CAMPAIGN FOR APRN CONSENSUS

Model for Uniform National Advanced Practice Registered Nurse (APRN) Regulation: A Handbook for Legislators

Introduction

This legislative resource was developed in response to requests for information about advanced practice registered nurse (APRN) regulatory issues. It outlines the **Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education,** which formulates national standards for uniform regulation of APRNs.

Model APRN regulation is aimed at public protection by ensuring uniformity across all jurisdictions. Uniformity of national standards and regulation not only allows for the mobility of nurses, it also serves the public by increasing access to care. Currently, each jurisdiction devises its own standards in regard to APRNs. This has resulted in a huge diversity of rules and regulations between jurisdictions. The lack of uniformity between jurisdictions leads to confusion on the part of the public, profession and related fields, given that even APRN titles differ from one jurisdiction to the next. The need for standardization also affects the livelihood of practicing APRNs and their ability to relocate to areas experiencing health care shortages. An APRN may have extensive experience in one jurisdiction, but is limited in mobility because moving to another jurisdiction would mean being subject to different qualifications or standards of practice.

The recommendations offered in this booklet present an APRN regulatory model that is a collaborative effort among APRN educators, accreditors, certifiers and licensure bodies. The recommendations reflect a collaboration among regulatory bodies to achieve a sound model and continued communication, with the goal of increasing the clarity and uniformity of APRN regulation. This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialties, describes the roles and population foci, and presents strategies for implementation.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN®), which came together to form the APRN Joint Dialogue Group, representing 144 organizations. Together, this group designed a framework whereby jurisdictions can implement and oversee the uniform licensure, accreditation, certification and education of APRNs.

We hope you use the information provided to guide your decisions with regard to APRN practice, licensure, education and certification.

Advanced Practice Registered Nurses (APRNs)

APRNs include certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs) and certified nurse practitioners (CNPs). There are currently over 250,000 APRNs in the U.S. (U.S. Department of Health and Human Services Health Resources and Services Administration, 2010). Over the past several decades, the number of APRNs has increased and their capabilities have expanded, becoming a highly valued and an integral part of the health care system. APRNs provide care in a wide array of practice settings, including hospitals, physician offices, home care, nursing homes, schools and various types of clinics. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs needs to be effectively aligned in order to continue to ensure patient safety while at the same time, expanding patient access to care.

APRN Definition

An APRN is a nurse with a graduate degree who has been licensed in an advanced role that builds on the competencies of registered nurses (RNs). Licensure as an APRN is contingent upon completion of an accredited graduate-level education program and passage of a national certification examination. An APRN must have extensive clinical experience, and have acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients. An APRN accepts responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which includes the administration and prescription of pharmacologic and nonpharmacologic interventions.

APRNs are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession and the licensing board to comply with the requirements of the jurisdiction's nursing law and to assure that quality advanced nursing care is rendered; to recognize limits of knowledge and experience; to plan for the management of situations beyond the APRN's expertise; and to consult with or refer patients to other health care providers, as appropriate.

APRN Roles

All APRNs are educationally prepared to provide a variety of services across the health wellness-illness continuum to at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting, but rather by patient care needs. Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and implementation within each APRN role varies. Licensure and scope of practice are based on graduate education in one of the four roles and in one of the defined population foci.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care to individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites; obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists and plastic surgeons.

Certified Nurse-Midwife (CNM)

A CNM provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, child birth, and care of a newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center and a variety of ambulatory care settings, including private offices, and community and public health clinics.

Clinical Nurse Specialist (CNS)

A CNS is a unique APRN role that integrates care across the continuum and through three spheres of influence: patient, nurse and system. The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. The primary goal of a CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress; and facilitate ethical decision making. A CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups and communities.

