An Incremental Regulatory Approach to Implementing the APRN Consensus Model

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In 2011, the North Dakota Board of Nursing (BON) became one of the first to implement the National Council of State Boards of Nursing's advanced practice registered nurse (APRN) Model Rules to become fully aligned with the APRN Consensus Model. The process was successful due to the collaborative efforts of the BON and the North Dakota Nurse Practitioner Association (NDNPA). This achievement consummated more than 2 decades of work by the BON and other stakeholders to allow APRNs to work to their full scope of practice. This article describes the legislative approach used by the BON and the NDNPA and provides recommendations for states considering similar action.

North Dakota has a small population (672,591) in a large area (69,000 square miles) (U.S. Census Bureau, 2010). The state is prosperous because of the diversity of farming, oil, and gas industries. North Dakota also boasts a balanced budget with a surplus. However, the rural areas remain underserved: 60.8% of the population (U.S. Census Bureau, 2010) resides in rural communities, and 74% of physicians reside in the cities of Bismarck, Fargo, Grand Forks, Mandan, and West Fargo. Only 26% of physicians are in rural areas (Hart, Klug, & Peterson, 2012), though 40% of APRNs practice in rural areas (North Dakota Board of Nursing Database, 2012). Nurses licensed in North Dakota include 11,533 registered nurses; 3,556 licensed practical nurses; 859 advanced practice registered nurses (APRNs), of whom 486 have prescriptive authority.

APRNs are providing health care across all spectrums and in all regions of North Dakota. Without the presence of APRNs, additional unmet health care needs would exist. Gaining independent practice for APRNs in North Dakota allows for additional advancements in the provision of accessible, high-quality health care. This article describes the legislative approach used to gain this independence for APRNs in North Dakota.

Influential National Reports

Since 2008, three national reports have contributed to the momentum for allowing APRNs to practice independently, and all three were influential during recent legislative proceedings concerning APRNs practicing independently in North Dakota.

First, representatives from key national nursing organizations began developing a document to address the preparation, practice, and regulation of APRNs. This work culminated in the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (National Council of State Boards of Nursing [NCSBN], 2008). Developed collaboratively by regulators, APRN certifiers, national nursing program accreditors, and representatives of APRN professional organizations, the model was endorsed by 48 professional organizations.

The Consensus Model indicates the nursing profession's agreement that education, accreditation, certification, and licensure of APRNs must be consistent from jurisdiction to jurisdiction to ensure patient safety while expanding access to care. The Consensus Model can be used as a guidepost to achieve consistency among states.

Following, in January 2010, the Josiah Macy Jr. Foundation convened a multidisciplinary conference to address complex issues related to primary care (Cronenwett & Dzau, 2010). Participants included nurses and physicians from diverse geographic areas throughout the United States and various sectors affected by the challenges related to primary care. Their conversations pivoted on national efforts to enhance quality, access, and reliability of health care while working to make health care available to several million uninsured and underinsured people. The Macy Foundation conference report recognized that APRNs have proven to be effective primary care providers and noted that "regulatory and reimbursement policy barriers often prevent efficient and effective use of their services" (Cronenwett & Dzau, 2010, p. 2).

Lastly, in October 2010, the Institute of Medicine published *The Future of Nursing* report, the result of a 2-year initiative launched by the Robert Wood Johnson Foundation (Robert Wood Johnson Foundation, 2010). The committee working on the report was charged with producing a document with recommendations "for an action-oriented blueprint for the future of nursing, including changes in public and institutional policies at the national, state, and local levels" (Institute of Medicine, 2010, p. 1). One key recommendation called for nurses, including APRNs, to function to the full capacity of their education and preparation.

