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Past Event: 2026 APRN Roundtable - Evolution of the APRN Consensus Model: A Brief Overview and Key Updates Video Transcript

Event

2026 APRN Roundtable

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- [Denise] Hello, everyone, and welcome to our session on "Evolution of the APRN Consensus Model: A Brief Overview and Key Updates." I'll be presenting today along with Dr. Wesley Davis and Dr. Margaret Carman. If you have questions along the way during the presentation, please add them to the Q&A box.

We'll be having live Q&A after the session. Dr. Davis, Dr. Carman, and I have nothing to disclose regarding this session. So, our objectives of today, I'll briefly review the APRN Consensus Model and the guidance within the Consensus Model for future evolution.

The next objectives will be presented by Dr. Davis, who will discuss the emergency NP as a population proposal. And Dr. Carman will then review acute care across the lifespan as a delineation in the lifespan population. So let's get going.

So why was the APRN Consensus Model created? Well, prior to 2008, APRNs were assuming a larger role in providing high-quality, low-cost, effective healthcare. Despite the increase in APRN programs and providers, patient access to APRNs was limited. And it was really limited by the lack of common definitions of the APRN roles, increasing number of nursing specialties, debates about appropriate credentials and scope of practice, and lack of uniformity in educational program content and therefore state regulations.

The APRN Consensus Model sought to address all these challenges. The APRN Consensus Model is really a regulatory model and was the product of the work that was completed jointly by the National Council of State Board of Nursing, APRN Advisory Committee, and the APRN Consensus Workgroup.

It serves as the guiding document for APRN preparation, practice, and regulation. It identifies the four APRN roles and the foundational educational elements, for example, the 3Ps, advanced pathophysiology, advanced pharmacology, and advanced physical assessment as 3 separate courses, 500 clinical hours at the minimum, and health promotion content.

It also describes specific role and population educational components. It gives guidance to achieve consistency among states in regulation of APRNs and alignment with education, certification, and practice.

While we often think of the Consensus Model as starting in 2008, there was years of groundwork leading up to it. In 1993, was when the National Council State Board of Nursing adopted a position paper on licensure of APRNs, including rules. In 1995, National Council worked with the certifiers to assure that certification exams were suitable for regulatory purposes, meaning exams undergo accreditation, developing the basis for the elements of the exams to be legally defensible and psychometrically sound.

In 2003, a draft APRN vision paper outlined areas of concern and the path forward for an ideal regulatory model. Around that same time, the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties submitted a proposal to the Alliance for Nursing Accreditation to establish a process to develop a consensus on APRN credentialing.

Then, in 2006, the two groups got together but continued to work separately until 2007, when they formed the Joint Dialogue Group, and it was decided to combine efforts into one paper. So the publication of the APRN Consensus Model happened in 2008, and since 2008, we've been working on implementation of the model.

Since the APRN Consensus Model was endorsed in 2008, stakeholder organizations representing the pillars of LACE, which are Licensure, Accreditation, Certification, and Education, have made substantive changes to fully implement the model. However, since licensure is driven by individual states and their regulatory bodies, and licensure and authorization to practice vary state by state, it's still a work in progress.

There are seven main elements of the regulatory framework, and adoption of the Consensus Model elements move states towards regulatory uniformity. Although there has been significant progress in integrating these components into nurse practice acts, there continues to be states that have not adopted all the elements of the framework.

This can result in a lack of uniformity from one jurisdiction to another. I thought I'd talk a little bit about the LACE network. The original organizing groups and stakeholders that participated in the development of the APRN Consensus Model formed the LACE Network as a means of communication.

Over time, this has evolved into an active network representing not only the four pillars of licensure, accreditation, certification, and education, but also have added practice organizations. Here are the key elements of the APRN Consensus Model that the stakeholder groups could agree on at that time.

So this is what was put forward. This was a huge effort, and I have deep respect for those involved in this momentous decision. It was not perfect, but it formed a solid foundation for APRN practice and regulation. You'll see from the slide that APRN regulation takes place at the role and population level. There are four roles and six populations.

Certified nurse practitioner, clinical nurse specialist, certified nurse midwife, and certified registered nurse anesthetist. Additionally, there are six population foci. Family individual across the lifespan, pediatrics, adult gerontology, women's health, gender related, neonatal, and psych mental health.

Now, when you move up the model to specialty preparation, that is additional knowledge that builds on the role and population. It can't replace educational preparation at the role and population level, and it can't expand one scope of practice beyond the role or population.

A key point here is entry to practice certification demonstrates eligibility for licensure in most states, and certification is based on population foci and the APRN roles. Specialty certification demonstrates additional knowledge, but is not regulated at the state level.

Because both of the populations that are being put forward are largely primarily within the nurse practitioner realm, I thought I'd discuss a little bit more about how the nurse practitioner role and populations are seen.

For nurse practitioners and not for other APRNs, there's a further population distinction for adults and pediatrics between acute care and primary care. At this point in time, acute care and primary care nurse practitioner delineation applies only to adult gerontology and pediatric population foci. Scope of practice of primary care or acute care NP is not setting-specific, but it's based on the patient's needs.

Programs can prepare individuals across both primary care and acute care competencies, but if programs prepare graduates across both sets, the graduate must be prepared with the Consensus Model-based competencies for both, and must successfully obtain certification in both acute care and primary care NP roles.

Now, the APRN Consensus Model, when conceived, they knew that it would likely evolve. The document recognized that there may be a need for new roles and new populations as healthcare continued to evolve at a rapid pace.

Therefore, they outlined requirements for consideration for a new population or new role. It should encompass a unique or significantly different set of competencies. The scope of practice is not entirely subsumed within other roles. It should be vetted and discussed within the LACE network.

And actually, one of the populations we're going to be talking about today, population proposals, is currently put before the LACE network. And educational standards and practice competencies must exist, and be consistent, and be nationally recognized by the profession.

