White Paper

Emerging Views on Nurse Practitioner Scope of Practice

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Executive Summary

In 2008, a nationally accepted regulatory model was developed through consensus by over 40 stakeholders that support uniformity in regulations that provide for the creation of licensure, accreditation, certification, and education for Advanced Practice Registered Nurses. For Nurse Practitioners, this model is predicated on the need for consistency in the role and population focus, and not on specialization to obtain licensure as specialization is viewed as a subfield of a practice role of the APRN. Emerging practice acts developed by states Boards of Nursing have viewed that subspecialization demonstrated as additional certification must be present in order to provide care versus demonstrated education, training, and experience. This white paper provides information regarding APRN subspecialization in order to practice in certain care delivery settings.

Introduction

In 2008 the National Council of State Boards of Nursing (NCSBN) with input from a diverse group of 48 professional nursing organizations developed and published the APRN Consensus Model (NCSBN, 2008). The goal of the Consensus Model was to standardize the licensure, accreditation, certification and education of advanced practice registered nurses (APRNs) across the U.S. The APRN Consensus Model defined the four APRN roles: certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), and clinical nurse specialist (CNS). Each APRN is licensed to provide care to patients in at least one of the population foci in a nationally recognized role and population-focused competencies. The model established six population foci that state boards of nursing and national certifying organizations should use to guide APRN licensure and certification requirements:

- Family/ Individual Across the Lifespan
- Adult-Gerontology
- Neonatal
- Pediatrics
- Women's Health/Gender-Related
- Psychiatric/Mental Health

There has been wide variation in APRN educational programs across states in required course content, credit hours, specialty focus, and competencies/skills of the graduate. Creating a uniform, national model of regulation for state boards of nursing to utilize would increase provider transparency (i.e., the public would know the education and credentials of an APRN), make tracking of quality outcomes easier; improve public protection and patient safety. A national model of regulation for APRNs would facilitate licensure mobility of APRNs from one state to another. Authors asserted that gaining consensus on APRN scope of practice could also improve patients' access to care by APRNs (NCSBN, 2008).

The large majority of APNs in Wisconsin, 6500 of 8000 (81%) are nurse practitioners (Zahner, S. J., Pinekenstein, B., Henriques, J., Merss, K. B., LeClair, J., Alnuaimi, N., & Krainak, K. (2023). For the sake of this white paper, we will limit our discussion to nurse practitioner (NP) scope of practice.

In 2013 nursing certification organizations launched several new nurse practitioner certifications and retired others in an effort to align more closely with the Consensus Model and national accreditation standards. The change that impacted the most NPs was the combination of the Adult and Gerontological NP certifications, and then to differentiate certification exams for primary care from acute care for Adult-Gerontological NPs, since the earlier Acute Care NP certification did not specify a population focus. Those NPs who held certification as an Adult NP, Gerontological NP or Acute Care NP were notified that if they let their certification lapse that they would not be able to renew that particular board certification.

The Consensus Model asserted that education, certification, and licensure of an individual must be congruent in terms of role and population focus. APRNs may specialize, but they cannot be licensed solely in a specialty area. Specialty practice builds upon an individual's role and population focus, providing depth in one's practice. The Consensus Model states:

Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e., nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organization. (Consensus Model, 2008, p. 5)

Specialty APRN practice represents additional knowledge and a more focused concentration for practice than the APRN role/ population focus. Specialty practice addresses a subset of an individual role's population focus. Examples of specialty foci are oncology, hospice and palliative care, heart failure, substance abuse, sleep medicine, travel health, nephrology, adolescent diabetes, and pain management. The criteria for defining an

APRN specialty has been established by the American Nurses Association (ANA) (2004) and updated in 2017 when it established a review program for recognition of a nursing specialty, approval of a specialty nursing scope of practice statement, acknowledgment of specialty nursing standards of practice, and affirmation of focused practice competencies (ANA, 2017).

