

# Scope of Practice FAQs for Consumers

## Advanced Practice Registered Nurses (APRNs)

### 1. Who are advanced practice registered nurses (APRNs) and what do they do?

Advanced practice registered nurses (APRNs) are registered nurses (RNs), who receive additional education, in the form of master's degree or higher, within one of four advanced practice nursing roles. The four roles are: nurse practitioners, nurse anesthetists, nurse-midwives, and clinical nurse specialists. **Nurse practitioners** serve as primary, and in some cases, specialty care providers, diagnosing and treating variety of illnesses. **Nurse anesthetists** work primarily in hospitals and health care institutions, and provide care and advice related to the delivery of anesthesia before, during and after surgical, diagnostic, therapeutic and obstetrical procedures. **Nurse midwives** provide primary care with a focus on women's health services, including family planning, gynecological exams, prenatal care, labor and delivery, and newborn care. **Clinical nurse specialists** provide patient care and expert advice in one of several nursing practice specialties related to setting (e.g., critical care), population (e.g., pediatrics or women's health), type of care (e.g., psychiatric or rehabilitation), disease or medical subspecialty (e.g., diabetes or oncology), or other types of medical problems (such as pain or wounds).

### 2. How are APRNs regulated?

APRNs are regulated primarily by State Boards of Nursing. They must first be licensed as RNs after completing an appropriate program of study and passing a national exam, among other requirements. Then they must obtain a master's (or doctorate) degree within one of the APRN roles and can then apply for state licensure as APRNs. Additional regulations, such as extra exams and professional experience requirements, vary depending on state and specialty.

### 3. What are the scope of practice issues around APRNs?

The APRN profession encompasses a wide variety of advanced nursing specialties; hence a wide variety of scope of practice issues is associated with this profession. However, the main scope of practice issue across all APRN specialties is *independent practice*. This means enabling APRNs to provide direct patient care services without supervision by or forced collaboration with physicians, whether the services are provided in a hospital, a private office, a clinic, an outpatient center, or a patient's home. All APRNs collaborate, consult with, or refer to physicians. Many APRNs practice in health care teams with physicians and other types of health care providers. The issue is whether specific legal requirements for physician involvement limit the services APRNs can provide and areas where they can practice, thereby making it more difficult for consumers to access a full range of care from these providers.

### 4. How are APRNs trained?

APRNs undergo an RN educational program, which includes courses in life sciences, physical sciences, clinical sciences, quality improvement mechanisms, organizational structure and leadership principles, evidence-based practice, and health information technology, along with a professional clinical experience component caring for patients in a hospital and community settings. Following licensure as an RN, these professionals become eligible to pursue a master's or doctorate degree in their chosen specialty area. A minimum of a master's degree is required to be licensed as an advanced practice registered nurse. While graduate degrees in advanced practice nursing vary

widely depending on the specialty area, all APRN master's degree programs share basic core curriculum requirements, which include coursework in health promotion and disease prevention, physiology and pathophysiology, health assessment, pharmacology, foundations of nursing practice, research, professional ethics, policy, finance and organization of health care delivery, and diversity and social issues, along with additional courses focused on the selected area of practice. All APRN programs also require that students successfully complete professional clinical experience in performance of direct patient care in the role the individual has selected.

**5. What evidence is there to demonstrate the ability of APRNs to deliver safe, effective, quality care?**

APRNs have amassed an abundant evidence base that supports the removal of unnecessary restrictions on scope of practice. Multiple studies and meta-analysis reviews (studies that summarize and evaluate findings from a collection of other studies) have found that APRNs provide care that is comparable or equivalent in quality to the care provided by physicians. In addition studies have shown that APRNs have high patient satisfaction, in some cases higher than for physicians. NPs have been shown to spend more time with patients, order more tests, and be more likely to schedule follow-up visits than primary care physicians. A recent Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, prepared by the Committee on the RWJF Initiative on the Future of Nursing contains a review of a variety of evidence, including studies, reports, publications related to legislative activity, data from the Nursing Research Network, case-studies, and expert opinion from diverse group of highly regarded authorities on different aspects of health care delivery. The Committee's first primary recommendation is that both federal and state governments should remove scope of practice barriers that prevent APRNs from practicing to the full extent of their education and training.