There's also characteristics of the process outlined in the APRN Consensus Model that mirror the process that happened to develop the original Consensus Model. It should be initiated by nursing, national in scope, and be inclusive, transparent, and accountable. It should be consistent with all the standards for licensure, accreditation, certification, and education, be evidence-based, and consistent with regulatory principles.

So today, we're going to talk about two new population proposals. Emergency NP and acute care across the lifespan. Thank you for your time and attention today. Don't forget to put your questions in the Q&A tab. And now, I'm going to turn it over to my colleague, Dr.

Wesley Davis, who will be discussing the emergency NP proposal. Wesley?

- [Dr. Davis] Thank you, Denise. So, I'll start by introducing myself really quickly. I'm Wesley Davis. I am currently serving as the Wyoming APRN representative for the Wyoming State Board of Nursing. I also work as the dual family and emergency nurse practitioner program coordinator at the University of South Alabama.

And I serve clinically as the chief of the medical staff at Crook County Medical Services District in Sundance, Wyoming. So, I want to start by briefly framing what I'll cover in my part of the presentation today. At a high level, this discussion is about alignment, specifically how aligning education, certification, licensure, and scope with the realities of emergency care impacts both patient safety and regulatory effectiveness.

We'll look at how recognizing the emergency nurse practitioner as a population helps reduce the variation we currently see across states and supports a more consistent competency-based regulatory approach. And finally, we'll connect that regulatory alignment to something very tangible, access to emergency care, particularly in settings where advanced practice nurses are essential to maintaining services.

Ultimately, this comes down to a central question. Do our current APRN populations reflect the care actually delivered in emergency settings? So, I'd like to start with a simple question. Emergency care is the only area of healthcare where the APRN is responsible for evaluating and stabilizing any patient of any age and with any condition immediately upon presentation.

So, the question is, what current APRN population is educated, certified, and licensed for that responsibility? If we look at our existing populations, family, adult gerontology, pediatric, neonatal, etc., each of these are defined by age or patient type with clear boundaries around who they are prepared to care for.

But in emergency care, those boundaries don't exist. And that leads us to a critical issue. No APRN population is fully aligned with the responsibilities required in emergency care. That gap is what we're going to talk about today. Let's start by grounding this in how APRNs are regulated.

Under the Consensus Model, education, certification, and licensure are aligned to a defined patient population, not the setting. And those populations are intentionally structured around age and patient needs to create clear, safe boundaries.

You see that on the left of this slide. In most areas of healthcare, those boundaries are operational. Adult ICUs, they don't admit infants. Postpartum units, you don't admit and manage pediatric critical care. And APRNs can appropriately decline care outside their population focus. That's not a limitation.

That's actually how regulation protects patients. But emergency care is different. And you can see this on the right side of the screen. The patient defines the population by presentation. It's across all ages, and it's unpredictable. There's no defined conditions. And under EMTALA, care is immediate, and it cannot be declined.

So this isn't just undifferentiated care. It's universal responsibility. And this is where the misalignment becomes clear. Emergency APRNs are expected to evaluate, diagnose, stabilize, and determine disposition for any patient at any time.

But no existing APRN population is educated and certified for that full responsibility. So what you see in the center is the problem. The framework does not align with clinical reality. Emergency care is not just primary care plus acute care. It's full-spectrum, unscheduled care across all ages and all acuities. And yet, APRNs providing that care are regulated within population boundaries that don't fully reflect what they are required to do.

And that misalignment has consequences. Inconsistent state interpretation, confusion in credentialing, and variability in preparation, which raises a simple question. Do our current APRN populations actually reflect the reality of emergency care? And if it doesn't, what is the appropriate way to fix that?

Now, let's take that concept out of theory and look at what actually takes place in an emergency department. This is a real snapshot of an ED tracker board from a community emergency department. It's staffed overnight by a nurse practitioner with the nearest referral center approximately 30 miles away. Just take a moment and look at these patients.

In a single shift, we have a solo nurse practitioner caring for, there's a 1-month-old infant with a fever, there's a toddler with a sore throat, there's an adolescent who has suicidal thoughts, an adult with a woman's health problem, there's an elderly patient who's unresponsive, there's blurred vision, suspected overdose, there's a primary care patient that needs a medication refill, and everything in between.

So, just in this one community ER, all of the current APRN populations are represented at once. Now I want to ask you a very practical regulatory question. Which of the currently recognized APRN populations are educated, certified, and licensed to manage all of these patients?

In other words, if a concern were brought to your board that an APRN, educated and certified in any one of the current APRN populations, was managing this full group of patients, would you say they are practicing within their population scope? One of the most important factors that shapes care provided in the emergency department is EMTALA.

It's the Emergency Medical Treatment Labor Act. EMTALA fundamentally changes how emergency care is delivered. Because under this law, emergency departments are legally required to provide a medical screening exam, stabilizing treatment, and appropriate disposition to any patient who presents.

There are no population boundaries, there's no exclusions based on age, there's no exclusions based on diagnosis, there's no distinction between acute, chronic, primary, or complex care. This is where emergency care becomes structurally different from all of the other APRN populations. Because in every other setting, the population defines the care.

Here, it's the reverse. The patient presentation defines the APRN's responsibility. They're responsible for diagnosing and managing undifferentiated presentations across the entire lifespan immediately. And this is the key point. EMTALA removes the very boundaries that our current APRN populations are built upon.

So now we have a situation where the federal legal expectation is full spectrum, immediate responsibility, but the regulatory framework is still based on defined population limits. And that is the misalignment. Emergency care is not defined by age, diagnosis, or setting.

It is defined by a federally mandated obligation to evaluate and stabilize any patient who presents. So, building on EMTALA, let's now look at how this actually plays out across different practice settings. Because this is where the distinction starts to hit home and become clear.

Under the Consensus Model, APRN education, certification, and licensure are aligned with patient populations defined by age and health needs, not by setting. And importantly, the majority of the time, these systems where APRNs practice reinforce those boundaries.

