, Raleigh, NC 27607 (ekugler@ncbon.com). **N C Med J. 2011;72(4):285-288.** ©2011 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2011/72407

TABLE 1.
Components of the Definition of the Advanced Practice Registered Nurse (APRN)

Component	Description
Education	Completed an accredited, graduate-level education program in 1 of the following 4 recognized APRN roles: certified nurse midwife, clinical nurse specialist, certified registered nurse anesthetist, and nurse practitioner
Certification	Passed a national certification examination that measures APRN, role, and population-focused competencies; maintains recertification
Direct care	Acquired advanced clinical knowledge and skills 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
Practice	Practice builds on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy; APRNs are 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 nonpharmacologic interventions
Experience	Has clinical experience of sufficient depth and breadth to reflect the intended license
Licensure	Licensed to practice as an APRN in 1 of the 4 APRN roles
Accountability	Licensed practitioners, with no statutory requirement for supervision by, direction from, or collaboration with another health care professional, 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 and planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care professionals as appropriate

Note. Definition is from [6].

have title protection in our state. A foundational requirement for all North Carolina APRNs, regardless of role, however, is that all must have a current unencumbered registered nurse license issued by the North Carolina Board of Nursing.

The mandate for physician supervision and other restrictions stemming from the regulatory requirements for APRNs in North Carolina prevent advanced practice nurses from using their full complements of knowledge and skills and from being full participants in meeting the health care needs of North Carolinians, in both rural and urban areas. The IOM report states that “now is the time to finally eliminate the outdated regulations and organizational and cultural barriers that limit the ability of nurses, including APRNs, to practice to the full extent of their education, training, and competence” [4p145]. The report further asserts that “the

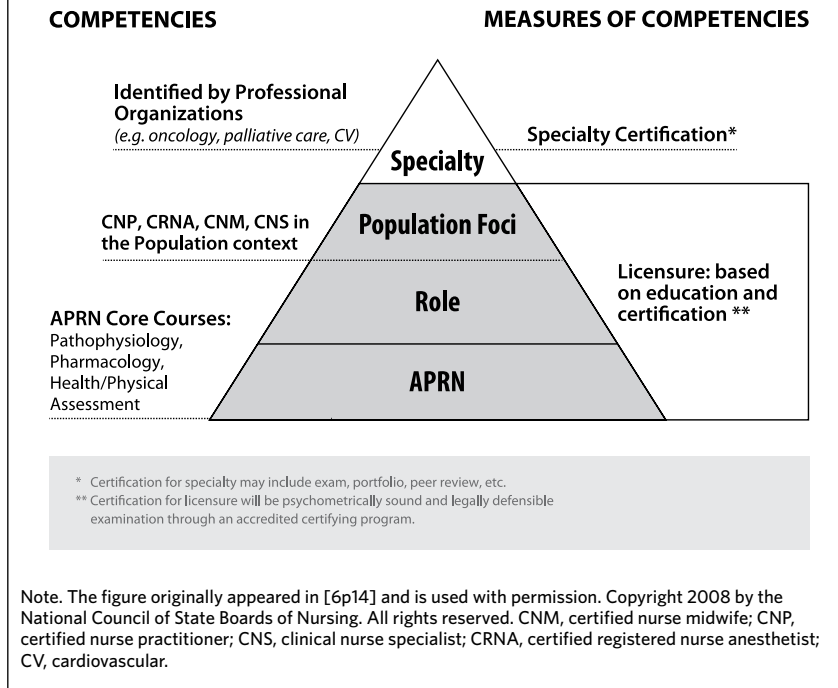
contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by the decades of research that has examined this question....No studies suggest that care is better in states that have more restrictive scope-of-practice regulations for APRNs than in those that do not. Yet most states continue to restrict the practice of APRNs beyond what is warranted by either their education or their training” [4pp98-99].

Efforts to broaden the legal authority of APRNs to provide a level of health care that matches their education, training, and competencies appear to be gaining momentum [4]. In July 2008, after an intensive 5-year process, members of a variety of nursing stakeholder groups, represented by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee, agreed to a comprehensive model for APRN regulation [6]. The primary goal of the consensus model is to bring clarity and uniformity to the ways that APRNs are educated, certified, and licensed, to promote patient safety and public protection [6]. The goals of this consensus process were to strive for harmony and common understanding in the APRN regulatory community, to promote quality APRN education and practice; to develop a vision for APRN regulation, including education, accreditation, certification, and licensure; to establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and to produce a written statement that reflects consensus on APRN regulatory issues [6].

The consensus model stipulates that advanced practice nursing consists of the 4 APRN roles and that the legal title for individuals practicing in these roles should be “APRN.” Nationally accredited educational programs educate APRNs at the graduate level in 1 of the 4 roles and in at least 1 of 6 population foci (ie, family/individual across the life span, adult-gerontology, pediatrics, neonatal, women’s health/gender related, and psych/mental health). Individuals who complete the approved educational programs must obtain national certification that is congruent with their educational preparation. The individuals will then be licensed by boards of nursing at the level of one of the APRN roles and in at least one of the population foci (Figure 1) [6].

