

ANA's Principles for Advanced Practice Registered Nurse (APRN) Full Practice Authority

Purpose

The American Nurses Association's (ANA's) Principles for APRN Full Practice Authority provide policymakers, advanced practice registered nurses (APRNs), and stakeholders with evidence-based guidance when considering changes in statute or regulation for APRNs.

Background

With the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), now more than ever there is a growing sense of urgency for states to increase the number of health care providers, particularly primary care providers. Supported by a growing body of evidence on the safe and cost-effective provision of care by APRNs, there is a [national call to remove all barriers to full practice authority](#) from organizations such as the [Institute of Medicine](#) (IOM), the [National Governors Association](#) (NGA), the [Federal Trade Commission](#) (FTC), the [Bipartisan Policy Center](#), and the [Veteran's Health Administration](#), among others.

ANA strongly supports full practice authority for all APRN roles. "Full practice authority" is generally defined as an APRN's ability to utilize knowledge, skills, and judgment to practice to the full extent of his or her education and training. The American Association of Nurse Practitioners has offered a definition of full practice authority as "the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing" (Issues At-A-Glance: Full Practice Authority, 2014).

Twenty-one states and the District of Columbia currently grant full practice authority to one or more APRN roles **upon licensure and/or certification**. Several of these states have passed full practice authority legislation or made similar regulatory changes since passage of the ACA in 2010. The National Council of State Boards of Nursing (NCSBN) maintains the [APRN map project](#), which provides an overview of each state's implementation of the Consensus Model for APRN Regulation, including independent practice

(defined as “no requirement for a written collaborative agreement, no supervision, no conditions for practice”).

While many are working to obtain full practice authority for APRNs through legislative and regulatory efforts, analysis has revealed a disturbing trend in state legislation requiring a supervised post-licensure practice or transition period, often referred to as “transition to practice” requirements, further delaying APRN full practice authority. In several states (see table below), legislation has been enacted with the intention of moving closer to full practice authority for one or more APRN roles, yet the legislation includes new requirements for a supervised practice period following licensure and/or certification. These legislative restrictions are modeled in concept after the state of Maine’s 1995/2007 legislation, a supervised practice provision of 24 months. Discussion with stakeholders reveals that these changes have not been based on evidence but are the result of political compromise. As demonstrated in the table, states have unique time periods and standards for this “transition to practice,” none of which are supported by the evidence or research.

As states begin to implement these requirements, there is a growing realization of the potential impact on the workforce and access to care. In a report published in November 2014, the [Nurse Physician Advisory Taskforce for Colorado Healthcare](#) (NPATCH) described how it evaluated perceived barriers created by the legislation passed in that state: employers are reticent to hire new graduates because they are unable to prescribe independently, supervision requirements create an unnecessary burden for preceptors and mentors, and APRNs are often unable to be empaneled and bill for services independently. The Taskforce generally found the barriers to be real and made recommendations to streamline the process for APRNs to obtain prescriptive authority, including reducing the transition requirement to six months’ full-time or 1,000 practice hours.

States with “Transition to Practice” Barriers

State	Year Legislation Passed	Transition Requirement	APRN Role Affected	Oversight Requirement/Comments
Maine	1995/2007	24 Months	CNP	Physician or CNP
Colorado	2009	3,600 Hours	CNP, CNS, CNM, CRNA	Required when seeking independent prescriptive authority; physician or physician and APRN
	2015	1,000 Hours	CNP, CNS, CNM, CRNA	Hours reduced for prescribing mentorship with a physician or APRN required when seeking autonomous prescriptive authority
Vermont	2011	24 Months and 2,400 Hours	CNP, CNS, CNM, CRNA	Collaborative Agreement with an APRN or physician
Nevada	2013	2 Years or 2,000 Hours	CNP, CNS, CNM	Required when seeking independent CS II prescriptive authority; collaborating physician-approved protocols for CS II prescribing
Minnesota	2014	2,080 Hours	CNP, CNS	Collaborative Agreement with an APRN or physician
Connecticut	2014	3 Years and 2,000-Hours Minimum	CNP, CNS	Collaborative Agreement with a physician
New York	2014	3,600 Hours	CNP	Collaborative Agreement with a physician; attestation of collaboration requirement
Nebraska	2015	2,000 Hours	CNP	Transition-to-Practice Agreement with a supervising provider (MD, DO, or NP)

State	Year Legislation Passed	Transition Requirement	APRN Role Affected	Oversight Requirement/ Comments
Maryland	2015	18 Months	CNP	An applicant who has never been certified by Maryland or another state shall consult and collaborate with a physician or CNP mentor (who has at least 3 years' experience)
Delaware	2015	2 Years and 4,000 Full-time Hours Minimum	CNP, CNS, CNM, CRNA	Collaborative Agreement with a hospital or integrated clinical setting ("Independent Practice")
West Virginia	2016	2 Years	CNP, CNS, CNM, CRNA	Collaborative Relationship and Agreement with a qualified collaborating health care professional (physician or APRN) when seeking full autonomous prescriptive authority
Virginia	2018	5 years FTE based on a 36 hour work week, 1,800 hours per year for a total of 9,000 hours	CNP	File an attestation from the collaborating physician with the Board of Nursing

National APRN organizations have provided information and guidance for their memberships on this issue through position statements and briefs, which are referenced in this document. Continued and increasing variability in state practice requirements for APRN full practice authority does not bring the nation toward consensus, but institutes additional layers of unnecessary regulatory constraint and costs.