For example, in primary care and in ICU, responsibility is defined and limited by age, acuity, and patient needs. If you look at primary care, a patient presents with chest pain. The clinician or the APRN evaluates the patient, and if something serious is suspected, they refer that patient to the emergency department.

If you look at intensive care setting, if you have a patient that's admitted for a critical condition, such as a brain herniation, you can consult specialty services like neuro. For MI, you can consult cardiology. You can also consider that adult ICUs, they don't routinely accept pediatric patients. Pediatric ICUs, they don't admit elderly patients.

So, in both of these examples, you have the ability to refer or consult specialty services. Again, responsibility is distributed and defined. Now, compare that to emergency care. Responsibility is no longer defined by age, condition, or acuity. It is defined by whoever presents for care.

So, there's no option to refer first. There's no option to wait for a specialist. There's no option to decline. As an FNP working in an ER, I can't tell the 41-year-old chest pain patient that he has to wait for cardiology because his acute presentation is outside of my scope. As an adult gerontology acute care NP, I can't tell the woman delivering a preterm infant that she will need to wait for a nurse midwife and a neonatal nurse practitioner because her presentation is outside of my scope.

Undifferentiated symptoms and episodic visits, they exist everywhere in healthcare. But only in emergency care does the APRN carry universal responsibility. And that responsibility is exactly what the current academic emergency nurse practitioner educational programs and board certification prepares APRNs for. So, while current APRN populations are appropriately defined by age and health needs, the emergency patient population is fundamentally different.

It's defined by patient presentation and universal responsibility, which brings us back to the core issue. If the responsibility is universal, shouldn't the population and the regulation reflect that? So, now that we've established how emergency care functions and the responsibility that comes with it, let's take a quick step back and look at where these patients actually go for care, and why doesn't our current specialty certification structure solve this problem.

As I've previously said, the emergency care population is defined by presentation. Patients present for undifferentiated illness, injury. They require immediate evaluation. It's time-sensitive. They need to be stabilized. It's across the lifespan and across the entire acuity spectrum, and it includes chronic care, acute care, and primary care.

And importantly, this population is not confined to a single location. Emergency care occurs. We see it in emergency departments, which is what most of us think about. EMS systems, critical care transport, life flight, urgent care, disaster response, and the list goes on. So, again, the population is defined by need and not setting.

So, now, how do we connect that to regulation? What we know from workforce data, including the PREPARED NP study, is that the majority of nurse practitioners in these emergency care areas are educated and certified under the family nurse practitioner population.

But here's the issue. The FNP population is built on primary care preparation. And it does not reflect the full breadth, acuity, and procedural expectations of emergency care that we've just walked through. So, the question becomes, does the ENP specialty certification fix that? And this is where the Consensus Model starts to make sense and become very clear.

Population focus defines the legal scope of practice. Specialty certification provides additional depth within that population. But specialty certification cannot expand population scope. So, even with the ENP specialty certification, the APRN is still licensed and regulated under the FNP population.

So, that underlying scope doesn't change. So, what we're left with is this. The current model, the FNP plus the ENP specialty, does not resolve the misalignment. It actually perpetuates it, because clinicians are still being regulated under a framework that does not fully reflect the care they're expected to provide.

And that brings us to the key conclusion of this slide. Specialty certification cannot redefine the patient population served. If emergency care is defined by a distinct patient population, then the regulation should recognize it at the population level.

Now that we've established what emergency care actually requires, let's talk about whether our existing APRN populations truly prepare clinicians for that responsibility. At first glance, it may seem like we already have all the pieces that we need. We hear a lot of nurse practitioners say, "Well, what if we combine adult gerontology acute care and pediatric acute care?"

But when we look at those closely, both clinically and from a regulatory standpoint, that approach really doesn't solve the problem. Each of these populations was intentionally designed with boundaries. For example, the family NP has primary care across the lifespan responsibilities. The adult gerontology acute care NP focuses on acute healthcare needs of adult patients.

Pediatric, neonatal, they have age-specific populations. And those boundaries matter because under the current regulatory model, they define what a clinician is educated, certified, and licensed to do. The national Crosswalk analysis cited on this slide here compared the ENP competencies, the ENP certification exam blueprint, and procedural expectations with all of the other existing APRN populations.

And the finding was kind of clear. There's no existing APRN population that fully aligns with emergency care practice. Even more importantly, the alignment was only ever partial because existing populations are all limited by age and acuity. For example, the adult gerontology acute care NP, they do have a lot of overlap when it comes to procedures and critical care, but they don't have the training and expertise for pediatric patients, or obstetric emergencies, or neonatal emergencies.

The inverse is the same with the pediatric acute care NPs. They have a strong pediatric expertise, but they don't have training for adult and geriatric emergencies. So combining the two does not create true alignment. It creates two partial scopes that are placed side by side. But emergency care doesn't work that way, and this is where the current framework fundamentally breaks down.

Because even if you stack those two population certifications together, you still do not create integrated competencies for emergency care or a single regulatory scope. What you're creating is more fragmentation and not alignment. And there's another critical reality here that we have to look at. Very few emergency departments in the United States are divided strictly into adult-only or pediatric-only divisions or care environments.

Most emergency departments, especially the ones in community settings and rural settings, require APRNs to manage the full lifespan at all times. So the real-world expectation is not, can you manage your population? Rather, the question is, can you manage whoever comes through the door? And the Crosswalk cited on this slide reinforces this.

Many of the ENP competencies, as we've already listed, the EMTALA-based responsibilities, the multi-patient, multi-variable, high acuity to chronic disease management, the full scope of procedural care, these are not fully represented in any single population or combination of populations. So the conclusion here is what's critical, and I want to be very clear.

This is not a gap that can be solved by combining existing populations because the issue is not missing pieces. It's a mismatch in how the population itself is defined. Emergency care is not adult plus pediatric. It is not primary care plus acute care.

