Impact of New Regulatory Standards on Advanced Practice Registered Nursing

The APRN Consensus Model and LACE

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The challenges facing the United States health care system are real and unsettling. The nation’s population is aging rapidly, with more than 20% of the population expected to be 65 years and older by 2030.1 We are bombarded with reports that rates of chronic diseases in children and adults are increasing at alarming rates. Despite having the highest per capita expenditure for health care in the world,2 the United States ranks 30th in infant mortality rates3 and ranks last out of 16 countries in preventable deaths.4 These figures are only a sampling of data that constantly remind us of the urgent need to increase access to quality health care services, and rethink the type and way that care is delivered in the current health care system.

Workforce projections show that more than 150,000 additional physicians will be needed in the next 10 to 15 years to meet the goal of providing health care access to all United States citizens (Association of American Medical Colleges, 2009). This shortage is expected to be even more acute for physicians prepared to provide primary care services. According to the American Academy of Family Physicians, the United States will need 40% more primary care providers by 2020 to meet the nation’s demand

KEYWORDS

- APRN regulation
- Consensus model
- Nursing leadership

KEY POINTS

- As health care needs increase, the advanced practice registered nurse (APRN) is an effective part of meeting those needs.
- The Consensus Model for APRN Regulation provides a framework to increase the APRN’s role and improve health outcomes in the United States.
- The goal of implementation of the Consensus Model by 2015 will require a unified effort by the nursing profession to meet health care needs.

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for primary care services. This concern is magnified by the fact that only 2% of all new physicians opted for primary care or general medicine residencies in 2008.\textsuperscript{5}

One promising and effective way to bridge the gap between needed and available primary care providers is to increase the production of Advanced Practice Registered Nurses (APRNs), particularly of nurse practitioners (NPs) and clinical nurse specialists (CNSs). APRNs are increasingly used to fill gaps in care, and represent a significant component of the United States health care workforce and providers of primary care services. A Government Accounting Office\textsuperscript{6} report on primary care projections and trends showed that NPs are the fastest growing group of primary care providers in the country. APRNs also have repeatedly been shown to provide high-quality care, typically at a lower cost.\textsuperscript{7–11}

According to the 2008 National Sample Survey of Registered Nurses,\textsuperscript{12,13} an estimated 250,527 or 8.2% of registered nurses were prepared as APRNs, an increase from an estimated 240,460 in 2004. This estimate, however, may not tell the full story. The lack of common titling, regulatory requirements, and recognition across states hinder the ability to accurately identify the number of APRNs practicing in the United States. Also, the numbers of APRNs may be higher than estimated because they have been historically billed under a physician’s name or as part of hospital services and are not counted separately in federal databases.

Despite the lack of definitive numbers, APRNs represent a significant and crucial resource to meeting the country’s growing health care needs. However, these resources must be used to the full extent and in the most effective way possible. The Institute of Medicine (IOM) report, Future of Nursing: Leading Change, Advancing Health, recognizes the importance of APRNs in meeting the country’s health care needs and delineates 4 key messages that directly affect advanced practice registered nursing.

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic profession.
3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.\textsuperscript{14(p4)}

The advanced practice nursing community, through the development of the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (LACE),\textsuperscript{15} has positioned itself to assume a leadership role within the health care system and participate as an equal partner in redesigning health care in the United States. The Consensus Model, reprinted in the appendix of the IOM report, has been recognized by policy makers and others outside of nursing as foundational to the future of APRN practice. Implementation, although still relatively early in the process, will be even more critical as nursing moves toward achieving this goal. Ongoing, transparent communication among all LACE entities has been recognized as the most critical component in achieving and maintaining consensus as advanced practice nursing moves toward the goal of full implementation of this new regulatory model by 2015.

