

APRN Talking Points: Consensus Model for APRN Regulation

Advanced practice registered nurses (APRNs), including certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs) and certified nurse practitioners (CNPs) are highly valued providers of health care services and an integral part of the health care system. In its recent report, *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine Committee endorsed higher levels of nursing education and the importance of allowing all nurses to practice to the full extent of their education and training. The education, accreditation, certification and licensure of APRNs needs to be consistent from jurisdiction to jurisdiction in order to continue to assure patient safety while expanding access to care.

The Consensus Model for APRN Regulation was developed through a collaborative process with participation of regulators, APRN certifiers, national nursing program accreditors and representatives of many APRN professional organizations. In total, the Consensus Model has been endorsed by 48 professional nursing organizations.

(Insert your state/jurisdiction) has already adopted some of the standards outlined in the Consensus Model, but the work must continue until all regulations have been enacted in all jurisdictions.

The benefits of implementing the national standards contained within the Consensus Model include: (Choose the talking points that apply to your state.)

- The entry-level education for all APRNs is a graduate degree or postgraduate certificate (postmasters or doctorate) awarded by an accredited academic institution. This assures the public that every APRN has achieved advanced education from an accredited program.

- Certification is required. This assures the public that in addition to advanced education, APRNs have passed a psychometrically sound exam that measures competency.
- That the title “advanced practice registered nurse (APRN)” will be adopted by all jurisdictions. The public should recognize the title of their care provider regardless of the jurisdiction they are in. The differing titles of APRNs across all jurisdictions leads to confusion by the public. One universally recognized title will eliminate doubt on the part of the public and foster uniform recognition for APRNs.
- An APRN will practice under both a registered nurse (RN) and APRN license, assuring public safety.
- The Consensus Model enhances mobility and utilization of patient care services provided by APRNs, many of whom are the only providers of health care services in local areas. Statutory autonomy will decrease barriers to provision of care and will increase access to care for patients.
- Independent prescriptive authority is essential to independent practice and is appropriate based on the APRN’s education and professional experience.

APRN Data

The ability of APRNs to provide safe, cost-effective, high-quality care is well documented in many studies over the past 30 years.

The 2010 report on the future of nursing published by the Institute of Medicine stated, “The United States has the opportunity to transform the health care system, and nurses can and should play a fundamental role in this transformation” In order to achieve this transformation, “Nurses should practice to the full extent of their education and training” (Institute of Medicine, 2010).

The landmark study published in the *Journal of the American Medical Association* (JAMA) in 2000 provided

CAMPAIGN FOR
APRN
CONSENSUS

WWW.NCSBN.ORG

111 E. Wacker Drive, Ste. 2900, Chicago, IL 60601 ■ 312.525.3600



definitive results demonstrating the quality of care provided by CNPs. In this study researchers evaluated the health status of patients receiving care from physicians or CNPs. The CNPs being studied practiced independently without a mandatory relationship with a physician. The patients were assigned to a physician or CNP for primary care following an urgent care or emergency room visit. The results indicated that the status of the patients treated by a CNP and those treated by a physician were comparable at the initial, six and 12 month visits. In a follow-up study two years later by some of the same researchers, the outcome was the same. The researchers determined that CNP care was comparable to that of a physician in all areas, including health status, satisfaction and use of specialists (Lenz, Mundinger, Kane, Hopkins & Lin, 2004).

The National Practitioner Data Bank ratio of malpractice and adverse actions for CNPs was 1:173 compared to 1:4 for medical doctors (MDs) and doctors of osteopathic medicine (DOs) (Pearson, 2009).

A study published in the *American Journal of Public Health* (1997) compared differences in obstetric care provided by obstetricians, family physicians and CNMs to low-risk patients. Researchers concluded that patients of CNMs had lower cesarean rates than the other providers (8.8 percent for CNMs compared to 13.6 percent for obstetricians and 15.1 percent for family physicians). Overall, CNMs used 12.2 percent fewer expensive hospital resources than the other providers (Rosenblatt, et al., 1997).

In 2006 findings of a study were published in the *Journal of Obstetric, Gynecologic and Neonatal Nursing* comparing perinatal outcomes in care provided by a physician or a CNM in a large inner city obstetric care setting. Researchers studied 375 patients and found no differences in neonatal (first six weeks after birth) outcomes and fewer interventions were used by CNMs (Cragin & Kennedy, 2006).