Rather, it's a distinct patient population that's defined by undifferentiated and episodic presentations across the lifespan, across the disease spectrum. And that's why the key takeaway from this slide is no existing APRN population, alone or combined with another, prepares APRNs for the full scope of emergency care practice.

Which brings us directly to a regulatory question. If no current population aligns with the responsibility, should we continue forcing emergency care into those existing populations, or should we recognize the population that actually exists? Now that we've defined the emergency care population and what it looks like, and we've demonstrated what APRNs are doing in those settings, we can see that specialty certification does not really fix the problem.

So, let's bring this back to what matters most to us as regulators, which is the licensure process. This is what protects the public. What you see on this slide is not theoretical. This is a rudimentary, if you will, but typical, appropriate, and necessary regulatory workflow used by many boards of nursing across the country. And it's important to say this clearly, this process is not flawed.

In fact, it is designed to protect the public. Boards do not independently assess clinical competency of APRNs. Instead, you rely on something much more standardized and defensible, which is accredited APRN education and certification. So, the process works something like this at a very high level.

First, you verify that the applicant has completed an accredited graduate program, an APRN program, within a defined population focus. And next, you verify that the applicant has passed a national certification exam that assesses entry-level competencies for that same population. And based on those

two pieces of evidence, as well as multiple other factors, based on those two pieces of evidence, you grant authorization to practice within that particular population focus.

Then you regulate the APRN at the level of licensure, which is the population focus. So, this structure is exactly what the current regulatory model intended. It creates role clarity, public protection, and interstate portability. But now let's overlay emergency care onto this process, because here's where the breakdown occurs. For the vast majority of APRNs working in emergency care, that education and certification that you're verifying is within the family nurse practitioner population, which, as we've already discussed, is built on primary care competencies.

So, when the board grants authorization, you're granting authorization based on verified primary care preparation. Now layer in what we've already established, which is emergency care requires immediate stabilization, all ages, all acuities, is EMTALA-driven. And then this highlights the key issue.

That competency is never verified in the licensure process because the ENP credential is a specialty. And under the consensus model, boards do not regulate specialty practice. So, what that means in practical terms is this. At the point of licensure, the board has no formal or standardized evidence that the APRN has competency or has demonstrated competency in emergency care.

And that is the moment that this becomes a regulatory issue, not a workforce issue, not an education issue, but a public protection issue. Because the entire licensure framework is built on one principle, and that's you verify education and certification before granting authority to practice.

But in emergency care, that verification step is missing. And that is what this slide is all about. A gap in the licensure evidence chain, not because the process is wrong, but because the population being regulated does not match the population being served by the APRN. So, the key takeaway here is that boards are doing exactly what they're designed to do, but we're doing it based on the wrong population framework for emergency care.

And that is why this becomes a regulatory solution, not an educational workaround. Because the only way to close this gap is to ensure that education, certification, licensure, and regulation are all aligned with the actual patient population being served. So, if we go back to that licensure process and we recognize that the gap occurs at the point where competency is supposed to be verified, the next question is, what are the consequences of this gap?

And this slide shows how that gap quickly moves beyond theory and into real regulatory and patient safety implications. At the top of this slide, you see the root problem. The ENP is recognized as a specialty and not a population, which means that education, certification, and licensure are not fully aligned with established emergency care competencies and responsibilities.

Because this does not stay contained, it immediately translates to the state level. States are left to interpret the misalignment on their own. So, what do we see? What are the consequences? There's inconsistent scope interpretation. The states define what ENPs can and cannot do differently.

There's conflicting credentialing standards. Employers and the institutions that hire these APRNs, they create their own rules. Workforce confusion. Which APRN should we hire? Employer uncertainty. There's no clear expectation for training or certification. And most importantly, this is not a hypothetical situation.

We're already seeing the evidence. There's significant variation across states. There's inconsistent recognition of ENP practice. So, what started as a misalignment in licensure has now become this fragmentation in regulation. And that fragmentation scales. At the national level, we begin to see inconsistent standards for entry into practice, barriers to workforce mobility, variation in how care is delivered.

And this is the key point, because this is what directly intersects with your role as Boards of Nursing. Public protection is now at risk. Because when regulation is inconsistent, patient expectations are inconsistent. When competency verification is unclear, practice expectations are unclear.

And when those vary across states, patient safety varies with geography. That is the exact problem that the consensus model was designed to prevent. So, the takeaway from this slide is not just that there's a gap. It's that the gap propagates through the entire regulatory system, and it ultimately trickles down and reaches the patient.

And that's why this is not simply a workforce issue. It's not an educational issue, but it's a patient safety issue. So, we've talked through the problem, the mismatch, the licensure gap, and how that gap reaches the patient. Now the question is, what does alignment actually look like? The answer is simple.

It's a return to the original intent of the APRN consensus model. When the ENP is recognized as a population, the existing LACE framework works exactly as it was designed to do. And importantly, we're not creating a new process. We are applying the current process correctly. So first, education and accreditation.

The Board verifies that the APRN has completed an emergency nurse practitioner academic program. Certification is then used to verify that the APRN has the competencies for entry-level practice into emergency care. And this is the critical shift. For the first time, the Board has the objective evidence of emergency care competency before licensure.

And finally, licensure is granted within the emergency care population, and regulation aligned at the same level. So now what is taught, what is tested, what is licensed, and what is regulated are fully aligned.

That's the model working as it was intended. And the impact is immediate. Patient safety improves because competency is verified before practice. Role clarity is restored, interstate portability is strengthened, and regulatory oversight is tied directly to education and certification. So the key takeaway from this slide is this.

This isn't a new framework. It's the correct application of the existing one. And when regulation reflects the population actually being served, the system works the way it was designed to. So, as I close my part of the presentation, I want to bring us back to the central question of the presentation, which is, does regulation reflect reality?

