

APRN Consensus Model Frequently-Asked Questions

Below are frequently asked questions developed by LACE (Licensure, Accreditation, Certification and Education) to clarify the APRN Consensus Model. LACE is the implementation mechanism for the APRN Consensus Model.

1. Why was the Consensus Model developed?

There is increased appreciation of the important role that APRNs can play in improving access to high quality, cost-effective care. However, the lack of common definitions regarding the APRN roles, increasing numbers of nursing specializations, debates on appropriate credentials and scope of practice, and a lack of uniformity in educational and state regulations has limited the ability of patients to access APRN care. The Consensus Model seeks to address these issues.

2. Who developed the Consensus Model?

The document is the result of the collaborative work of the APRN Consensus Work Group and National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee with extensive input from a larger APRN stakeholder community. A complete list of all the organizations that took part is found on pages 29-39 of the report.

3. How is the role of APRN defined?

The document provides a detailed definition of an APRN (pp. 6-8). There are four APRN roles defined in the document (pp. 7-8):

- certified registered nurse anesthetist (CRNA)
- certified nurse-midwife (CNM)
- clinical nurse specialist (CNS)
- certified nurse practitioner (CNP)

4. Will I still be able to practice as an APRN after the APRN Consensus Model is implemented?

The ability of an APRN to practice and the scope of that practice are determined by state law (i.e., the state's nurse practice act and Board of Nursing Rules). When a state adopts new eligibility requirements for licensure, currently practicing APRNs are expected to continue to practice within that state if they maintain an active license. In addition, the Model recommends that state boards adopt language that would allow APRNs to move from another state and be licensed in the new state if they meet the education criteria that were in place when that individual was originally licensed to practice. Model legislative language that stipulates that an APRN will be grandfathered and allowed to practice has been developed by NCSBN. It is anticipated that legislation to implement the Model in each state will employ this language. APRNs currently in practice should keep abreast of legislative efforts in their own states and engage in activities to ensure that a grandfather clause is included.

5. How must APRNs legally represent themselves after the implementation of the APRN Consensus Model?

APRNs must legally represent themselves as APRN plus the specific role (i.e., CRNA, CNM, CNS, CNP). This representation includes the legal signature. The population and specialty may also be included in addition to the role (e.g., APRN, CNP, adult oncology). APRNs prepared and licensed for more than one role would use the relevant designations.

6. How does an acute care NP fit into the APRN Consensus Model?

The certified nurse practitioner (CNP) is educationally prepared to meet core competencies for all NPs and competencies for a population focus. The competencies at the population focus may be primary care or acute care. Currently, the acute care NP preparation is available with an adult-gerontology or pediatric focus. The graduate of an adult-gerontology acute care NP program is eligible to sit for an acute care adult-gerontology NP certification exam. Similarly, the graduate of a pediatric acute care NP program is eligible to sit for an acute care pediatric NP certification exam. Graduates of acute care population focused NP programs are not eligible to sit for primary care population focused NP certification exams and vice versa. The certified NP would identify himself/herself as an APRN-CNP with either an adult-gerontology or pediatric acute care population focus.

7. What is the difference between an APRN and a nurse with a graduate degree?

An APRN is a registered nurse who has completed a graduate degree or postgraduate program that has prepared him/her to practice in one of the four advanced practice roles (i.e., CRNA, CNM, CNS, or CNP). This includes the advanced knowledge and skills to provide direct patient care in the health promotion and maintenance of individuals. Nurses with advanced education in areas of practice that do not include direct care to individuals such as public health or administration are not APRNs and do not require the additional regulatory oversight beyond the RN license.

8. Why is the APRN Consensus Model called a regulatory model?

The APRN Consensus Model is called a regulatory model based on the broad definition of regulation. According to *Webster's Dictionary*, regulation is defined as 'the control according to rule, principle or law.' For the APRN Consensus Model, this includes those entities that control the preparation and credentialing of the APRN including nurse educators, certifiers, and licensing regulators. It also includes the accreditors of nurse education programs.

9. If the APRN's legal title is APRN plus role, how will the employer know in what population focus or foci the APRN is educated?

It will be the responsibility of the employer to verify the APRN's license. The license will identify the population focus or foci .

10. Why does the APRN Consensus Model require APRN educational programs to be pre-approved?

Having APRN educational programs pre-approved will eliminate barriers of not being eligible for certification and/or licensure. By having accrediting bodies pre-approve APRN educational programs before students enter the program, accreditors can ensure that programs meet established educational standards and that graduates of the program will be eligible to sit for national certification.

11. How can APRN educational programs be sure that their graduates meet the eligibility criteria for APRN certification and licensure?

The pre-approval process conducted by the nursing accrediting bodies will help to ensure that new graduates meet eligibility requirements for certification and licensure. Existing programs should keep students informed of certification and licensure requirements.

12. I am an APRN. What will happen to my practice if I am grandfathered to practice by my state after the implementation of the APRN Consensus Model?

Because of a commonly-used regulatory mechanism called grandfathering, it is anticipated that there will be no difference in your practice. Grandfathering is a provision in a new law exempting those already in the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state of their current license. It is also anticipated that APRNs applying for licensure by endorsement in another state would be eligible for grandfathering if they meet certain criteria. In addition, it is important to remember that grandfathering is an individual process for each state, so eligibility requirements for practice may vary state by state. Employers also may establish new or separate requirements for professionals granted credentials to practice in that facility. For more information about grandfathering, see the Consensus Model report (p. 14).