**6. Which states allow APRNs to independently deliver a broad range of services?**

The scope of practice for APRNs varies widely by state and specialty. For example, in the case of nurse practitioners (NPs), the most numerous of APRN roles, 22 states and DC allow NPs to diagnose and treat without physician involvement: (AK, AZ, CO, HI, ID, IA, KY, ME, MI, MT, NH, NJ, NM, ND, OK, OR, TN, UT, WA, WV, and WY. In contrast, 24 states require a formal *relationship*, documented in writing, between an NP and a physician: (AL, AR, CA, DE, FL, GA, IL, KS, LA, MD, MA, MS, MO, NE, NV, NY, NC, OH, SC, SD, TX, VT, VA, and WI.) This *relationship* requirement varies from state to state and could call for supervision, delegation, authorization, or more general direction and collaboration. The remaining 4 states also require some form of *relationship* between NPs and physicians, but do not require documentation of such relationship: CT, IN, MN, and PA. When it comes to prescriptive authority, only 13 of the 23 jurisdictions that allow autonomous practice by NPs allow them to prescribe medications for diagnosis and treatment without the involvement of a physician: AK, AZ, DC, ID, IA, ME, MT, NH, NM, OR, RI, WA, and WY. The remaining 38 states all require documented physician involvement for NPs to be able to prescribe medications.

In the case of certified nurse-midwives, 18 jurisdictions allow CNMs to diagnose and treat without requiring physician supervision or formal collaborative agreements; other states vary as to requirements for physician involvement. All states confer prescriptive authority to CNMs, although 11 require physician involvement.

For certified registered nurse anesthetists (CRNA) the ability to provide anesthesia in hospitals and outpatient settings without supervision is controlled by both state and federal regulations. State regulations have to allow CRNAs to practice in hospitals and outpatient settings without supervision from physicians, and the state must also opt out of federal Medicare requirements for physician

supervision (otherwise hospitals will not be reimbursed for CRNAs' services). Currently, 16 states have state laws that do not require CRNAs to be supervised and have opted out of the federal supervision requirements; other states either do not allow CRNAs to practice without supervision by a physician or have not opted out of the federal Medicare requirement for physician supervision of CRNAs.

The clinical nurse specialist role includes a wide variety of clinical specialties in nursing. Depending on the specific specialty, APRNs in this role practice in different settings, under different conditions, and with different types of expertise. Thus, the states do not generally have a unified scope of practice for this group, but rather determine the scope separately for each specialty or group of specialties through a combination of legislation and regulations.

- For information on state regulations of nurse midwives including scope of practice see American College of Nurse Midwives *State Legislative and Regulatory Developments & State Fact Sheets* at [http://www.midwife.org/state\\_legislation.cfm](http://www.midwife.org/state_legislation.cfm).
- For information on state regulations of nurse anesthetists, including scope of practice and opt-outs from federal supervision requirements see American Association of Nurse Anesthetists (AANA) *State Issues* at <http://www.aana.com/Advocacy.aspx?id=131&linkidentifier=id&itemid=131>.
- For information on state regulations of clinical nurse specialists contact the National Association of Clinical Nurse Specialists (NACNS)

## **7. How do APRNs collaborate with physicians in their work?**

All APRNs collaborate with physicians, share information, and coordinate care as fellow members of a health care team. Nurse anesthetists collaborate with surgeons, the primary care and specialty physicians who diagnose patients and refer them to surgery or other procedures requiring administration anesthesiology, and other members of the health care team present during the procedure. Nurse practitioners collaborate with primary and specialty care physicians to gather information about a patient's medical history, consult regarding course of treatment, and refer for additional evaluation and treatment. Nurse midwives collaborate with obstetricians, including consultation and referrals for cases that present a high risk of serious complications during the delivery. Clinical nurse specialists regularly collaborate with physicians both within their specialty and those in other specialties, as relevant to the care of each patient. This collaboration happens as a prudent and necessary part of delivering care to patients. However, some states require APRNs to enter into *collaborative practice agreements* with physicians. In such cases the care that can be delivered by an APRN is limited by what the physician who signs the agreement is willing to accept. The *collaborative practice agreement* specifies who the APRN must collaborate with and how. In some states, physicians are required, as part of this relationship, to oversee certain services and review the APRN's patient charts. Some states limit the number of APRNs with whom a physician can officially collaborate.

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