Certified Nurse Practitioner (CNP)

For a CNP, care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms, as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, including taking comprehensive histories, providing physical examinations, and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education and counseling, as well as the diagnosis and management of acute and chronic diseases. CNPs are prepared to practice as primary care CNPs and/or acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

Quality of APRN Care

The recent report published by the Institute of Medicine (IOM) stated "a number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system." The report continues to state that "The United States has the opportunity to transform the health care system, and nurses can and should play a fundamental role in this transformation." And that "Nurses should practice to the full extent of their education and training" (IOM, 2010).

The ability of APRNs to provide safe, cost-effective, high quality care that is comparable to care provided by physicians is well documented in many studies conducted over the past 30 years. The landmark study published in the *Journal of the American Medical Association* (JAMA) in 2000 provided definitive results demonstrating the quality of care provided by CNPs. In this study, the researchers evaluated the health status of patients receiving care from physicians or CNPs; however, the CNPs practiced independently without a mandatory relationship with a physician. The patients were assigned to a provider for primary care following an urgent care or emergency room visit. Researchers found the status of the CNP patients and the physician patients 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).

In a review of studies comparing nurses and doctors in providing primary care services, the authors concluded, "[t]he findings suggest that appropriately trained nurses can produce as high quality care as primary care doctors and achieve good health outcomes for patients. Indeed nurses providing first care for patients needing urgent attention tend to provide more health advice and achieve higher levels of patient satisfaction compared with doctors" (Laurant, Reeves, Hermens, Braspenning, Grol, & Sibbald, 2009).

Beyond patient satisfaction, a 2009 study related to CNPs showed that the safety ratio of CNPs was significantly higher when compared to the safety ratios of medical doctors (MDs) and doctors of osteopathic medicine (DOs). The National Practitioner Data Bank ratio of malpractice and adverse actions for NPs was 1:173 compared to 1:4 for MDs and DOs (Pearson, 2009).

Studies showed that CNPs had more complete records, gave more advice to patients, and had longer consultations with patients (Horrocks, Anderson, & Salisbury, 2002). The difference in APRN approach to care is attributed to nursing education, which focuses on prevention, wellness and health maintenance (Gordon, 2010). This approach "results in better patient management with fewer visits to emergency rooms and hospitals" (Gordon, 2010). Overall, "nurse practitioners seemed to provide a quality of care that is at least as good, and in some ways better, than doctors" (Horrocks, Anderson, & Salisbury, 2002).

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 the 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, Dobie, et al., 1997).

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

A study published in 2003 compared surgical patients' safety with anesthesia services provided by a CRNA or an

anesthesiologist (Pine, Holt, & Lou, 2003). Over 400,000 cases were studied in 22 states. 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 that hospitals where CRNAs were the sole providers of anesthesia services (without anesthesiologists on staff) had results similar to those in hospitals in which 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 CRNA's 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 surgical 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 was women with a 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 receiving 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, Youngblut, Brown, 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. The 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).

It stands to reason that one way to improve access to patient-centered care would be to allow nurses to make more decisions at the point of care. Yet in many cases, outdated regulations, biases and policies prevent nurses, particularly APRNs, from practicing to the full extent of their education, skills and competencies (Hansen-Turton, et al., 2008; Ritter & Hansen-Turton, 2008; Safriet, 2010).