ANA and our constituent and state nurses associations (C/SNAs) are committed to working with other national nursing organizations and key stakeholders to remove barriers to APRN practice in order to ensure patients have access to safe and effective care from the providers of their choice.

Essential Principles

1. Consensus across four APRN roles

ANA endorsed the [Consensus Model for APRN Regulation](#) and fully supports the definition of APRNs as licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. ANA endorses the Nurse Practitioner Roundtable’s white paper, “Nurse Practitioner Perspective on Education and Post- Graduate Training,” and believes the principles espoused in that document apply to all APRN roles.

- a. Research conducted by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA), (Cook, 2013) reports recent graduates of accredited certified registered nurse anesthetist (CRNA) programs are prepared and perform competencies for entry into practice upon certification and licensure.
- b. In the Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives, the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists affirm that graduates of accredited certified nurse-midwife (CNM)/certified midwife (CM) educational programs who hold professional certification are licensed independent providers.¹
- c. In the document A Vision of the Future for Clinical Nurse Specialists, prepared by the National Association of Clinical Nurse Specialists (NACNS), NACNS espouses “An earned graduate degree in nursing from a nationally accredited program that prepares NSs represents attainment of core knowledge of advanced practice nursing and knowledge specific to CNS practice” (Goudreau, et al., p. 32).

2. Role competence

- a. APRNs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. There is no evidence to support the need for additional post-licensure supervision of APRN practice beyond current educational and certification standards.

¹In several states, CNMs are not regulated as APRNs. For a detailed summary of the evolution of midwifery certification in the United States and recommendations for implementation of the APRN Consensus Model, see [Midwifery in the United States and the Consensus Model for APRN Regulation](#).

3. The FTC and the Bay Area Council Economic Institute (Weinberg & Kellerman, 2014) have noted that **unsubstantiated supervision increases health care costs** and may exacerbate existing and projected health care workforce shortages.

4. Accountability

- a. Each APRN is personally accountable for his or her practice, and to patients, the respective licensing board, the nursing profession, and society. The notion that physicians should supervise care provided by APRNs or that written collaborative agreements are needed is outdated.
- b. It is within an APRN's professional judgment and responsibility to assess and treat patients within the bounds of his or her legally authorized scope of practice.
- c. Individual accountability extends to legal liability. It is inappropriate to expect physicians, or any other providers, to accept responsibility or liability for care in which they have not been directly involved.

5. Patient-centered, team-based, collaborative care

APRNs have been leaders in the development of innovative models of care delivery and are fully prepared to serve as primary care providers in patient-centered primary care or medical homes. Costly and unnecessary legislative and regulatory requirements for physician supervision are at odds with efforts to build interdisciplinary teams and create a more effective health care system.

6. Evidence-based policy

Decades of research have established the safety and effectiveness of care by APRNs, and that body of evidence has led institutions and organizations from the IOM to the NGA to AARP to call for the lifting of barriers to APRN practice. While further research on the safety and effectiveness of APRNs is unnecessary, ANA welcomes well-designed research studies to better understand the APRN workforce, the impact of restrictions to APRN practice, and how best to increase access to effective patient-centered care.

Terminology

For a more detailed discussion of relevant terminology, see [Words Matter: Guide to Discussing APRN Practice](#).

APRN – The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), and clinical nurse specialist (CNS).

Full practice authority – Full practice authority is generally agreed to be defined as APRNs’ ability to utilize knowledge, skills, and judgment to practice to the full extent of their education and training.

Consultation and collaboration – Consultation is the process whereby one provider whomaintains primary management responsibility for a patient’s care seeks the advice or opinion of another member of the health care team. Collaboration is the process whereby two providers jointly manage the care of a patient. Like physicians, APRNs consult and collaborate with many other health care providers, often on a daily basis, seeking advice that will improve patient care, developing collaborative management plans, and referring patients for specialized care. Physicians do so freely without any requirement or consideration of a written agreement.

Collaboration becomes a barrier to practice when laws or regulations spell out requirements for *written* collaborative agreements, which are typically a result of compromise in the legislative arena.

The removal of barriers to APRN practice is critical to achieving ANA’s strategic goals, and work toward that goal is highly valued by ANA members. ANA developed the Principles for APRN Full Practice Authority to provide guidance to C/SNAs as we work to “advocate for a health care system where RNs and APRNs can practice to the full extent of their knowledge and professional scope.” (ANA 2014–2016 Strategic Goals)

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