The Consensus Model for APRN Regulation: Review and update

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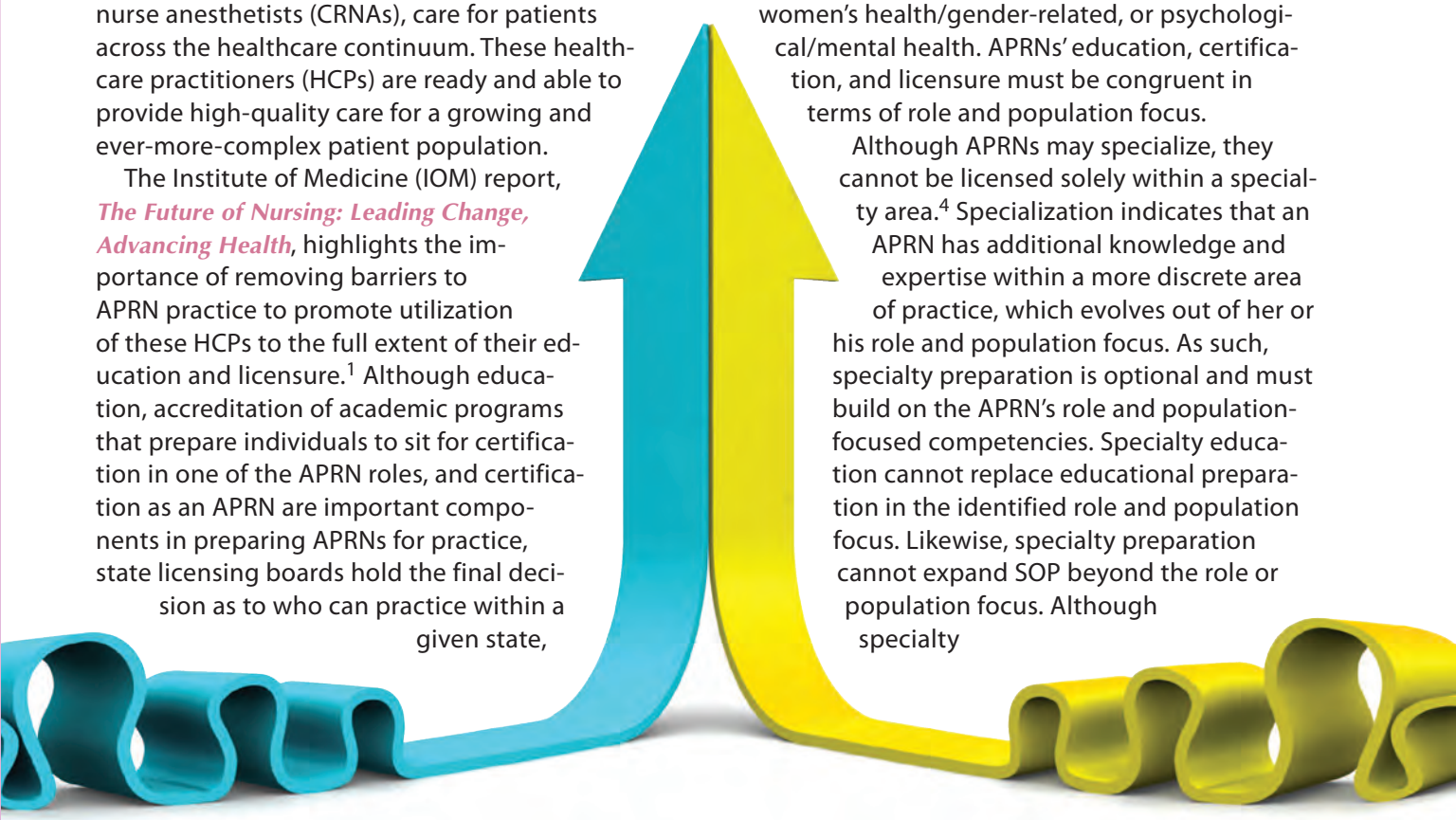
The current policy and demographic environment poses expanded opportunities for advanced practice registered nurses (APRNs). Expansion of Medicaid eligibility in most states, and increased access to affordable health insurance promised by the Health Insurance Exchanges created through the Patient Protection and Affordable Care Act (PPACA), signal an increase in the number of individuals seeking healthcare services at all levels. Likewise, changing demographics indicate a need for improved efficiency and care coordination so as to better manage and maintain rising numbers of aging patients with multiple chronic conditions. APRNs, including certified nurse practitioners (CNPs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs), care for patients across the healthcare continuum. These healthcare practitioners (HCPs) are ready and able to provide high-quality care for a growing and ever-more-complex patient population.