Need for Uniform APRN Regulation

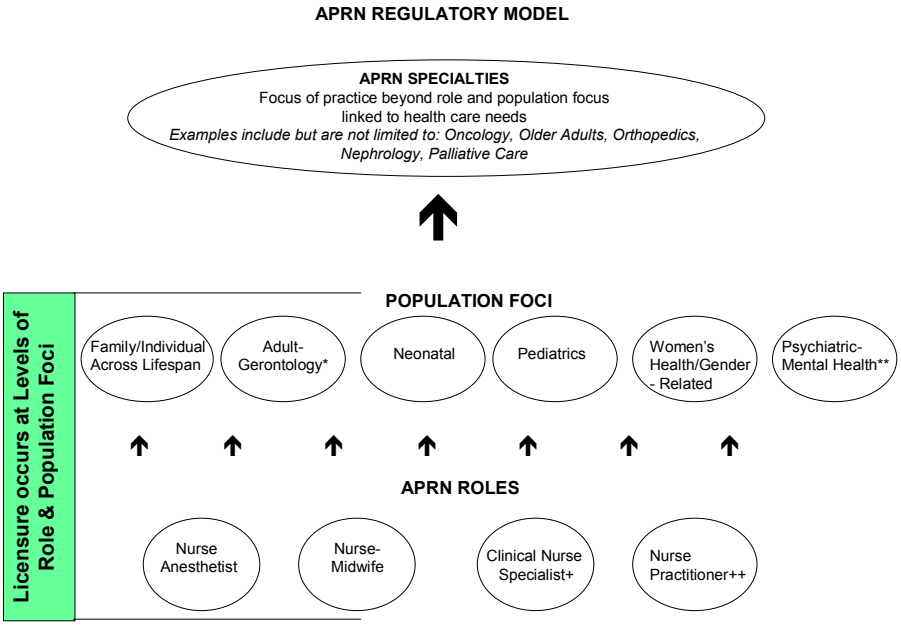
With the passage of the Affordable Care Act, the need for experienced nurses is more important than ever. Expansion of coverage will simultaneously create a demand for qualified care providers. APRNs are in a position to competently fill the gaps in access to care that will result when an estimated 32 million Americans become newly insured (Croft, 2010).

Currently, there is no uniform model of regulation of APRNs across the jurisdictions. Each jurisdiction independently determines the APRN legal scope of practice, the roles that are recognized, the level of prescriptive authority, the degree of collaboration, the criteria for entry into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from jurisdiction to jurisdiction and also directly affects patients through decreased access to care.

Model APRN National Standards

The goal of the Consensus Model for APRN Regulation is to create consensus among the jurisdictions in their efforts to establish a common understanding in the APRN regulatory community that will continue to promote quality APRN education and practice; design a vision for APRN regulation, including education, accreditation, certification and licensure; set standards that protect the public; improve mobility and improve access to safe, quality APRN care.

The following section outlines the major components of the regulatory model developed by the Joint Dialogue Group. It identifies the title to be used, licensure requirements, and accreditation and education standards. Also included is a diagram that illustrates the structure and relation of the model entities.



* The population focus adult-gerontology encompasses the young adult to the older adult, including the elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

+ The CNS is educated and assessed through national certification processes across the continuum from wellness through acute care.

++The CNP is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting specific, but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

New National Standards for APRN Regulation

Title

The title "advanced practice registered nurse (APRN)" is the licensing title to be used for this subset of nurses who are prepared with advanced, graduate-level nursing knowledge to provide direct patient care in one of the four APRN roles. At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. Only those who are licensed to practice as an APRN may use the APRN title or any of the APRN role titles. An APRN may also indicate the population and specialty title in which they are professionally recognized, in addition to the legal title of APRN and role.

Licensure

APRNs will be regulated via an APRN license. APRNs will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci.

Boards of nursing have the responsibility to:

1. License APRNs (except in states where state boards of nurse-midwifery regulate nurse-midwives);
2. Ensure APRNs have completed the congruent education requirements and national certification examination;
3. Allow for mutual recognition of APRN licenses through the APRN Compact;
4. Have at least one APRN representative position on the board of nursing and utilize an APRN advisory committee that includes representatives of all four APRN roles; and
5. Institute a grandfathering clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

Accreditation

All developing APRN education programs or tracks must be preapproved, have preaccreditation, or be accredited prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited and their graduates must be eligible for national certification used for state licensure. Accreditation must be completed by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA).

Accreditors have the responsibility to:

1. Evaluate and assess APRN education programs in light of the APRN core, role core and population core competencies;
2. Assess developing APRN education programs and tracks using established accreditation standards and granting preapproval, preaccreditation or accreditation prior to student enrollment;
3. Include an APRN on the visiting team when an APRN program/track is being reviewed; and
4. Monitor APRN educational programs throughout the accreditation period.

Certification

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes.

