

# POSITIONING ADVANCED PRACTICE REGISTERED NURSES FOR HEALTH CARE REFORM: CONSENSUS ON APRN REGULATION

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Advanced practice registered nurses (APRNs) have positioned themselves to serve an integral role in national health care reform. This article addresses both the policy and the process to develop this policy that has placed them in a strategic position. A successful transformation of the nation's health system will require utilization of all clinicians, particularly primary care providers, to the full extent of their education and scope of practice. APRNs are highly qualified clinicians who provide cost-effective, accessible, patient-centered care and have the education to provide the range of services at the heart of the reform movement, including care coordination, chronic care management, and wellness and preventive care. The APRN community faces many challenges amidst the opportunities of health reform. However, the APRN community's triumph in reaching consensus on APRN regulation signifies a cohesive approach to overcoming the obstacles. The consensus model for APRN regulation, endorsed by 44 national nursing organizations, will serve as a beacon for nursing, as well as a guidepost for consumers and policymakers, on titling, education, certification, accreditation, and licensing for all four APRN roles. (Index words: Advanced practice registered nurses; Health care reform; Policy) *J Prof Nurs* 25:340–348, 2009. © 2009 Elsevier Inc. All rights reserved.

Our nation's health care providers—physicians, nurses, hospitals, and others—work hard to provide lifesaving and life-improving care to millions of Americans. The level of care provided is often excellent, but it has become increasingly evident that the way care is delivered and paid for in our health system does not always encourage the right care at the right time for each and every patient. (Baucus, 2008)

**T**HE RELEASE OF Senator Max Baucus' November 12, 2008, white paper on health care reform accelerated the national movement toward reform and

amplified the calls for substantive change. Most stakeholders agree that meaningful reform must address some fundamental challenges facing the nation's health care delivery system, including the lack of access to care, increasing costs, and the need to improve care quality. Change of this magnitude will require multiple approaches as well as the utilization of all qualified health care providers to the full extent of their education and scope of practice. For reform to be effective, nurses, particularly advanced practice registered nurses (APRNs), must be a significant part of the solution.

The drive to reform health care has significant implications for APRN nursing education and practice while also presenting a range of new opportunities, particularly in the area of primary care. As the largest group of health care providers, nurses are arguably in the best position to realize the goals of health care reform, which include enhancing access to affordable care, providing patient-centered care, focusing on wellness and prevention, improving quality and outcomes of care, emphasizing chronic illness management, assisting

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patients in making informed choices, and improving care coordination. Fortunately, many policy makers are increasingly aware of the potential contribution that nurses can make in achieving these goals.

The APRN regulatory community, including educators, certifiers, accreditors, and licensing bodies, has reached a milestone that provides a unified and stronger platform from which APRNs can argue they should be included in health care reform decisions and solutions. This article addresses both the policy and the processes to develop this policy that have placed APRNs in this strategic position. For the past 6 years, representatives of national APRN organizations have met, discussed, debated, and finally reached agreement around a consensus model for APRN regulation. This model establishes guidelines for titling, education, certification, accreditation, and licensing for the four APRN roles—certified registered nurse anesthetists (CRNAs), certified nurse–midwives (CNMs), clinical nurse specialists (CNSs), and certified nurse practitioners (CNPs). In addition to nationally recognized standards for APRN regulation, the consensus model clarifies the role and scope of APRNs, which will help policy makers and consumers understand the central role these providers must play in any reformed health care system.

### The Role of APRNs in Health Care Reform

Multiple challenges and opportunities face the APRN community related to health care reform, including preparing nurses in sufficient numbers to meet workforce needs, educating APRNs with the knowledge and skills needed to practice in a very different health care system, and preparing APRNs to provide care to an increasingly diverse and older population. According to workforce projections, it is estimated that more than 150,000 additional physicians will be needed in the next 10–15 years to meet the goal of providing health care access to all U.S. citizens (Association of American Medical Colleges, 2009). The projection is for this shortage to be particularly acute for physicians prepared to provide primary care services. This concern is highlighted by the fact that only 2% of all new physicians opted for primary care or general medicine residencies in 2008 (Hauer et al., 2008). In addition, the number of older adults will outstrip the number of providers prepared to address the special needs of this growing population. By 2030, 20% of the population will be more than 65 years old, and at least 75% of those older than 65 years will have at least one chronic illness (He, Sengupta, Velkoff, & DeBarros, 2005).

To meet the nation's need for primary care providers, APRNs are increasingly used to fill this gap while maintaining quality care and often lowering health care costs. According to the 2004 *National Sample Survey of Registered Nurses* (U.S. Department of Health and Human Services, Health Resources and Services Administration [U.S. DHHS], 2006), 240,460 registered nurses are prepared as APRNs, an increase of 22.5% from 2000.

However, this number may be much higher because APRNs are invisible in many venues since they frequently bill under a physician's name and are not counted separately in federal databases. According to the American Association of Colleges of Nursing (AACN) data, the number of APRNs graduated between 2004 and 2008 was 27,035 (AACN, 2009), which brings the total population closer to at least 270,000.