13. If I want to specialize as an APRN in an area such as oncology, palliative care, or nephrology, how would I do so after the APRN Consensus Model is implemented?

Areas such as oncology, palliative care, and nephrology are among the many specialty areas of APRN practice and are not one of the population foci in the APRN Consensus Model. To be eligible for APRN licensure and certification, the APRN must complete his/her educational program in a role and population focus (or foci) as defined in the Consensus Model but can also specialize in a more specific area of practice. Preparation in a specialty area of practice is optional, but, if included in the educational program, it must build on the APRN role/population focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus. Educational programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN educational programs, including preparation in the APRN core, role, and population core competencies. A specialty area of practice is developed by the professional organization and is not regulated by boards of nursing. Professional organizations determine the expected competencies for the specialty and establish

certification or assessment requirements. It is not required but recommended that the APRN practicing in a specialty area of practice seek specialty certification if available.

14. Will the Model define age parameters for each population focus?

The APRN Consensus Model does not define the age parameters for any of the population foci. Definitions may exist in other processes such as educational competencies and/or certification requirements.

15. What is the timeline for transition from adult-focused educational programs to the combined adult-gerontological population focus now included in the APRN Consensus Model?

A target date for full implementation of the Consensus Model and all embedded recommendations is the year 2015. A process is currently underway to identify the competencies for the merged adult-gerontology foci in the CNS and NP roles. When these competencies are available, the expectation is that adult and gerontology NP and CNS programs will proceed with a merger to a single adult-gerontology NP or CNS program. In fact, many programs have already begun to merge the two foci. These merged programs will prepare graduates to provide comprehensive care to the entire adult population which includes the young adult through the older adult including the frail elderly. The NP and CNS certifying bodies will also develop certification exams that comprehensively assess this merged population focus. Certification entities have indicated that they will have these expanded exams to meet the Model requirements.

16. What is the timeline for needed educational changes to be made in all APRN programs for congruence with the Consensus Model?

As identified in the in the Consensus Model a target date for full implementation is the Year 2015. To meet this target date it is anticipated that changes in many educational programs may occur before 2015 to ensure that graduates are prepared to meet certification and licensure criteria. However, it is important to note that not all APRN groups are operating on the same timeline and so there will likely be various dates when full implementation will occur for all APRNs. Educational programs must continue to monitor changes in licensure requirements in individual states, as well as, changes in certification and accreditation requirements that may occur prior to or after 2015.

17. What should the academic transcript include?

The transcript is official documentation from the academic institution and is a complete record of the individual's academic history at the institution. The transcript must specify the role and population focus of the APRN educational program as completed by the individual. The transcript should also include sufficient detail to enable verification that the individual completed core educational requirements. For example, in implementing the Consensus Model, the NCSBN APRN Model Act/Rules and Regulations specify that the transcript should include the 3 P courses. A transcript (or other similar official documentation) must be available for degree-granting and postgraduate certificate programs.

18. What can be done to move academic institutions to providing the needed transcripts?

The accrediting and certifying bodies can place such requirements on educational programs to motivate academic institutions to move forward with providing the necessary official documentation for graduates of both degree-granting and certificate programs.

19. What is LACE?

LACE is proposed as a communication network to include organizations that represent the Licensure, Accreditation, Certification, and Education components of APRN regulation. LACE is intended to be a transparent process for communicating about APRN regulatory issues, facilitating implementation of the APRN Consensus Model, and involving all stakeholders in advancing APRN regulation.

20. Are LACE and the APRN Consensus Model the same thing?

No. The APRN Consensus Model stands alone as a product of the work done jointly by the NCSEB APRN Advisory Committee and the APRN Consensus Work Group. LACE (see # 19 above) is broader in nature and is a mechanism to include all interested stakeholders representing the components of LACE in ongoing communications and implementation of the Model.

21. How do LACE and the APRN Consensus Model relate to the DNP?

The educational criteria within the APRN Consensus Model relate to the preparation of all APRNs, regardless of whether a master's or doctoral degree is conferred. A Doctor of Nursing Practice (DNP) program that is preparing an individual for entry into an APRN role must meet all of the criteria put forth in the Model. The Model does not require or preclude the DNP as an entry level degree for APRNs.

22. Are there advocacy tools available for use in explaining the Consensus Model to others, particularly state legislators?

Organizations participating in LACE have developed presentations and other resources to address questions specific to their members/stakeholders.

23. How realistic is the 2015 target implementation date?

2015 is a target date for full implementation of the APRN Consensus Model. The organizations participating in LACE have agreed to work towards this target date. Therefore, we encourage action now towards this implementation, recognizing that some components will take longer than others to accomplish.

24. Does the Consensus Model require a graduate degree in Nursing?

No, the Consensus Model specifically states that "APRN education must be formal education with a graduate degree or post-graduate certificate (either post-master's or

post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA)" (pg 10). Although many types of nurse practitioners must have a graduate degree in nursing in order to take their national certification exams, this is not the case for nurse-midwives or nurse anesthetists. Many accredited programs in nurse-midwifery and nurse anesthesia confer graduate degrees in nursing-related fields such as midwifery or health sciences, and the national certification processes for both nurse-midwives and nurse anesthetists do not require a graduate degree in nursing. The Consensus Model recognizes the validity of these other degrees.