We've talked through what emergency care actually requires, what it looks like. We care for any patient, any age, with any condition, any level of acuity, for diagnosis and stabilization. And we compared that to our current regulatory framework and the current existing APRN populations. The conclusion is clear.

No existing APRN population fully aligns with emergency care practice. Family nurse practitioners, adult gerontology acute care NPs, pediatric acute care NPs, they all provide important strengths, but

none of them individually prepare APRNs for the full scope of emergency care. And importantly, combining populations does not solve the problem because combining adult and pediatric acute care for the purposes of emergency care does not create true alignment.

It creates two partial scopes that are placed side by side. But emergency care is not practiced in parts. It's practiced as a single continuous responsibility across the lifespan, across all acuity levels. So I'll close by saying this. Emergency care is a distinct APRN population.

And if regulation is to reflect reality, that population must be recognized within the regulatory framework. So thank you for taking the time to listen to my presentation on the emergency nurse practitioner proposal. So now I'd like to turn it over to Meg Carman, who will discuss the acute care across the lifespan.

- [Dr. Carman] Thank you, Wesley. My name is Meg Carman. I am an acute care and an emergency nurse practitioner, and I just stepped back into full-time clinical practice after 15 years teaching an acute care nurse practitioner programs at several different universities.

So, my background includes neurocritical care. I've been a trauma nurse practitioner, and my love and passion has been as an emergency nurse practitioner in community and large academic settings. So I've kind of been all over the place. And I proudly serve as the voting member on the LACE network for the Emergency Nurses Association, where I'm a consultant and currently leading a group to explore the possibilities of acute care across the lifespan and that potential on the consensus model for APRN regulation.

So the objectives for my piece of this talk will be to discuss the background for proposing a proposal to recognize acute care across the lifespan as a delineation, and we'll talk about that, of the lifespan population on the consensus model. We're going to examine 12 questions that have been posed by the LACE steering committee that are used to guide this proposal.

It's the same for the emergency nurse practitioner proposal. And I'm going to include that in the handouts for my part of the talk here. And we're going to discuss the current status. Where is the proposal right now? A lot of people have been told that we're working on it. There's a lot of assumptions. And so maybe we can talk about what's actually going on here today, and to think about what the proposed timeline is, where can you look for that to be submitted?

Who's working on the groups? And what are some insights and conclusions that we've come to along the way? The questions are very 360-degree, the good, the bad, what are the implications? So just a little bit of background. Lifespan really does exist on the current consensus model for APRN regulation. It's not apparent, but at the time that the consensus model was developed, family was identified and developed, which represents birth to the older adult and on towards death.

So it does exist. But during those initial discussions of the joint dialogue group, they determined that they would not develop the acute care piece of that at that time. And if you look and are reading the consensus model, you can see in the box on page 10, that it describes this below and says, at this time, the delineation, and that's why we are calling this a delineation, it is not a new role, it is not a new population.

The population of lifespan exists. It is a delineation between primary and acute care as currently exists for the adult gerontology nurse practitioner and the pediatric nurse practitioner. And so we're kind of filling in a gap that was existing on the model, but it wasn't a mistake. That was a decision at that time.

And as we all know, the consensus model was left open for evolution and change as healthcare exists. So it's been left as a future opportunity, and the future is now. So since 2008, when the consensus model was published, patient care has increased in its acuity, its complexity, and its time sensitivity.

We see increased demand for acute care nurse practitioners. And certainly, our colleagues who are pediatric or adult gerontology nurse practitioners are right on the front lines in intensive care units and across healthcare, managing these patients with acute care needs. But there are many practice populations that require acute care across the lifespan.

Many of them are specialties, and many of them are situated in rural or critical access facilities. For example, I now serve as a hospitalist in a critical access hospital. We may get pediatrics, and we may get adult or gerontology patients. And so I have to extend my scope of practice there.

And organically, it makes sense since the beginning of nurse practitioners, family nurse practitioners have been there and filling in the needs, especially in these areas of healthcare where there's an increased need. So it makes sense that over time, in these practices where lifespan was needed, that family nurse practitioners have moved in and filled those gaps.

But as the acuity has increased, now we see that there is perhaps a need for a new delineation, a new group of APRNs who are trained in acute care across the lifespan, who have more breadth in their scope.

And we know that the FNP curriculum is more geared towards primary care, although it is not clearly stated. That is not clearly stated in the consensus model. So there's been some gray areas there. And as the consensus model has gained momentum and has been adopted across the United States, we've seen increasing confusion and uncertainty.

And certainly, the regulators have spoken to me about that regarding scope and who should be where and how is this aligned with practice. And alignment of licensure, accreditation, certification, education, as we know, was the point of the LACE model in the first place. So maybe we can fill in these gaps. At the same time where there is confusion, that has been an issue and decreased marketability for some nurse practitioners in particular who need to manage the full lifespan of patients with acute care.

And very often, those jobs are given to physicians assistants. This is a problem that we see in emergency care. It is in various ICU and other acute care settings, where if you need lifespan and the employer is looking at I need someone who can do lifespan, but this is acute care, then they may choose the physicians assistant.

So we want to stay in the market. And we also heard time and time again from people that we interviewed that they really want to hire the nurse practitioner and that they're very, very well prepared for these positions. In the emergency department, which is, of course, the focus of the Emergency Nurses Association, the organization that I represent, we conducted a study three years ago, looking at what emergency nurse practitioners do in the emergency department, the care setting where we are typically seeing patients.

And most of the previous work had been either self-report, the Delphi project that was done around 2008 to look at ENP practice, and subsequent practice analyses have been either self-report, or they have included large segments of urgent care that was in there. So it looks, from what we had seen so far, as if a large portion of what is seen in the ED is very, very low-level.

So we'd created a pilot study, and we looked at a large academic teaching institution, something that we can use for a pilot and then replicate for community hospitals, etc. And we looked at actual CPT codes to see the level of medical decision-making and the complexity of the patients that were seen by a cohort of emergency nurse practitioners. This was a very large sample size.