Certification programs have the responsibility to:

1. Follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure;
2. Assess the APRN core and role competencies across at least one population focus of practice;
3. Assess specialty competencies, if appropriate, separately from the APRN core, role and population-focused competencies;
4. Be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA);
5. Enforce congruence between education and certification examination;
6. Provide a mechanism to ensure ongoing competence and maintenance of certification; and
7. Participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Education

APRN education consists of an extensive broad-based education, which includes appropriate clinical experiences, as well as coursework in graduate-level courses in advanced physiology/pathophysiology, advanced health assessment and advanced pharmacology, including pharmacodynamics, pharmacokinetics and pharmacotherapeutics.

APRN education programs/tracks leading to APRN licensure, including graduate degree granting and postgraduate certificate programs, have the responsibility to:

1. Follow established educational standards and ensure attainment of the APRN core, role core and population core competencies;
2. Be accredited by a nursing accrediting organization that is recognized by the USDE and/or CHEA;
3. Be preapproved, preaccredited or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. Ensure that graduates of the program are eligible for national certification and state licensure; and
5. Ensure that official documentation (e.g., transcripts) specifies the role and population focus of the graduate.

For entry into APRN practice and for regulatory purposes, APRN education must:

1. Be formal, comprehensive education with a graduate degree or postgraduate certificate;
2. Prepare the graduate to practice in one of the four identified APRN roles across at least one of the six population foci;
3. Provide a basic understanding of the principles for decision making in the identified role; and
4. Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which includes the administration and prescription of pharmacologic and non-pharmacologic interventions.

APRN Specialization

Preparation in a specialty area of practice is optional, but if included, must build on the APRN role/population-focused competencies. APRNs cannot be licensed solely within a specialty area. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialization does not expand an APRN's scope of practice. A specialty evolves out of an APRN role/population focus and indicates that an APRN has additional knowledge and expertise in a more discrete area of specialty practice. Competence at the specialty level will not be assessed or regulated by boards of nursing, but rather by the professional organizations. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms. Professional certification in the specialty area of practice is strongly recommended.

Emergence of New APRN Roles and Population-foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus.

Conclusion

Establishing uniform APRN regulations across all states is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge, the Consensus Model for APRN Regulation will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

A target date for full uniformity across all states is the year 2015. Because this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators and employers, it is expected that the recommendations will inform decisions made by each of these entities as they fully implement the Consensus Model for APRN Regulation.

Organizations Represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American College of Nurse-Midwives

American Nurses Association

American Organization of Nurse Executives

Compact Administrators

National Association of Clinical Nurse Specialists

National League for Nursing Accrediting Commission

National Organization of Nurse Practitioner Faculties

National Council of State Boards of Nursing

NCSBN APRN Advisory Committee Representatives (5)

Organizations Participating in APRN Consensus Process

Academy of Medical-Surgical Nurses

American College of Nurse-midwives Division of Accreditation

American Academy of Nurse Practitioners

American Academy of Nurse Practitioners Certification Program

American Association of Colleges of Nursing

American Association of Critical Care Nurses Certification

American Association of Neuroscience Nurses

American Association of Nurse Anesthetists

American Association of Occupational Health Nurses

American Board for Occupational Health Nurses

American Board of Nursing Specialties

American College of Nurse-Midwives

American College of Nurse-Midwives Division of Accreditation

American College of Nurse Practitioners

American Holistic Nurses Association

American Nephrology Nurses Association

American Nurses Association

American Nurses Credentialing Center

American Organization of Nurse Executives

American Psychiatric Nurses Association

American Society of PeriAnesthesia Nurses

American Society for Pain Management Nursing

Association of Community Health Nursing Educators

Association of Faculties of Pediatric Nurse Practitioners

Association of Nurses in AIDS Care

Association of PeriOperative Registered Nurses

Association of Rehabilitation Nurses

Association of State and Territorial Directors of Nursing

Association of Women's Health, Obstetric and Neonatal Nurses

Board of Certification for Emergency Nursing

Council on Accreditation of Nurse Anesthesia Educational Programs

Commission on Collegiate Nursing Education

Commission on Graduates of Foreign Nursing Schools

District of Columbia Board of Nursing

Department of Health

Dermatology Nurses Association

Division of Nursing, DHHS, HRSA

Emergency Nurses Association

George Washington University

Health Resources and Services Administration

Infusion Nurses Society

International Nurses Society on Addictions

International Society of Psychiatric-Mental Health Nurses

Kentucky Board of Nursing

National Association of Clinical Nurse Specialists

National Association of Neonatal Nurses

National Association of Nurse Practitioners in Women's Health, Council on Accreditation