In early 2004, after repeatedly hearing reports that CNSs and NPs were not able to be certified or licensed to practice after graduating from an APRN program or that APRNs moving to another state were no longer able to practice, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse
Practitioner Faculties (NONPF) jointly presented their concerns to the Alliance for APRN Credentialing (the Alliance). The Alliance, created in 1997, was convened by the AACN to provide a forum to regularly discuss issues related to nursing education, practice, and credentialing. The membership comprises organizations that accredit APRN programs, certify APRNs, and develop APRN educational standards. The Alliance agreed to convene a national consensus process and invited 50 organizations to participate. The first APRN Consensus Conference was held June 2004 and included representatives of 32 organizations focused on APRN practice, education, certification, accreditation, or licensure. Barbara Safriet, an attorney and long-time advocate for APRN full scope of practice, chaired this first consensus conference, which ultimately led to the development of what has become known as the Consensus Model, which delineates the future model for all APRN regulation.

As an outcome of the first consensus conference, the Alliance formed a workgroup comprising representatives from 23 organizations, and charged them with developing a consensus statement that addresses the issues that had been identified with the goal of creating a future model for APRN regulation. Jean Johnson, Senior Associate Dean for Health Sciences at George Washington University and a gerontology NP, was asked to facilitate this consensus process, which eventually extended over a 5-year period. As the APRN Work Group was beginning its work, the American Nurses Association (ANA), in collaboration with the AACN, convened a second stakeholders’ meeting in December 2004. This meeting reinforced the need to address the multitude of issues surrounding APRN regulation. Over the next several years, participation in this larger consensus process grew to more than 60 nursing organizations that self-identified as having a stake in APRN regulation. The AACN and ANA reconvened the larger APRN stakeholder group several times throughout the 5-year consensus building process to share and solicit feedback on recommendations as they emerged. In 2006, the National Council of State Boards of Nursing (NCSBN) APRN Advisory Panel, having drafted its own report on APRN regulation, met with the APRN Work Group to discuss areas of common agreement and disagreement. As discussions continued, both groups agreed that one joint report should be developed that addressed the future regulation of advanced practice nursing. In 2008, the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education was finalized by the APRN Joint Dialogue Group (comprising representatives of the NCSBN APRN Advisory Panel and the APRN Consensus Work Group) and was disseminated widely. Forty-eight nursing organizations quickly endorsed the Model and implementation began immediately. The complete list of endorsing organizations and those participating in the APRN Work Group, the APRN Joint Dialogue Group, and the larger consensus process can be found in the document at http://www.aprnlace.org. Because the Model has significant implications for all APRN regulation and practice, every APRN is strongly encouraged to access and read the entire document and to stay up to date regarding ongoing decisions and processes as implementation continues over the next several years.

**LACE AND IMPLEMENTATION OF THE CONSENSUS MODEL**

The Consensus Model report recommended the creation of a formal communication mechanism known as LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities. The purpose of LACE is to provide a formal mechanism for facilitating transparent and aligned communication among all stakeholders. In 2010, 28 organizations signed an agreement to support the creation and maintenance of this electronic platform. LACE, not
a separate or formal organization, provides a mechanism to communicate current information regarding the implementation of the Consensus Model to the public and provides a platform for APRN regulatory bodies to share updates regarding implementation, discuss concerns that arise, and work on joint positions or documents as needed. The LACE site can be accessed at http://www.aprnlace.org.

THE CONSENSUS MODEL: IMPLICATIONS FOR ALL APRNs

The Consensus Model delineates a model for the regulation of all APRNs and, therefore, has implications for all APRNs. Building on the model of regulation described by Styles, the Model addresses the licensure, accreditation, certification, and education of all APRNs. Synergistic expectations and requirements for each of these regulatory components are delineated. The diagram depicting the APRN regulatory model is shown in Fig. 1.

**Definition and Titling of an APRN**

Advanced Practice Registered Nurse or APRN is the legal title used to recognize 4 distinct roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), CNS, and certified NP; and is the credential to be used by individuals licensed in any of these 4 roles. The definition of an APRN includes graduate-level education in 1 of the 4 recognized roles; national certification; preparation for health promotion as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and nonpharmacologic interventions; and the provision of direct care to patients.