As you can see, there were approximately 8,000 patients in this. And we compared that also on the graph here to the Emergency Severity Index, which has established a triage and determines the resources and the hemodynamic stability of patients seen. And as you can see here, it looks like in this emergency department, we do need to replicate it, but there was not a lot of low-level decision-making, quick, easy things like, you know, refill, medication refills, or upper respiratory infections.

No, we're seeing that there was critical care being performed by these emergency nurse practitioners and a very, very high level of acute care, complex medical decision-making. So that informed us, although, you know, we need to get more general data on all of acute care. It could be orthopedics, it could be other specialties.

But for us in the emergency departments, this really pointed us to the need for acute care and acute care across the lifespan, as most emergency departments are undifferentiated, not a pediatric and an adult gerontology ED. And when we look at the reality of what is going on in the emergency department, but we need to try to get a little more data, which is hard to do, on what are these other populations?

APRNs, managing acute care across the lifespan populations, often select the family nurse practitioner to cover lifespan. And as I've said, historically, this makes sense, but we're at a point where the curriculum does not match the job scope. And we need to think about providing the opportunities for APRNs to become appropriately trained, prepared, certified, and licensed.

Individuals completing dual certification often choose an FNP to get the lifespan, and then they get adult gero acute care NP. But that doesn't include the need to perform or provide pediatric acute care. And so there's still a gap there. Now, we know that among the different APRN roles and populations, there's a lot of overlap.

And that's part of the beauty of the consensus model. We should be collaborating. And there is some overlap. There may be some overlap that occurs with primary care. But ultimately, an APRN who is in a lifespan acute care population will need to be able to render stabilization in acute care.

And so we need to come up with a solution. If the APRN scope doesn't cover lifespan, that job may go to a PA. And it's not just the emergency department. It would include burn centers and burn intensive care units, hospitalists, particularly critical access, interventional radiology, orthopedics. The list goes on and on.

These are just a few. And there's that increased need in rural settings. So our approach, and there are two paths. You heard from our colleagues from AAENP about the proposal for emergency as a new population. We had some deliberations at ENA and its Advanced Practice Advisory Council, and determined that we thought that emergency as a population is one solution, but that acute care across the

lifespan as a delineation and filling in that gap in the model would be another solution that we thought might fit better in the bigger picture of the consensus model.

And so our final decision was to proceed with a proposal. ENA called together one group from various nursing organizations. The thought was that we would move forward with a proposal. And then in 2024, we called together a work group that represents the various pillars of LACE as well as practice.

And they have been working to look at, and this is the traditional consensus model, creating this delineation. So as you can see on the far left, it's individual across the lifespan. And so adding in that delineation. So let me just show you here what we're talking about. So, whereas the adult gerontology and pediatric populations had a decision of the delineations between primary and acute, this would add in family would now be identified as primary care and acute care across the lifespan, or we're not married to that name, would be the new delineation on the model.

The roles would remain the same, and that opens opportunity for those roles to look at adoption of the delineations. The considerations. Family is not clearly defined. We know that. So there's a gap, but it's also an opportunity. Acute care currently has scope, standards, and competencies across the lifespan. So those could be used to develop and to define this new delineation.

And nurse practitioners' education has evolved, particularly in the last few years, with the new essentials and also with the implementation guide for nurse practitioner faculty. And this all focuses more on curriculum with the use of core competencies. In summer of 2023, I believe it was, we went to the LACE steering committee and said, "What do we need to do to develop this proposal? And what is expected in terms of format?"

And they gave us 12 questions. And this is really an exploration. I'm really pleased at the very well-rounded views that the work group that has been convened has had to look at each question. And I've broken these into themes here. You can look at the 12 actual blank questions. But it really asks you, how well does the proposed change to the consensus model align with what's already there in terms of how does this affect, how would this change the roles, the populations, the specialties?

And specialty practice is also kind of left on the side. And this would provide an opportunity to further develop specialty practice. What are the implications for the current roles, the populations, and the pillars? And what is currently out there in terms of curriculum regulation? We're a little bit different than the emergency population group in that this work is not completed.

This is sort of where they started with the LACE network and with the dialogue group in thinking about what could be. And it will definitely take more work should this idea be adopted. We need to look at where is there the overlap?

How is it unique? But it's about the good and the bad and all of the implications. And that needs to be included in this proposal. But ultimately, it's really about providing safe and effective patient care. And as you move through the 12 questions, it really asks you to think very, very intensely about how is this going to serve the greater good?

Patients, families. How does it affect the individual APRN practice? And how does it advance our profession? So right now, where the group is at is technically question number seven. But what we have found is acute care across the lifespan would provide a more broad platform and option for acute patient care and serve these individuals.

It will be similar to the FNP for primary care. And there is still a need for the primary PNP, AGPCNP. But also with acute care, the pediatric ACNP, the adult gero ACNP is not going anywhere. There's a clear need.

The mechanisms would need to be in place to assure that practice covers the lifespan. This is not an answer for everyone to just go get their acute care across the lifespan and then go into a pediatric acute care situation. No, we need to look at both certification and recertification in terms of practice hours and the educational and continuing education content.

Age and acuity. In our initial discussions, a lot of concerns about the neonates. And so, age and acuity, we see, should align with the NONPF's Nurse Practitioner Competency Implementation Guide for NP faculty. And that provides a really nice delineation of acute care, and then what is lifespan.

And for acute care across the lifespan, this would begin with the individual who is born at 37 weeks or more gestation, consistent with the age range for the family nurse practitioner, but the acuity ranges for the adult gero and the pediatric nurse practitioner.

So that was very helpful to the work and really answered a lot of our gray questions. So that's where we are right now. Recurring themes and what we have found over and over as we're answering these questions, whether it's about the impact on accreditors, on certifiers, the changes that would be proposed would be the same as for any change to the consensus model.