A study published in 2003 compared surgical patients' safety with anesthesia services provided by a CRNA or an anesthesiologist. Over 400,000 cases were studied in 22 states. The researchers found no statistically significant difference between mortality rates of patients treated by CRNAs independently versus those in which the CRNA collaborated with the anesthesiologist. In addition the findings indicated in hospitals where CRNAs were the sole providers of anesthesia services (without anesthesiologists on staff), the results were similar to those in hospitals where anesthesiologists provided or directed anesthesia services (Pine, Holt & Lou, 2003).

In 2001, the Center for Medicare & Medicaid Services allowed states to opt-out of the requirement for physician oversight of CRNAs' provision of anesthesia care to patients. A new study of data from opt-out and non-opt-out states was published in *Health Affairs* in 2010. The researchers compared outcomes of care provided by CRNAs and anesthesiologists, each practicing independently and as a team. The Medicare A/B data were collected over seven years and the results indicated that in opt-out states, the CRNA solo group mortality rates were lower than that of the solo anesthesiologist group, both before and after the implementation of the opt-out. In addition, researchers found comparable surgical complication rates among the three provider groups, leading them to conclude that removal of the supervision requirement for CRNAs does not increase anesthesia risks to patients (Dulisse & Cromwell, 2010).

Outcomes of care by CNSs on prenatal, maternal and infant health and cost through one year after delivery were published in the *American Journal of Managed Care* in 2001. The complex group of patients studied were women at high risk of delivering low-birth weight babies. The patients received home care provided by CNSs or traditional care in the office setting. The group that received care from CNSs experienced a lower infant mortality rate, fewer preterm babies, more twin pregnancies carried to term, fewer prenatal hospitalizations and fewer infant rehospitalizations, with a cost savings of more than 750 hospital days and more than 2.8 million dollars (Brooten, et al., 2001).

A 1994 study reviewed the effects of a discharge planning protocol implemented by CNSs as compared to the standard hospital discharge protocols. Researchers found from initial discharge to six weeks after discharge, patients who were in the medical intervention group had fewer readmissions to the hospital, fewer total days if rehospitalized, lower readmission charges and lower charges for health care services following discharge from the hospital. The researchers concluded the interventions by CNSs improved patient outcomes after hospitalization and decreased costs (Naylor, Brooten, Jones, et al., 1994).

This is a just small sample of the literature. For more information visit www.ncsbn.org/170.htm.

Works Cited

- Brooten, D., Youngblut, J., Brown, L., et al. (2010). A randomized trial of nurse specialist home care for women with high-risk pregnancies: Outcomes and costs. *American Journal of Managed Care*, 7(8), 793-803. Retrieved January 7, 2010, from <http://www.ajmc.com/issue/managed-care/2001/2001-08-vol7-n8/Aug01-333p793-803>
- Cragin, L., & Kennedy, H.P. (2006). Linking obstetric and midwifery practice with optimal outcomes. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(6), 779-785.
- Dulisse, B., & Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs*, 29(8), 1469-1475.
- Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.
- Lenz, E.R., Munding, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research Review*, 61(3), 332-351.
- Munding, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Wei-Yann, T., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. *Journal of American Medical Association*, 283(1), 59-68.
- Naylor M., Brooten D., Jones R., Lavizzo-Mourey, R., Mezey, M., & Pauley, M. (1994). Comprehensive discharge planning for the hospitalized elderly. *Annals of Internal Medicine*, 120, 999-1006.
- Pearson, L.J. (2009). The Pearson report: A national overview of nurse practitioner legislation and healthcare issues. *American Journal for Nurse Practitioners*, 13(2), 9.
- Pine, M., Holt, K.D., & Lou, Y.B. (2003). Surgical mortality and type of anesthesia provider. *AANA Journal*, 71(2), 109-116.
- Rosenblatt, R.A, Dobie, S.A, Hart, L.G., Schneeweiss, R., Gould, D., Raine, T.R., et al. (1997). Interspecialty differences in the obstetric care of low-risk women. *American Journal of Public Health*, 87(3), 344-351.