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**Fig. 1.** The APRN Regulatory Model. a The Nurse Practitioner role is divided into acute care and primary care roles for the adult-gerontology and pediatric populations. (From APRN Consensus Work Group, & National Council of State Boards of Nursing APRN Advisory Committee. (2008). Consensus model for APRN regulation: licensure, accreditation, certification & education. Available at: http://www.aacn.nche.edu/education-resources/APRNReport.pdf. Accessed November 28, 2011.)
This definition provides clear parameters for APRNs. Only individuals who have graduated from an accredited APRN education program, are nationally certified, and are licensed under the criteria delineated in the Model may use the title APRN. The importance of other advanced areas of nursing practice that do not provide direct care to individuals, such as public health nursing, administration, and informatics, are recognized but not included in the definition of APRN.

**Education**

The Model stipulates that all APRNs must be educated in a graduate or postgraduate certificate program that prepares them in 1 of the 4 APRN roles and in at least 1 of 6 identified populations: across the life span/family, adult-gerontology, pediatrics, women’s health/gender specific, psychiatric/mental health, and neonatal. The education must be broad and comprehensive in nature, and must prepare the graduate with the nationally recognized APRN core, role, and population-focused competencies. The program must ensure that graduates are eligible for national certification and state licensure, and the transcript or official documentation must specify the role and population focus of the graduate. Any specialty preparation in a more in-depth area of practice, such as in oncology, palliative care, or dermatology, may be included as part of the graduate education program or in a separate program, but must be over and above the broad comprehensive education in the role and population. The model for building the APRN curriculum is shown in Fig. 2.

One component of the Model that has caused some confusion is the bifurcation of the NP role. Under the Model, NPs prepared to provide care to the adult-gerontology or pediatric populations can be educated as either primary care NPs or acute care NPs, which have separate national consensus-based competencies and separate certification processes. Education programs may prepare graduates across both roles; however, graduates must be prepared with the competencies for both roles and must successfully obtain certification in both the acute and primary care NP roles.

Although not a new requirement, all APRN education must include the APRN core: 3 separate, graduate, comprehensive courses, commonly referred to as the 3 Ps: advanced health assessment, advanced physiology/pathophysiology, and advanced physiology/pathophysiology, and advanced physiology/pathophysiology.

pharmacology. The specific requirements for these 3 graduate-level APRN core courses are:

- Advanced health assessment must include all body systems and advanced techniques
- Advanced physiology/pathophysiology must include concepts across the entire life span, which is defined as prenatal through death, including the frail elderly
- Advanced pharmacology must include all broad categories of pharmacologic agents and not just those commonly used by the role/population.\(^\text{15(p11)}\)

One commonly asked question regarding the APRN core is: can these 3 courses be designed for just one role or specific population, such as for pediatric NPs? Agreement among the LACE organizations clarifies that it is not who is sitting in the classroom, but rather the content and outcomes of the courses that are important. Therefore, if a course for pediatric NPs or any single APRN role or population is included in the program of study, the course content must meet the requirements as defined above. A clarifying statement on the 3 APRN core courses is posted on the LACE site at http://www.aprnlace.org. In addition to these 3 separate courses, additional content in these 3 areas must be included in the diagnostic and management courses specific to the role and population.

The 6 population-focused areas of practice present significant changes to the way APRNs, particularly NPs and CNSs, are educated and certified. The adult-gerontology population requires the merging of the current adult and gerontology curricula. Under this model, all NPs and CNSs prepared to care for the adult or gerontology populations must now be prepared with the competencies previously recognized for adult and gerontology practice. New national consensus-based competencies have been developed for the:

- Adult-gerontology acute care NP
- Adult-gerontology primary care NP
- Adult-gerontology CNS.

These competencies can be accessed at http://www.aacn.nche.edu/education-resources/competencies-older-adults. In addition to the redesign of the adult-gerontology APRN curriculum, these competencies are being used as a foundation for the development of new certification examinations for these 3 roles/population-focused areas of practice.

In addition to expanding the education of adult and gerontology NPs and CNSs, the Model recognizes the urgent need to prepare APRNs to care for the growing older adult population. Therefore, all APRNs who provide care to older adults, including the CRNA, CNM, women’s health NP, psychiatric/mental health (psych/MH) NP, family NP, and women’s health CNS, must have additional preparation in the care of the older adult. To facilitate these curricular modifications, recommended competencies for NPs and CNSs who care for older adults have been developed and can be found at http://www.aacn.nche.edu/education-resources/competencies-older-adults.