FIGURE 1

Timeline of Major Legislative Events

1992	• Advanced practice registered nurses (APRNs) recognized for licensure in North Dakota
1996	• APRNs granted initial prescriptive authority
2003	• Opt-out requirement for physician supervision of certified registered nurse anesthetist practice granted • APRNs given power to authorize mobility-impaired parking permits for residents and provide medical certification of death
2008	• Joint rule related to expedited partner therapy
2009	• APRNs recognized as primary care practitioners for Medicaid patients
2011	• North Dakota Senate Bill (SB) 2148 passed • Consensus Model fully implemented in North Dakota

In North Dakota, the only impediment to full implementation of the Consensus Model was a statute requiring a collaborative affidavit for APRNs to prescribe legend drug and controlled substances. Initially granted in 1996, prescriptive authority for APRNs required physician collaboration and consultation between the Board of Medical Examiners (BME) and the board of nursing (BON). Moving from a dependent and collaborative prescriptive authority with a physician to independent practice required legislative and regulatory actions that involved the BON and APRNs across the state.

Period of Legislative and Regulatory Advances

In 1992, the groundwork for gaining independent practice for APRNs was laid when the North Dakota state legislature and the BON recognized APRNs for licensure. This foundation was essential for effective implementation of prescriptive authority initially granted in 1996. Figure 1 depicts a timeline of legislative achievements from 1992 to 2011.

Between 2003 and 2008, several other legislative actions set the tone for future initiatives. In 2003, when states were given the option, North Dakota requested an exemption from the Centers for Medicare & Medicaid Services (CMS) requirement for physician supervision of certified registered nurse anesthetists as providers of anesthesia services (Federal Register, 2001) in hospitals, critical access hospitals, and ambulatory surgical centers. A formal request was made to the CMS by the governor and was granted on October 14, 2003.

Later in 2003, rural hospitals, nursing homes, and city and county officials supported legislation allowing APRNs to complete medical certifications of death (North Dakota Century Code, 2009). This legislation was also successful.

Finally, in 2008 a groundbreaking collaborative effort among the BME, the Board of Pharmacy, and the BON led to a rule related to expedited partner therapy (North Dakota Administrative Code, 2008–2009). Having these three groups unite, collaborate, and support joint rule making was extraordinary. The legislation during this period gave APRNs, various nursing organizations, and stakeholders the opportunity to further educate the citizens about the ability of nurses to provide a variety of health care services.

During this period of legislative advances, APRNs identified certain barriers to their practice. For example, the Balanced Budget Act of 1997 gave states the authority to determine who would be recognized as primary care providers (PCPs) for Medicaid recipients. At that time, North Dakota did not include APRNs in their definition of PCPs. In 2008, a bill allowing APRNs to be recognized as PCPs for Medicaid patients was drafted and then adopted. The presence of APRNs in the state capital promoted the recognition of APRN roles and fostered relationships with legislators. All these driving forces facilitated the movement to enhance the scope of practice for APRNs.

Repealing Collaborative Prescriptive Authority

During the fall of 2010 and winter of 2011, the BON was in the middle of rule promulgation with the goal of adopting the Uniform APRN Model Rules (NCSBN, 2008). The model rules were utilized as a framework for all APRN regulation except the requirement regarding independent prescriptive authority. However, in a remarkable coincidence, a landmark piece of legislation was in review in the legislative assembly. In March 2011, North Dakota Senate Bill (SB) 2148, a bill initiated by NDNPA to allow for independent practice of APRNs in North Dakota, was passed by overwhelming margins. The adoption of this bill began the process of repealing the BON's administrative rule requiring APRNs to have a physician's signed affidavit attesting to collaboration for prescriptive authority. The BON as well as many other groups and organizations (including physicians, AARP, and North Dakota hospitals and hospital CEOs) supported this legislation.

Initiation and Adoption of Legislation SB 2148

The North Dakota Nurse Practitioner Association (NDNPA) was founded in 2006 from a statewide grassroots effort. The mission of NDNPA is to promote quality health care in North

Dakota through support, advocacy, leadership, and continued education of APRNs.