National Association of Pediatric Nurse Practitioners

National Association of School of Nurses

National Association of Orthopedic Nurses

National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties

National Conference of Gerontological Nurse Practitioners

National Council of State Boards of Nursing

National League for Nursing

National League for Nursing Accrediting Commission

National Organization of Nurse Practitioner Faculties

Nephrology Nursing Certification Commission

North American Nursing Diagnosis Association International

Nurses Organization of Veterans Affairs

Oncology Nursing Certification Corporation

Oncology Nursing Society

Pediatric Nursing Certification Board

Pennsylvania State Board of Nursing

Public Health Nursing Section of the American Public Health Association.

Rehabilitation Nursing Certification Board

Society for Vascular Nursing

Texas Nurses Association

Texas State Board of Nursing

Utah State Board of Nursing

Women's Health, Obstetric & Neonatal Nurses

Wound, Ostomy, & Continence Nurses Society

Wound, Ostomy, & Continence Nursing Certification

References

American Association of Colleges of Nursing. (1996). *The essentials of master's education for advanced practice nursing education*. Washington, DC: Author.

American Association of Colleges of Nursing. (2004). Position statement on the practice doctorate in nursing. Retrieved January 7, 2011, from http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Washington, DC: Author.

American College of Nurse-Midwives. (2002). *Core competencies for basic midwifery practice*. Silver Spring, MD: Author.

American Educational Research Association, American Psychological Association and National Council on Measurement in Education. (2002). *Professional and occupational licensure and certification: Standards for educational and psychological testing*. Washington, DC: American Psychological Association, Inc.

American Nurses Association. (2004). *Nursing: Scope and standards of practice*. Washington, DC: Author.

Association of Women's Health, Obstetric and Neonatal Nurses & National Association of Nurse Practitioners Women's Health. (2002). *The women's health nurse practitioner: Guidelines for practice and education, (*5th ed.). Washington, DC: Author.

Atkinson, D. J. (2000). Legal issues in licensure policy. In C. Schoon & I.L. Smith (eds.), *The licensure and certification mission: Legal, social, and political foundations. Professional Examination Service.* New York: Forbes Custom Publishing.

Bauer, J. (1998). *Not what the doctor ordered: How to end the medical monopoly in the pursuit of managed care,* (2nd ed.). New York: McGraw-Hill Companies.

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

Citizen Advocacy Center. (2004). *Maintaining and improving health professional competence: Roadway to continuing competency assurance*. Washington, DC: Author.

Council on Accreditation of Nurse Anesthesia Educational Programs. (2004). *Standards for accreditation of nurse anesthesia educational programs*. Chicago: Author.

Cragin, L., & Kennedy, H.P. (2006). Linking obstetric and midwifery practice with optimal outcomes. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 35*(6), 779–785.

Croft, C. (2010). Health reform by the numbers. Retrieved December 30, 2010, from http://www.whitehouse.gov/health-care-meeting/by-the-numbers

Dulisse, B., & Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs, 29*(8), 1469-1475.

Finocchio, L.J., Dower, C.M., Blick N.T., Gragnola, C.M., & The Taskforce on Health Care Workforce Regulation. (1998). *Strengthening consumer protection: Priorities for health care workforce regulation*. San Francisco, CA: Pew Health Professions Commission.