In August 2008, following closely on the heels of the APRN consensus model, the NCSBN board of directors approved the Model APRN Act and the Model APRN Administrative Rules [7]. These documents translate the components of the APRN consensus model into legal statutory language, and they are now the national standards for APRN regulation. As a result, many states around the country are in the process of putting these standards into place, through various levels of rule and statutory changes. The IOM, as part of recommendation 1, calls on state legislatures to reform scope-of-practice regulations to conform to the model act and administrative rules and ties funding for nursing education programs to only those programs in states that have adopted the model act and rules [4].

FIGURE 1.
Relationship Among Advanced Practice Registered Nurse (APRN) Educational Competencies, Licensure, and Certification



The North Carolina Board of Nursing has established the APRN Advisory Committee. The committee includes education and practice representatives from each of the 4 APRN roles, as well as representatives from the public and from employers of APRNs, and is composed of the following 14 members: Gale Adcock, Diana Hatch (public representative), James Hicks, Adam Linker (public representative), Bobby Lowery, Katherine Pereira, Dolly Pressley Byrd, Joy Reed (employer representative), Pamela Reis, Linda Sangiuliano, Nancy Shedlick, Victoria Soltis-Jarrett, Mary Tonges (employer representative), Susan Williams, Nancy Bruton-Maree (board member liaison), and Eileen Kugler (board staff liaison).

The purpose of the committee is to assist and support the board in issues related to APRN practice and regulation, including consideration in the consensus model, the model act, and the administrative rules. The committee charge for 2010-2012 is to study North Carolina APRN licensure, accreditation, certification, and education models; identify gaps with the national Consensus Model for APRN Regulation; and make recommendations to the board.

In moving forward with this charge, the committee has studied the consensus model, the model act, and the administrative rules; determined the major gaps between these documents and North Carolina laws and rules regulating APRN practice across the 4 roles; studied APRN regulatory models used in other states; reviewed the IOM report; and conducted a review of the literature pertaining to APRN practice as it relates to patient safety and quality of care.

The committee will provide recommendations to the board by December 2011.

Conclusion

Many stakeholders in health care have affirmed the need to place a higher priority on the provision of high-quality, safe, and cost-effective primary care in this country. Many people will not be able to access needed health care, owing to the steep increase in the size of the aging population; a large increase in the number of individuals covered by health insurance, because of the implementation of health care reform; and fewer health care professionals choosing the primary care field [8]. The states—and North Carolina is no exception—need to find ways to meet this growing demand and use all health care professionals to the full extent of their preparation and skills. The IOM report recommends that scope-of-practice barriers be removed, to allow APRNs to practice to the full extent of their education and training and to assist in the important work of meeting the health care needs of the population. North Carolinians will certainly benefit from this approach. The North Carolina Board of Nursing’s APRN Advisory Committee is working toward providing recommendations on how this can be accomplished. NCMJ

Eileen C. Kugler, RN, MSN, MPH, FNP manager-practice, North Carolina Board of Nursing, Raleigh, North Carolina.

Linda D. Burhans, RN, PhD associate executive director of education and practice, North Carolina Board of Nursing, Raleigh, North Carolina.

Julia L. George, RN, MSN, FRE executive director, North Carolina Board of Nursing, Raleigh, North Carolina.

Acknowledgments

Potential conflicts of interest. All authors have no relevant conflicts of interest.

References

1. Phillips SJ. 22nd annual legislative update: regulatory and legislative successes for APNs. *Nurse Pract.* 2010;35(1):24-47.
2. LeBuhn R, Swankin D. Reforming Scopes of Practice: A White Paper. Washington, DC: Citizen Advocacy Center. <http://www.cacenter.org/files/ReformingScopesofPractice-WhitePaper.pdf>. Published July 2010. Accessed May 23, 2011.
3. O'Grady E. Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality. In: Hughes RG, ed. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Vol. 2. Rockville, MD: Agency for Healthcare Research and Quality; 2008:601-620. <http://www.ncbi.nlm.nih.gov/books/NBK2641/>. Accessed May 23, 2011.
4. Institute of Medicine of the National Academies. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press; 2011.
5. Center to Champion Nursing in America. *Improving Access to Primary Care: The Growing Role of Advanced Practice Registered Nurses*. <http://championnursing.org/sites/default/files/u/ImprovingAccessToPrimary%20Care-APRNs.pdf>. Accessed May 23, 2011.
6. National Council of State Boards of Nursing. *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*. Prepared by the APRN Consensus Work Group and the NCSBN APRN Advisory Committee. https://www.ncsbn.org/FINAL_Consensus_Report_070708_w_Ends_013009.pdf. Published July 2008. Accessed May 23, 2011.
7. National Council of State Boards of Nursing. *Model APRN Act and Model APRN Administrative Rules*. https://www.ncsbn.org/Article_XVIII_1.31.11.pdf. Published January 2011. Accessed May 23, 2011.
8. Co-chairs' Summary of the Conference: *Who Will Provide Primary Care and How Will They Be Trained?* Prepared on behalf of the Josiah Macy Jr. Foundation. http://www.josiahmacyfoundation.org/docs/macy_pubs/jmf_ChairSumConf_Jan2010.pdf. Published January 2010. Accessed May 23, 2011.



Moving is the best medicine.
Keeping active and losing weight are just two of the ways that you can fight osteoarthritis pain. In fact, for every pound you lose, that's four pounds less pressure on each knee. For information on managing pain, go to fightarthritispain.org.

Ad Council

ARTHRITIS FOUNDATION®