If a new exam needs to be created, that there's going to be costs, there's going to be time, there's going to be resources, that would be the same for any proposed change. And you don't not make a change because there's going to be implications. It does provide a streamlined path for education, certification, and licensure of these individuals. And for that, then we're going to probably better ensure that people get the preparation that they need and align better with the scope that they are performing in clinical practice.

It improves our marketability if there is this acute care across the lifespan, APRN, who is able to meet all age ranges. And there's opportunity to ensure that the preparation is better aligned with certification and licensure. We're filling in that gap.

Acute care across the lifespan programs will require representative clinical experiences. It will need to be across the lifespan. And it will, we acknowledge, require more hours. It is not duplication and just putting together the adult gero and the PEDS acute care program. Work will need to be done.

This is just the start. But it will require more hours than other programs. And the future work needs to include defining the bounds of that curriculum, similar to the FNP with the primary care, adult, general, and pediatric NP. It could be clinical nurse specialists, so it's not limited to NP. We need to establish recommendations for how much clinical time is appropriate for that and set expectations for continued competency and certifications for a delineation that extends across the lifespan.

There will be overlap as there are with all of the roles and populations of APRNs. Acute care across the lifespan will overlap with the FNP in terms of some low-level acute care needs. And that is the same as with others. There is a distinct need, and it very much lies in rural populations and in specialties, but it is there.

It's hard to quantify, but it is there. And it highlights the importance of consultation and collaboration, which is one of those core competencies of all nurse practitioners and APRNs. There's potential for the development of CNS programs, and NACNS has been involved in all of these conversations, including our work group.

So there's potential for not only NPs to benefit from this, but also our clinical nurse specialist colleagues. So just imagine in the future, if we were to have acute care across the lifespan. Two examples. So the acute care across the lifespan NP in a burn center, except it's a 12-year-old with severe burns. That NP, with their specialty training, is able to manage that patient through their burn resuscitation, get them into their critical care phase, and the initial phases, but perhaps there are complications.

There's collaboration and consultation with the pediatric acute care NP who's working in the PICU. So they're working together to provide the best care for this patient and their family. Secondly, what about the acute care across the lifespan NP working in the emergency department, like me, who has a patient, subarachnoid hemorrhage, it's an adult, and transitions to my friend, Jen Wardell, here, who's an adult geriatric acute care nurse practitioner in the neurocritical ICU?

Sends that patient up, turns around, and discharges their patient, who they've provided excellent care to, who's now going home with croup after getting their steroids. So this is the future that I'm seeing, and I'm hoping for. And that is what our group is working on right now.

In summary, the time has come acute care would field a special need for safe and effective patient care across the lifespan. We can create a streamlined path for individuals who do provide acute care across the lifespan. And that would eliminate so much of this grayness and confusion that is seen by employers, legislators, even the lay public as they hear things.

And it would provide a platform for further developing specialty practice and that unique body of knowledge that is needed in specialties more and more as healthcare advances. Lifespan exists as a population. This is a delineation that we're talking about that existed at the time the model was published. The 12 questions are really...

They're not just this is a good idea. We really are looking very seriously at the good, the bad, the potentials for this. But the priority is safe and effective patient care. And this will only be the start of our work. And we hope that all of you will join in with us if this moves forward. Thank you very much.

And we look forward to hearing your questions.

- [Woman] Hello, Denise and Meg. Thank you for joining us. Unfortunately, Wesley is unable to join us at this time, but thank you for giving the time and for both excellent presentations.

Denise, the first question that came in from our audience is for you. Could you explain a little bit further the population of women's health, gender-related, as it kind of is in comparison to perinatal-related care or just kind of go into a little bit more detail about what that specific population, who they would care for?

Well, I'm certainly not the expert in women's health gender-related, but my understanding is it's related to, for example, a nurse practitioner that's caring for patients who are women's health, that have women's health issues.

And it's a little bit different than you would normally your patient population for a general nurse practitioner. And I think the second part of the question was on neonatal.

- Perinatal, actually.

- I'm not really sure. Yeah, I'm not really sure on... I know that for women's health, gender-related, there is some neonatal care, but I'm not sure exactly how many weeks, what the week delineation is for that. Maybe Meg knows.

- This is why I love the Implementation Guide for Nurse Practitioner Faculty. So I believe it's under 37 weeks gestation, but you refer back to the Consensus Model, and throughout our work, we go back to that original document, and you can usually find it there, and it's on the NCSBN website.

- Thank you for that shout-out, Meg. Yes, it is available on our website. So, for Denise, when someone is going into a certain population, such as adult gero in a primary care track, would they be able to sit for a certification exam that is, for instance, the primary mental healthcare provider based solely on experience, not having gone back to receive additional education in that area?

- Well, the short answer is no. They would have to meet the educational qualifications in order to be able to sit for that certification exam. So, for example, if you had a nurse practitioner who is currently practicing and wants to be able to practice in mental health, they would need to go back for a postgraduate certificate in order to be able to sit for that certification exam.

- Thank you, Denise. So Meg, for acute care across the lifespan, which I'll just call ACAL for just our sake of our conversation here, does neonatal care fall into that at all, or would that be considered separate?

- So if you look at a neonate being defined as that first month of life, it would be an individual who is born at 37 weeks gestation to 1 month. And yes, in that case it would, and there will need to be curriculum developed for that.

- Thank you. Sort of along those lines, what challenges do you see, or in reverse, what opportunities do you see by presenting ACAL as a delineation to the current population in the Consensus Model?

- I think this is finally providing a platform for those individuals who have a practice that requires acute care across the lifespan. It doesn't replace specialty as a pediatric or adult gero, but there is such a need. And what we're seeing is many of the specialty practices, as well as the rural critical access settings, where you don't have dedicated pediatric or sometimes adult resources and practices.