Professional certification in specialty practice is strongly encouraged. The Consensus Model allows that new specialties will emerge based on the health needs of the population. The Consensus Model acknowledges that competency in specialty areas could be acquired in multiple ways: "by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations, etc.) (Consensus Model, 2008, p. 11).

It was not the intent of the framers of the Consensus Model to limit the geographic setting where APRNs could practice, rather health care needs should define the need for acute and primary care. The National Organization of Nurse Practitioner Faculties (NONPF, 2012) stated that there is much overlap between acute care and primary care of patients, and "it is inappropriate and restrictive to regulate acute and primary care NP scope and practice based on settings. Regulation should be based on educational preparation, certification, and scope of practice." There is a large area of overlap between the practice of an NP who practices in a community setting and one who practices in a hospital. For example, a patient may present to the primary care clinic or urgent care setting with acute chest pain or shortness of breath. It is essential for the primary care NP to be able to assess and emergently treat this patient, and call for emergency transport to take this patient to a facility where appropriate level of care can be provided for an unstable condition. When this patient arrives at the hospital, he is evaluated, treated, and stabilized, and during the hospitalization, the hospitalist NP may address chronic conditions such as diabetes control, need for influenza and pneumonia immunizations, or blood pressure management. It is common practice for hospitalists, both physicians and NPs, to be the providers of care at skilled nursing facilities, providing both acute and chronic care to residents. Home care is

another area in which hospitalists are providing care, highlighting an overlap in practice with primary care providers.

As the APRN Consensus Model is adopted across the U.S., several state Boards of Nursing have adopted narrow and proscriptive views of the Consensus Model. For example, in the rural state of Wyoming, the Board of Nursing (BON) determined that Family NPs were "working in the wrong areas" in the emergency department (ED) and as hospitalists (Burns, 2018). The BON set out on a state-wide phased-in communication/education project to bring NPs into compliance with the Wyoming nurse practice act, administrative rules, and the Consensus Model. They notified employers that they were responsible to adequately credential their providers and encouraged employers to review job descriptions and privilege cards of their APRNs. The upshot was that many Family NPs needed to add a post-graduate certificate in adult-Gerontological Acute Care Nurse Practitioner (AG/ACNP) to be able to continue practice in the ER and in the hospital. The Ohio BON (OAAPN, 2018) and the Veteran's Administration (Jensen, 2018) have also determined that some NPs are practicing outside their scope and are working to bring them into compliance with their interpretation of the Consensus Document through additional education and clinical hours.

An example of overreach

The Emergency Nurses Association (ENA) and the American Association of Emergency Nurse Practitioners (AAENP) have pushed back on state boards of nursing and healthcare organizations' initiatives to require Family NPs (FNPs) to obtain additional graduate education to be able to work in emergency departments. ENA and AAENP, the specialty nursing organizations responsible for emergency nursing practice, "have valid and reliable scientific evidence of scope and standards of practice, competencies, guidelines for academic and fellowship programs, and certification examinations" (Hoyt & Ramirez, 2018). ENA published the first Competencies for Nurse Practitioners in Emergency Care in 2008 (ENA, 2008), which were validated by an expert work group and supported by the findings of a Delphi Study (Hoyt, K., et al., 2010). These competencies were revised and

updated by an expert panel in 2019 (ENA, 2019) to meet the criteria for affirmation of practice-focused competencies by the ANA (2017).

ENA and AAENP state that according to CDC (2014) more than 40% of the more than 141 million patients seen in the Emergency Department (ED) are women and children, and only 3-5% are critical care patients. The majority of patients who visit EDs are not as ill and are discharged home. ED providers "manage 28% of all acute care visits for insured patients and two thirds of acute care visits for the uninsured" (Pitts, Carrier, Rich & Kellerman, 2010). In 2015 11% of patients had emergent care needs, and 62% were urgent/semi-urgent/non-urgent; 10.4% were admitted to the hospital, and 69% were discharged to follow-up with primary care; an additional 9.4% had no primary care provider to follow up with (CDC, 2017). Children comprised 20-25% of all patients presenting to general, non-specialty EDs (Chamberlin, Krug & Shaw, 2013). These data support that Emergency NPs must be educated to care for patients across the lifespan. Therefore, an Acute Care NP by education and certification does not possess the scope of practice to see the majority of patients seeking care at the ED. For most NPs in emergency care, it is most appropriate that ENP educational preparation, licensure, and certification center and build upon the family population focus of the Consensus Model.

