A Primer on Advanced Practice Registered Nurse (APRN) Practice

Who are APRNs?	What do APRNs do?
Nurse Practitioners (NPs)	Take health histories; conduct physical exams; diagnose and treat acute and chronic illnesses; provide immunizations, health education, and counseling; prescribe and manage medications and therapies; order and interpret diagnostic tests. *Settings: outpatient practices, health centers, retail clinics, schools, hospitals, homes.*
Clinical Nurse Specialists (CNSs)	Serve as expert clinicians, consultants, researchers, and educators; address health system issues to improve quality and safety. *Settings: health systems, hospitals, other clinical sites.*
Certified Registered Nurse Anesthetists (CRNAs)	Administer anesthesia and related care for surgical, therapeutic, diagnostic, and obstetrical procedures; provide pain management. *Settings: hospitals, outpatient surgical centers, dental offices.*
Certified Nurse-Midwives (CNMs)	Provide primary care; gynecological exams; family planning services; management of low-risk labor and delivery; prenatal, neonatal, and postpartum care. *Settings: hospitals, birth centers, community health centers, homes.*

Sources: Adapted from Institute of Medicine, *Future of Nursing: Leading Change, Advancing Health* (2010); APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee, *APRN Consensus Model* (2008)
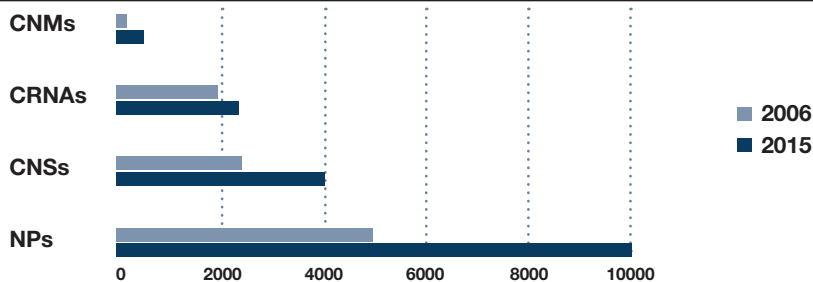
How many are there?

By Role

NPs	222,000
CNSs	69,000*
CRNAs	48,000
CNMs	11,000

Sources: American Association of Nurse Practitioners (2016), National Association of Clinical Nurse Specialists (2015), National Board of Certification and Recertification of Nurse Anesthetists (2016), American Midwifery Certification Board (2015)

*NACNS estimate of RNs who have the education and credentials to practice as a clinical nurse specialist

Graduation Trends – A Growing Workforce

Sources: American Midwifery Certification Board, National Board of Certification and Recertification of Nurse Anesthetists, American Association of Colleges of Nursing, National Organization of Nurse Practitioner Faculties

How do nurses prepare for advanced practice?

Undergraduate education	Earn a baccalaureate nursing degree.
Licensure	Obtain and maintain licensure as a registered nurse. Achieved by graduating from a nursing program approved by a state board of nursing, passing a national standardized exam (NCLEX-RN), and meeting additional state board of nursing requirements.
Graduate education	Earn a master's degree or practice doctorate from an accredited program, with advanced course work and clinical education in physical/health assessment, pharmacology, pathophysiology, and the topics below.

	NPs	CNSs	CRNAs	CNMs
	Health promotion, disease prevention, disease management; topics related to the population served.	Topics related to the population served and within the CNS spheres of influence: patient/client care, nursing practice, and health care organization.	Anesthesia. Note: CRNA students must complete at least one year of critical care nursing prior to enrolling.	Midwifery, care of newborns, primary and reproductive health care for women, and treatment of sexually transmitted diseases in male partners.
Graduate-level clinical training	A minimum of 500 faculty-supervised clinical hours (1,000 recommended for a practice doctorate).	A minimum of 500 faculty-supervised clinical hours (1,000 for a practice doctorate).	A minimum of 2,000 hours and 600 cases across designated categories.	As many hours as needed to attain core competencies.
Certification	National standardized exam linked to APRN role and population served. (Certification exams exist for some, but not all, CNS specialties.)			
Post-certification professional development	Clinical practice and continuing education hours required for periodic recertification. Specific requirements vary by role, population focus, specialty, and credentialing body and, in some cases, include reexamination.			

Sources: American Association of Colleges of Nursing, National Association of Clinical Nurse Specialists, National Board of Certification and Recertification of Nurse Anesthetists, Accrediting Commission for Midwifery, National Task Force on Quality Nurse Practitioner Education, Council on Accreditation

The Case for Removing Barriers to APRN Practice

In 2010 the Institute of Medicine issued a report, *The Future of Nursing: Leading Change, Advancing Health,* that called for the removal of laws, regulations, and policies that prevent advanced practice registered nurses (APRNs) from providing the full scope of health care services they are educated, trained, and, in most cases, professionally certified to provide. Since then, several states have lifted restrictions on APRN practice, but work remains to be done.

Barriers to APRN Practice

State practice acts, institutional rules, and federal statutes and regulations from the Centers for Medicare and Medicaid Services (CMS) prevent APRNs from practicing to the full extent of their education and training. These barriers reduce access to care, create disruptions in care, increase the cost of care, and undermine efforts to improve the quality of care.

Recent Breakthroughs

- Since 2010 eight states have granted nurse practitioners (NPs) full practice authority (i.e. the ability to practice to the full extent of their education, training, and certification).

- As of March 1, 2017, 21 states and the District of Columbia allow NPs full practice authority. At least 12 states are considering legislation to remove practice barriers for one or more APRN roles.

- The National Council of State Boards of Nursing provides model legislation based on the APRN Consensus Model to facilitate this process.

- The Department of Veterans Affairs (VA) issued a final rule at the end of 2016 that grants APRNs in three of the four roles (NP, certified nurse-midwife, and clinical nurse specialist) full practice authority.

- The Federal Trade Commission, National Governors Association, AARP, American Enterprise Institute, American Hospital Association, Robert Wood Johnson Foundation, The Heritage Foundation, and others have endorsed removing APRN practice barriers.

What Policymakers Need to Know

Opponents of full practice authority say it would allow APRNs to practice medicine without supervision despite having received far fewer hours of formal education than physicians receive.

APRNs practice nursing, not medicine. They are appropriately educated to provide the scope of services for which they are licensed and certified, and a growing body of research suggests that full practice authority for APRNs reduces costs and increases access to high-quality care.

Opponents of full prescriptive authority for APRNs say that involving physicians in APRN prescribing protects patients.

No state requires APRNs to consult with a physician before writing prescriptions for individual patients.

Opponents of full prescriptive authority for APRNs say it would put patients at risk for drug addiction.

A recent analysis of a study by the Centers for Disease Control and Prevention found that "states with independent APRN prescribing laws prescribed significantly fewer opioid [sic] and benzodiazepines," two classes of drugs linked to painkiller overdose deaths.

Proponents of mandatory collaborative practice agreements (CPAs) say they encourage APRNS to engage in team-based care and ensure that APRNs are supervised by more knowledgeable physicians.

CPAs neither mandate nor encourage APRNs and physicians to collaborate in individual patient care. In some states, any physician—regardless of specialty or knowledge of an APRN's practice area—may be eligible to enter into a CPA. At rural hospitals with no anesthesiologists on staff, for example, a certified registered nurse anesthetist might have a CPA with a surgeon. In at least one case, an NP providing primary care had to enter into a CPA with a pathologist—the only willing physician in her geographic area—to avoid disrupting her patients' care.

Andy Cross/The Denver Post via Getty Images

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