Before initiating the legislation SB 2148, NDNPA sought the approval of the BON. After the BON provided regulatory support, NDNPA began a massive statewide public education campaign. APRNs in all counties of the state were mobilized to articulate the position that the requirement for physician oversight of APRN prescribing was unnecessary and should be eliminated. APRNs informed their legislators at the local level about SB 2148.

Choosing the Right Legislator to Sponsor the Bill

Over the past decade, the North Dakota BME and the North Dakota Medical Association have opposed any legislation that expands the scope of practice for APRNs. In light of this continued opposition, NDNPA selected a bill sponsor who has a record of supporting health-related legislation and is a well-respected legislator known for her knowledge of health care issues. Furthermore, she encouraged APRNs to pursue legislation that would remove regulatory barriers to their practice. She collaborated with NDNPA to identify bill cosponsors and, through education and formal testimony, rallied her colleagues in both the Senate and the House to support the legislation.

Choosing a Respected Lobbyist

When determining who would be hired as a lobbyist, NDNPA interviewed a number of individuals. It was important to select a lobbyist who was well respected, knowledgeable on health care issues, and experienced in the legislature. The organization secured a retired attorney who had previously worked for the North Dakota BON as a special assistant attorney general. This lobbyist had vast experiences in governmental regulation, health law, and professional issues. He also had experience working on pharmaceutical, agriculture, and biotechnology matters. This connection was essential in forming alliances with legislators and other key stakeholders.

Building a Coalition

The core NDNPA legislative team was made up of four APRNs and the lobbyist. This group spent a great deal of time in the capital conversing with House and Senate legislators about the APRNs' role in the state, the challenges APRNs face because of regulatory barriers, and the advantages of supporting SB 2148. Much of the team's time was spent answering questions and sharing compelling arguments that conveyed the importance of passing SB 2148. In addition, NDNPA representatives communicated with APRN colleagues from areas where the requirement for a signed affidavit resulted in adverse effects, including barriers to practice and patient access to care. NDNPA representatives spoke with every legislator. Legislators from districts most affected by regulatory barriers were those from rural North Dakota. These legislators received additional education concerning the impact regulatory barriers were presenting to APRNs in their districts. In addition, the actual as well as potential negative impact these barriers were causing citizens of their districts were discussed. Most times, the APRN constituents from the legislator's district as well as individuals from the NDNPA committee met face to face with their legislator to discuss this issue and its impact on their community.

Key to the passage of SB 2148 was the fact that APRNs working the frontlines of patient care from all parts of the state were engaged in the process. Stories shared by APRNs provided a contextual reference for legislators. Some stories the APRNs shared are paraphrased in Table 1.

Using Relevant Data

At legislative hearings on the bill, the BON provided data on safe prescribing practices of APRNs in the state. The prescriptive authority committee minutes for the most recent 3 years, which were shared with legislators, did not contain a single practice issue. Furthermore, the BON testimony described the scarcity of disciplinary issues at the state and national levels related to APRNs and prescriptive authority (Pearson, 2009).

Testimony in the Assembly

In 2011, the bill was heard in the assembly. Testimony was prepared and delivered by four APRNs and representatives from the BON. The APRNs addressed the introduction of the APRN role, the NDNPA organization, barriers to care, the *Future of Nursing* and other national reports, APRN educational preparation, professional research demonstrating the quality of care provided by APRNs, access to care and rural health care issues, and a summary of support from health care facilities, state and national organizations, and many physicians. The BON representative testified regarding the safe prescriptive practice of APRNs in the state. Three other supporters of the bill testified: a House Representative, who is a nurse practitioner, and two physicians, who had served as collaborating physicians to APRNs.

Testimony was first heard in the Senate Human Services committee. With committee support, the bill was heard on the Senate floor and passed with a 33–11 vote. Subsequently, the bill was heard in the House Human Services committee. With a committee "do-pass" recommendation, the legislation was heard on the House floor, and it passed in the House with a vote of 85–7. The legislation was signed by the governor and became effective August 1, 2011.