In 2013 the American Nurses Credentialing Center (ANCC) established emergency nurse practitioner board certification (ENP-BC) by portfolio to demonstrate specialty practice knowledge, work experience, and role expertise (Evans, Hoyt, Wilbeck, Campo & Ramirez, 2015), but the ANCC certification is no longer offered. However, in 2017 the American Academy of Nurse Practitioners Certification Board (2020) offered Emergency Nurse Practitioner certification (ENP-C) by three routes:

- Continuing education and emergency practice hours as a Family NP (FNP) - requires current certification as an FNP, 2000 hours of emergency clinical practice within the past five years, completion of 100 hours of continuing education in emergency care which includes 30 credits of emergency procedures, and current active registered nurse (RN) license in the U.S., U.S. territories or Canadian province or territory.

- After completion of a graduate program that teaches emergency specific content building on a Family NP primary and chronic care content- requires current national certification as an FNP, completion of a graduate or post-graduate academic emergency care nurse practitioner program, and current, active RN license in the United States, US territories, or Canadian province or territory.
- After completion of an emergency fellowship program- requires current national certification as an FNP, completion of an approved advanced practice fellowship program in emergency care, and current, active RN license in the United States, US territories, or Canadian province or territory.

Complexity for NP practice

Is it reasonable to require all Family, Adult-Gerontological or Pediatric Nurse Practitioners to return to school for a post-graduate certificate to be able to practice in an acute care area? Even the Wyoming board of nursing asked the question whether there might be a bridge from FNP to ENP, an exam tool "by other means", perhaps with clinical check-offs to assure competency (Burns, 2018). An NP can always ask a school of nursing to conduct a gap analysis of the coursework and clinical hours needed to augment the previous graduate program to complete a post-graduate certificate in the specialty area, increasing the costs of an individual's education. By contrast, Family Medicine physicians practice not only in primary care and public health settings, but also in emergency departments/ urgent care settings, as hospitalists, in wilderness medicine, in sports medicine, and in multiple other medical specialties. Our Physician Assistant colleagues, likewise, practice in a wide variety of clinical settings and specialties.

It is an over-arching goal of the Wisconsin Nurses Association (WNA) NP Forum Board to encourage safe, responsible NP practice in Wisconsin. We believe it is essential that all NPs should regularly ask themselves these questions to ensure safe and legal practice. Refer to the self-assessment questions.

Self-assessment regarding current scope of practice

1. Have I met the requirements to practice as an NP in my state?

2. Does my education, training and experience match the scope of practice required to practice in my state?

3. Do I have the appropriate education, training, experience, and national certification required to practice in my clinical area?

4. Have I completed didactic and supervised clinical training to see this population of specialty patients?

5. Do I possess the clinical skills/ competencies required to treat the conditions of the patients I am seeing?

6. Have I demonstrated and maintained competence in my clinical area? How is this assessed on an ongoing basis?

7. If contemplating moving practice to a specialty/ new specialty area: How will I attain the skills and competencies needed? What mentorship is required, and is that mentorship available?

A call for supporting the tenets of the APRN consensus model

It is the strong belief and position of the WNA and the WNA NP Forum that we should not unnecessarily narrow the employment choices for NPs. There is no evidence to show that NPs practicing in diverse settings cause poor outcomes. Rather, it should be an option for NPs, especially NPs who have been practicing for a number of years in their specialty, to obtain the needed education, skills and competencies for their desired specialty through a combination of continuing education, a structured fellowship/practicum, mentorship, professional portfolio, and organizational credentialing and privileging. It is desirable for an NP to seek national certification in the specialty whenever it is available.

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