The Model also has significant implications for psychiatric/mental health APRNs. Under the Model, all psych/MH APRNs must be prepared across the life span. To examine the implications for psychiatric nursing and the changes that would need to be made to align psychiatric/mental health advanced practice nursing with the Model, the American Psychiatric Nurses Association and the International Society of Psychiatric Nurses appointed a joint task force. After extensive dialogue the task force made a series of recommendations, which have been adopted by both organizations, including that there be one entry educational focus: psychiatric/mental health NP with
preparation across the life span. Additional information regarding all recommenda-
Previous job analyses had shown little differentiation between the psych/MH NP
and CNS roles and practice. These 2 organizations continue to work with the other
education organizations to develop competencies for the psych/MH NP prepared to
provide care across the life span, and with certifiers to develop a new certification
examination for the role and across the life-span population. The impact on practice
and the potential need for additional specialty certification is also being discussed.

The inclusion of health maintenance and health promotion as a component of all
APRN education is also a new requirement and one that the certifying organizations
are concerned may be overlooked by APRN faculty. The health promotion/health main-
tenance content will vary depending on the role and population, but must be included in
the curriculum.

Accreditation

Under the Consensus Model, all APRN education programs must be accredited by
a national nursing or nursing-related accrediting body recognized by the Department
of Education or the Council for Higher Education Accreditation. This category includes
all graduate and postgraduate certificate programs. Another significant change is the
requirement that all new APRN programs or tracks must be preapproved or preaccre-
dited before students are admitted. Both the Commission on Collegiate Nursing
Education (CCNE) and the National League for Nursing Accrediting Commission
(NLNAC) have indicated that processes to carry out these new requirements will be
in place and fully implemented by 2012/2013.

Under the new regulatory model, the APRN accrediting bodies, which include the
CCNE, NLNAC, Council on Accreditation of Nurse Anesthesia Educational Programs
(COA), and Accreditation Commission for Midwifery Education (ACME), are also
charged with assuring that the education program includes the APRN core, role core,
and population core competencies. Graduates of these APRN education programs
must be eligible to sit for national certification in the role and population focus.

Certification

When the Consensus Model was finalized in 2008 several states, including some with
the largest number of APRNs, did not require national certification. Under the Model,
all APRNs must be nationally certified by an entity that is accredited by a national certi-
fication accrediting body. The certification examination must assess the APRN core,
role, and population-focused competencies. If a specialty is tested, it must be done
separately from the role and population.

All APRN certification organizations are assessing current examinations to determine
what changes are needed to meet the requirements of the Model. Some of these
changes include assessment of health promotion/health maintenance in all APRN certi-
fication examinations, and an emphasis on care of the older adult for all APRNs
prepared to provide care to adults. New examinations for the adult-gerontology acute
care NP, the adult-gerontology primary care NP, the adult-gerontology CNS, and the
psych/MH NP are being developed. Individual certifying bodies have established time-
lines for the implementation of these new examinations; however, the projected date for
implementation of these new certification examinations is 2012/2013. Decisions
regarding the retirement of the current examinations are also being made by the respec-
tive certification bodies. Therefore, currently certified APRNs, particularly all adult NPs
and CNSs, gerontology NPs and CNSs, and psych/MH NPs and CNSs, are urged to
remain vigilant for announcements from the certification bodies because the retirement
of these examinations will have significant impact on the options for recertification for these APRNs.

**Licensure**

Many states historically have used varying titles to recognize advanced practice nurses, including CRNP, ARNP, APN, and APRN. Also, many states recognized advanced practice nurses in only 1 or 2 roles. Other states recognized multiple and diverse specialties, particularly for NPs. Under the Model, APRN is identified as the legal title and credential to be granted to all advanced practice registered nurses meeting the definitional criteria. Boards of nursing (or boards of nurse-midwifery or midwifery in states where these regulate nurse midwives) are to be responsible for granting a second license to APRNs in all 4 roles: CRNA, CNM, CNS, and CNP. In addition, APRNs who meet the education and certification criteria delineated in the Model are to be licensed as independent practitioners with no regulatory requirements for collaboration, direction, or supervision.