The Institute of Medicine (IOM) report, ***The Future of Nursing: Leading Change, Advancing Health***, highlights the importance of removing barriers to APRN practice to promote utilization of these HCPs to the full extent of their education and licensure.[1] Although education, accreditation of academic programs that prepare individuals to sit for certification in one of the APRN roles, and certification as an APRN are important components in preparing APRNs for practice, state licensing boards hold the final decision as to who can practice within a given state, as defined by pertinent state statutes and regulations. As such, APRNs' scope of practice (SOP), roles, and criteria to practice vary from state to state, creating a patchwork of APRN regulations.[2] The Consensus Model for APRN Regulation, or **Consensus Model**, was finalized in 2008 and has since been endorsed by 48 professional nursing organizations as a framework for consistency in APRN regulation. The purpose of this article is to review key tenets of the Consensus Model and provide an update on the adoption of its key elements within the state regulatory scheme.[3]

Overview of the Consensus Model for APRN Regulation

The Consensus Model for APRN Regulation emerged over the last decade as a national effort to ensure consistency in APRN education and practice.[4] The Consensus Model encompasses the four pillars that define APRN SOP: licensure, accreditation, certification, and education (LACE). Under the Consensus Model, APRNs must be educated, certified, and licensed to practice in one of the four APRN roles—CNP, CNM, CNS, or CRNA—within one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psychological/mental health. APRNs' education, certification, and licensure must be congruent in terms of role and population focus.

Although APRNs may specialize, they cannot be licensed solely within a specialty area.[4] Specialization indicates that an APRN has additional knowledge and expertise within a more discrete area of practice, which evolves out of her or his role and population focus. As such, specialty preparation is optional and must build on the APRN's role and population-focused competencies. Specialty education cannot replace educational preparation in the identified role and population focus. Likewise, specialty preparation cannot expand SOP beyond the role or population focus. Although specialty



preparation may occur concurrently with APRN education in one of the four APRN roles and six population foci, it must be assessed separately and cannot be used for entry into APRN practice without preparation meeting the APRN role and population focus requirements. In addition, APRNs are not licensed at the specialty level. Likewise, specialization and experience at the RN level do not extend SOP at the APRN level.

Scope of practice, a key focus of the Consensus Model, is designated based on patient care needs rather than practice setting.[5] For example, acute care CNPs manage patients with unstable, chronic, complex, acute, and critical conditions. They focus on restorative care within the context of rapidly changing clinical conditions. By contrast, primary care CNPs focus on comprehensive, continuous care characterized by a long-term relationship between patient and CNP. Primary care CNPs manage most patient health needs and coordinate additional healthcare services beyond the primary care setting and their population focus or area of expertise. Of the six population foci, only adult-gerontology CNPs and pediatric CNPs are designated as acute care or primary care.

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Adoption of the APRN Consensus Model

The IOM report, *The Future of Nursing*, recommends that APRNs practice to the full scope of their education and training.[1] However, regulations that define APRN practice vary widely from state to state. Depending on the state, a CNP's ability to perform functions recognized as APRN competencies, such as assessing a patient's changing conditions, prescribing medications, or ordering and evaluating diagnostic tests, may be curtailed by state law. This regulatory inconsistency provides a barrier to full utilization of APRNs within a healthcare system facing HCP shortages and a population with increasingly complex health conditions.

The Consensus Model provides a framework for consistent regulation of APRN practice from state to state. The target for aligning APRN regulation across all states is 2015. The National Council of State Boards of Nursing's (NCSBN's) **Campaign for Consensus** seeks to "assist states in aligning their APRN regulation with the major elements of the Consensus Model" as follows:

- State recognition of each of the four described **roles** (CNP, CNM, CNS, and CRNA);
- **Title** of APRN in one of the four described roles;
- **Licensure** as an RN and as an APRN in one of the four described roles;
- Graduate or postgraduate **education** from an accredited program;
- **Certification** at an advanced level from an accredited program that is maintained;
- **Independent** practice; and
- **Independent** prescribing.

These major elements of the Consensus Model, if present in APRN regulation, would remove barriers to APRN practice. An NCSBN team has reviewed each of 55 states' or jurisdictions' nurse practice acts and rules, comparing current legislative language to that of the Consensus Model's major elements. The **Maps Project**, available at the NCSBN website, provides a state-by-state comparison of progress toward full Consensus Model implementation. During the NCSBN review, state nurse practice acts achieved one map point for each of the seven described elements of Consensus for each of the four APRN roles (28 possible map points). In terms of these maps, a higher number of points indicates that states have incorporated more Consensus Model elements in each of the four roles, whereas lower point scores correlate with more limited implementation. Based on Map Project data, approximately 66% of the 55 states and jurisdictions have implemented Consensus Model elements. Although this percentage suggests major progress, in reality, much work still needs to be done. Although many resources are dedicated to APRNs' achieving independent practice and prescriptive authority, these two elements remain the greatest barriers to full Consensus Model implementation.[6]

Conclusion

Consensus Model implementation holds promise for removing SOP barriers that limit APRNs' ability to fully practice at the top of their licensure. In addition, the Consensus Model provides the opportunity for clarity as to APRN SOP. Alignment of the four pillars guiding APRN SOP—licensure, accredi-

tation, certification, and education—can contribute to improved health outcomes and lower costs by improving access to care and supporting quality improvement and patient safety activities.

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