Communication

Communication with APRNs with prescriptive authority was an essential duty of the BON upon implementation of the new law. To spread the word, the BON used the following:

- An e-newsletter blast was sent from the BON to all APRNs who held prescriptive authority.

TABLE 1

Exemplars of APRN Practice in North Dakota

To provide a contextual reference for legislators, some advanced practice registered nurses (APRNs) described their experiences. This table offers a few examples and their implications.

Issue	Experience	Implication
Regulatory barrier	APRNs in several communities regularly found themselves with no local physician to serve as their collaborator. Therefore, they often had to find collaborators hundreds of miles away and, in more than one instance, several states away to fulfill this regulatory requirement.	Regulation requiring an affidavit is a formality that does not contribute to improved patient care. In fact, this regulation was an obstacle to access to and delivery of health care.
Rural environment	One weekend, a rural facility would have been uncovered if an APRN had not agreed to take call. Over the weekend, a patient in heart failure presented to the emergency department. As the sole provider for the community, the APRN admitted and stabilized the patient and sought a cardiology consult for additional treatment. Regulatory barriers that required a physician signature for consultation hindered patient care.	Patient care does not call for APRNs to consult a provider named on a piece of paper on file with a board of nursing (BON). Best practices call for all health care providers to consult the appropriate professional at the time the patient needs treatment. The requirement of a signed affidavit on file in the BON does not ensure effective consultation.
Access	During a hot summer day, a woman, age 54, presented with severe respiratory distress and abdominal pain. She had no previous relationship with the clinic; therefore, no medical records were available. Her status was significantly compromised (e.g., her blood pressure was 60/40 mm Hg). The APRN covering the rural health clinic implemented lifesaving measures.	Without access to the APRN's care and quick response, the woman may have died of anaphylactic shock. APRNs working to their full scope of practice improve health care.

- All legislative changes, which included the APRN prescriptive practice changes, were highlighted on the BON website.
- The legislative changes were underscored by the BON in the *Dakota Nurse Connection* print newsletter.

Recommendations

Many states are making efforts to fully implement the APRN Consensus Model. Despite the various challenges each will encounter, these recommendations may promote success:

- **Be patient.** To ensure the standardization of APRN regulation, incremental change in the law and rules may be necessary. Patience, resilience, and commitment to the cause are required for success.
- **Promote and maintain transparency.** BONs must examine their laws and regulations to determine which changes must be made to move toward the goal of the APRN Consensus Model. Professional organizations must be open and must educate all stakeholders about the intent and purpose of legislative changes. A fundamental strategy in health policy is to meet with adversaries and key stakeholders throughout the legislative process.
- **Create partnerships.** Collaborative efforts with professional organizations are essential. When professional organizations seek support for proposed legislation, BONs can support their efforts by providing information and offering testimony.
- **Form alliances.** BONs and professional nursing organizations must be actively involved in the campaign for the APRN Consensus Model and be familiar with the APRN associations in their state. BON members have a distinct perspective on APRN practice, and they can interpret statutory authority relating to scope of practice. Alliances between BONs and professional nursing organizations could promote legislative agendas by increasing APRN visibility.
- **Cultivate relationships.** Be mindful of the importance of respect for opposing points of view. Develop relationships with both proponents and opponents.
- **Focus the message.** The message must be clear and consistent in formal and informal communications among BONs, APRNs, professional organizations, and legislators. Employ a respected lobbyist to refine the message and its delivery.

Summary

The success of legislative efforts related to APRN regulation in North Dakota was multifactorial. Mobilization of the state APRN association with the support of the BON initiated the work. Strategic planning, clear communication, a positive outlook, informed stakeholders, public education, and professional commitment contributed to the intended result.

APRNs are encouraged to accept the challenge of engaging in public policy. With the support of state BONs, APRNs

can become change agents. Professional associations and BONs can work together to promote the high-quality patient care provided by APRNs and ensure the implementation of the APRN Consensus Model.

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