Gordon, S. (2010, April 25). Take advantage, New York, of our nurse practitioners. *Times Union.* Retrieved May 4, 2010, from http://albarchive.merlinone.net/mweb/wmsql.wm.request?oneimage&imageid=10366351

Hamric, A.B., & Hanson, C. (2003). Educating advanced practice nurses for practice reality. *Journal of Professional Nursing, 19*(5), 262-268.

Hansen-Turton, T., Ritter, A., & Torgan, R. (2008). Insurers' contracting policies on nurse practitioners as primary care providers: Two years later. *Policy, Politics, & Nursing Practice, 9*(4), 241-248.

Hanson, C. & Hamric, A. (2003). Reflections on the continuing evolution of advanced practice nursing. *Nursing Outlook, 51*(5), 203-211.

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systemic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal, 324,* 821.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality.* Washington, DC: National Academies Press.

Kaplan, L., & Brown, M. (2004). Prescriptive authority and barriers to NP practice. *The Nurse Practitioner, 29*(33), 28-35.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2005). *Substitution of doctors by nurses in primary care*. Cochrane Database System Review, 18(2). Retrieved January 7, 2010, from http://www2.cochrane.org/reviews/en/ab001271.html

Lenz, E.R., Mundinger, 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..

Marion, L., Viens, D., O'Sullivan, A., Crabtree, K., Fontana, S., et al. (2003). The practice doctorate in nursing: Future or fringe. *Topics in Advanced Practice Nursing eJournal, 3*(2).

Mundinger, 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.

National Association of Clinical Nurse Specialists. (2003). *Statement on clinical nurse specialist practice*. Philadelphia, PA: Author.

National Council of State Boards of Nursing. (1993). *Regulation of advanced practice nursing: 1993 National Council of State Boards of Nursing position paper*. Chicago: Author.

National Council of State Boards of Nursing. (1997). *The National Council of State Boards of Nursing position paper on approval and accreditation: Definition and usage*. Chicago: Author.

National Council of State Boards of Nursing. (1998). *Using nurse practitioner certification for state nursing regulation: A historical perspective*. Chicago: Author.

National Council of State Boards of Nursing. (2001). *Advanced practice registered nurse compact*. Chicago: Author.

National Council of State Boards of Nursing. (2002). *Regulation of advanced practice nursing: 2002 National Council of State Boards of Nursing position paper.* Chicago: Author.

National Council of State Boards of Nursing. (2002). *Uniform advanced practice registered nurse licensure/authority to practice requirements.* Chicago: Author.

National Council of State Boards of Nursing. (2002). *Regulation of advanced practice nursing.* Chicago: Author.

National Organization of Nurse Practitioner Faculties. (2000). *Domains and competencies of nurse practitioner practice.* Washington, DC: Author.

National Panel for Acute Care Nurse Practitioner Competencies. (2004). *Acute care nurse practitioner competencies.* Washington, DC: Author.

National Panel for Psychiatric-Mental Health NP Competencies. (2003). *Psychiatric-mental health nurse practitioner competencies.* Washington, DC: Author.

National Task Force on Quality Nurse Practitioner Education. (2002). *Criteria for evaluation of nurse practitioner programs.* Washington, DC: Author.

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.

Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century.* Washington, DC: National Academies Press.

Pine, M., Holt, K. D., & Lou, Y. B. (2003). Surgical mortality and type of anesthesia provider. *AANA Journal, 71*(2), 109-116.

Ritter, A., & Hansen-Turton, T. (2008). The primary care paradigm shift: an overview of the state-level legal framework governing nurse practitioner practice. *Health Lawyer, 20* (4), 20-28.

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

Safriet, B.J. (2010). *Federal options for maximizing the value of advanced practice nurses in providing quality, cost-effective healthcare.* Washington, DC: National Academies Press.

Safriet, B.J. (1992). Health care dollars & regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation, 9*, 417-488.

U.S. Department of Health and Human Services Health Resources and Services Administration. (2010). *The registered nurse population: 2008 national sample survey of registered nurses.* Washington, DC: Author.

World Health Organization. (2006). *WHO health promotion glossary: New terms.* Oxford University Press: Author.