The NCSBN at the 2008 Delegate Assembly approved the APRN Model Practice Act, which provides states with a template for developing legislation consistent with the Consensus Model. To facilitate the implementation of the Model, the NCSBN has developed a tool kit for state boards, legislators, and consumers, which includes guides for APRNs and consumers, a legislative handbook, an APRN checklist for state boards, frequently asked questions, and a video, *The Consensus Model for APRN Regulation*, posted on YouTube (http://www.ncsbn.org/2276.htm). An interactive tool featuring a series of maps also has been developed, which enables individuals, schools, and organizations to monitor overall progress toward full implementation of the Consensus Model and changes that have been made by individual states (http://www.ncsbn.org/2567.htm).

**Currently Practicing APRNs**

The Model defines a future for APRN regulation. The intent of this work is not to disenfranchise currently practicing APRNs. However, as transition to this new regulatory model occurs, changes may affect currently credentialed and practicing APRNs. Grandfathering is a provision in a new law exempting those already in or part of the existing system that is being regulated. Therefore, when states adopt new eligibility requirements, practicing APRNs will be permitted to continue practicing within the state(s) of their current license. However, grandfathering cannot be mandated when an APRN moves to another state. The Model and the NCSBN APRN Model Practice Act state, however, that an APRN should be eligible for licensure in that new state if he or she is currently practicing in the role and population-focus area, is nationally certified in that role and population, and meets the education requirements of the state in which the APRN is applying that were in effect at the time the APRN completed his or her education program. Even with this recommendation, the requirement for current, national certification in the role and population is the factor that may have a significant impact on many currently practicing APRNs who are not nationally certified and who move to another state.

As mentioned previously, another change that will affect a large number of currently practicing APRNs is the implementation of new certification examinations. Recertification, particularly for adult NPs and CNSs, gerontology NPs and CNSs, and psychiatric/MH NPs and CNSs, will only be available by meeting the practice and continuing education requirements and not through retesting once the current certification examinations are retired.
The year 2015 is identified in the Model as the target date for full implementation. The organizations tasked with the implementation of the Consensus Model recognized early on that implementation must be sequential. Changes in the education programs must occur first, followed by accreditation and certification. State licensing requirements would be the last, and in most cases, the most difficult to enact because in most states it would require new legislation. However, all 4 LACE components initiated implementation processes as soon as the Model was finalized in 2008. Based on this understanding, a projected timeline for implementation was developed (Fig. 3). Implementation dates for specific components or processes have varied only slightly since 2008, and full implementation of the Consensus Model remains on target for 2015. As this work progresses, all APRNs and other stakeholders are strongly encouraged to remain in communication with their respective professional organizations and to monitor information posted on the LACE Web site (http://www.aprlace.org).

The Consensus Model creates a synergistic interface between education, accreditation, certification, and licensure. When fully implemented the Consensus Model will allow APRNs to practice to the full scope of their education and more easily move from one state to another, increasing access to quality health care services for all populations. Uniform titling and credentialing will enhance APRN recognition by the public, policy makers, and other health professionals. Under the Model, APRN practice is not restricted by setting, but rather is patient-centered and based on patient needs. For example, the adult-gerontology acute care NP should not be limited to practice within the acute care hospital but rather provide care to acutely ill patients who are in the home, long-term care, or other health care setting. Likewise, the adult-gerontology primary care NP could provide increased continuity of care and follow patients into the acute care or long-term care facility to provide ongoing health maintenance and chronic disease management services.

The APRN community has been applauded for its ability to reach consensus on this landmark agreement. Endorsement by 48 national nursing organizations including all organizations with a stake in APRN regulation provides a powerful
and unified front for APRNs to become full partners in reshaping the health care system as envisioned by the IOM. To reach this goal, implementation of the Consensus Model in total is critical and is dependent on the ongoing participation and collaboration among all LACE entities.

REFERENCES