It's just badly needed. And then I think the second opportunity is that we don't really look to the specialties and that unique knowledge that is needed to practice in a specialty these days. The focus is really what program do I go to in school?

Now here's an opportunity where understanding the knowledge for burn care, for orthopedics, those could be really developed, and there's potential for specialty exam and certification really having meaning, perhaps not tied to licensure, but certainly in obtaining that job in that position.

- Thank you. Denise, this question is for you. Are the APRN specialties recognized within the Consensus Model itself?

- So, yes, the specialties are recognized, but as I talked about in my section, while specialties are recognized, regulation does not take place at the specialty level. And the big key in that is that Consensus Model clearly says that having a certification, for example, in a specialty does not expand your scope of practice if you did not get the population or role education to begin with.

So while it does expand knowledge, and it's really important for those of us that work in a specialty, it can't expand your scope of practice beyond your role in population.

- Thanks, Denise. So this question is for you, Meg. How will acute care across lifespan, or ACAL, differ from the emergency NP as a population within the Consensus Model?

- That is a wonderful question because in so many ways, we are proposing much of the same thing. If emergency is created as a population, then that is how you would be prepared, the program you would go to in school, you would be certified and presumably licensed in the state as an emergency nurse practitioner.

Acute care across the lifespan would be inclusive of other roles. So if the CNS groups wanted to develop curriculum, and a certification, and licensure, they could do so. So that's one of the things. The other thing is that it would provide a broader platform.

And so I think we would avoid creating more silos if the platform or the foundation that you're licensed at as acute care across the lifespan, and you're in the emergency department, say you wanted to move up to the surgical intensive care unit because it was peds and adults upstairs, then you could do that.

One concern I have with the emergency is that that's it, you're locked in. And so if you decide to go out of emergency, now you're going to have to go back and get an additional degree certification. And that's the problem that exists now because in emergency, really, to cover your scope of practice, you really should have pediatric, adult gerontology, acute care, and many would say FNP on top of that.

- Thank you. A little bit along those lines in this question again, it's for you, Meg, not to put you on the spot again, but would you consider, or do you consider that this could create some barriers for APRNs entering into practice, especially those that are located within states that do not have these educational programs offered, such as Hawaii or Montana, etc.?

- It's interesting because the program that has recently been opened is actually at the University of Nevada in Reno. So there are no distinct programs. It's sort of like chicken and egg.

We need to see whether that's going to be on the Consensus Model for universities to develop the curriculum and certifiers to develop the certification exam. So we are in a different place than the ENP group, which has developed all of these things for the specialty. So I think there's a lot of opportunity here.

Virtual and distance-based programs are a real thing. I've practiced, and my teaching practice I've taught in three different universities where it was a distance-based program. And if you build it, people will come.

- I do love that saying, yes. So, again, for Meg, how would ACAL be different than combining an adult gero NP and a pediatric acute care program, sorry, for both of them, acute care for both the adult gero and the pediatric, what would be the difference in just having one or both of those certifications?

- We have had quite a few discussions about this in our work group because it's really looking at life as a trajectory. And rather than taking PEDS and adult and sticking them together, no. This would be looking conceptually from a different perspective and saying, "This is the trajectory of lifespan, and we're going to look at the alterations in physiologic response, considerations for treatment, diagnostic modalities."

We would look at it in a different way and not as sticking two things together, but rather as that trajectory.

- Thank you, Meg. Denise, this question is for you. And Meg, feel free to chime in as well. What would either one of you want to see as the biggest takeaway for understanding the core reasoning and the core of the Consensus Model itself?

Denise, we'll start with you.

- So in general, I think that some of these issues that are brought up now seems like, well, why didn't they talk about this back in 2008 before they even did this? But you have to understand the development of the APRN Consensus Model was hard, hard work. And the Consensus Model that was developed back then was right for that time.

And it's really what they could come to consensus on. And they knew, our founders of the Consensus Model, really knew that there was going to be evolution and that there definitely would be more discussion.

I'm a little surprised that it's taken till now to really get at some of these meatier topics. But what I take away from it is, especially for regulators, these are tough discussions. And that's what the LACE Network is for: to tackle tough and difficult conversations and discussions.

I'm really grateful to both these groups, the acute care across the lifespan group, the emergency NP group, because in developing their proposal and realizing what their implications are across that would affect all the pillars of LACE plus practice, and most of all, how that could affect patient care is really something that we needed to talk about.

But now we have a platform to have discussion from two different perspectives. And I think it's a starting point. So, to me, I know that both the groups would like to be we got the proposal, let's put it before the LACE Network.

And they do represent organizations on the LACE network, so they know how things work, and just say, "Okay, my work is done." No, this is only the beginning of the conversation, and really needed to have the structure to have these conversations about how to approach both advanced practice nurses that are practicing across patient populations, as well as acuity levels.

So more to come.

- Thank you, Denise. Yes, absolutely more to come. So, same question for you, Meg. What do you see as kind of one of the biggest takeaways that our audience should have about the Consensus Model?

- To me, and I agree with Denise totally, it's about how they left it open for evolution and growth. But having gone to school and become a nurse practitioner before the Consensus Model, I love to see how we have taken what was many different types of programs, many different levels of expectation, erratic

licensure and regulation, and tried to bring this together so that anyone across this country has a good way to look at what should an APRN look like?

What is the quality of the education? It's a graduate degree, and bringing this all together so that there is alignment that results in safe patient care. And that's what it's really all about.

- Well, thank you very much. I want to thank both of you for your time today. And thank you to our audience members for putting such great questions in the chat, or I'm sorry, in the Q&A. Please continue to do so. During our live Q&As, we'll be going through there. And I want to say that we're going to have... Our next presentation will be after lunch.

Lunch will resume as soon as we are done here, and then we will resume at 1 p.m. Central Time. And we'll have Shannon Idzik, who is talking about the "Impact of Direct Patient Care Clinical Hours on NP Certification Pass Rates." Thank you so much.