A critical challenge for those advocating reform will be producing an increased number of APRNs to provide health care services to the growing number of uninsured and underinsured, to an increasingly diverse population, and to a rapidly aging citizenry. The 2008–2009 enrollments and graduations for CNPs (both master's and postmaster's certificate programs) are shown in Table 1. The number of graduates in those areas traditionally designated as primary care (family, adult, pediatric, gerontology, and women's health CNPs) totaled 6,297 (Fang, Tracy, & Bednash, 2009), an increase of 537 graduates over last year's figures. To close a potential gap of 100,000 to 200,000 primary care providers by 2025, more federal funding must be directed toward expanding the number of students in APRN programs.

Current and predicted faculty shortages also pose a serious barrier to increasing the number of APRNs. In 2008, only 916 nurses graduated with doctoral degrees in nursing; up from 653 in the previous year. This includes both research-focused (555, up from 531 in 2007) and Doctor of Nursing Practice program graduates (122 up from 36 in 2007). An additional 15,182 individuals graduated from master's degree programs in 2008 (Fang et al., 2009).

Insufficient numbers of faculty, clinical sites, and clinical preceptors were listed among the top reasons for not accepting all qualified applications in nursing education programs (Fang et al., 2009). AACN also reported that a total of 814 faculty positions were vacant at 449 nursing schools with baccalaureate and graduate programs during the 2006–2007 academic year (AACN, 2008). Critical issues faced by schools for faculty recruitment and retention included a limited pool of doctorally prepared faculty, lack of qualified applicants, and noncompetitive salaries. For the APRN population to expand, attention must be on overcoming the diminishing supply of nurse faculty.

Although meeting these workforce challenges will take a sustained, collaborative effort, reaching consensus around APRN regulation—encompassing licensure, accreditation, certification and education—has placed the APRN community in a much better position to surmount these obstacles.

### Reaching Consensus on APRN Regulation

The impetus to develop consensus around APRN regulation grew from concerns among nursing organizations about misunderstandings and inconsistencies across the four advanced practice registered nursing roles. State boards of nursing reported a variety of

**Table I.** Master's and Post Master's Nurse Practitioners (NP) Enrollments and Graduations 2008–2009 (source: Fang et al., 2009)

Clinical track/national certification examination	Master's		Post Master's	
	Enrollments	Graduations	Enrollments	Graduations
Family NP	16,680	4,090	1,063	361
Adult NP	4,281	1,171	331	116
Pediatric NP	1,883	634	69	31
Pediatric acute NP	160	46	35	47
Gerontological NP	451	137	52	30
Women's health NP	1,065	265	22	29
Neonatal NP	607	183	34	19
Adult acute care NP	2,389	606	103	40
Adult psychiatric–mental health NP	662	202	159	74
Family psychiatric–mental health NP	312	107	96	45
Other NP	59	7	4	1
NP dual tracks	768	187	47	12
Undeclared area of study	95	0		
Total	29,412	7,635	2,015	805

regulatory concerns related to educational preparation and certification requirements for applicants seeking state recognition to practice as APRNs and had established differing requirements for licensure across states. Certification bodies described significant variances among education programs and had diverse certification and recertification requirements. Education organizations recognized the need for increased consistency in preparation and titling across programs and the need for increased accountability of programs through nursing accreditation.

At various points during the mid-1990s to 2003, organizations made individual and collaborative efforts to address these issues. Some positive outcomes of these efforts were the development of the *Criteria for Evaluation of Nurse Practitioner Programs* as the national standard for nurse practitioner programs (National Task Force on Quality Nurse Practitioner Education, 2002), core competencies for master's degree programs (AACN, 1996), core CNP competencies (National Organization of Nurse Practitioner Faculties [NONPF], 1995, 2000, 2002, 2006), and national consensus-based CNP specialty competencies (National Panel for Acute Care Nurse Practitioner Competencies, 2004; National Panel for Psychiatric-Mental Health CNP Competencies, 2003; U.S. DHHS, 2002). APRN certification organizations, in collaboration with the National Council of State Boards of Nursing (NCSBN), established criteria and processes for certification programs that would result in legally defensible and psychometrically sound examinations that could be used for regulation of APRNs. In addition, the formation of networking groups such as the Alliance for APRN Credentialing and the annual APRN Roundtable hosted by NCSBN provided stakeholder organizations with venues to address mutual policy and process issues. Yet the work continued primarily within silos and did not yield a broad recognition and understanding of APRN regulation and the critical connections between the four roles and regulatory entities: licensure, accreditation, certification, and education.

In 2004, the NONPF and the AACN expressed concerns regarding the lack of common definitions for the APRN roles and varying interpretations of specialization, subspecialization, and credentialing. AACN and NONPF concurred on the need for some broad agreement on these topics, and the two organizations jointly submitted a proposal to the Alliance for APRN Credentialing (the Alliance) to establish a process to develop a consensus statement on the definition, titling, and credentialing of APRNs.

The Alliance, created in 1997, was originally convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. The Alliance membership consists of organizations that accredit APRN programs, certify APRNs, and develop APRN educational standards. This group agreed to convene a consensus process and invited 50 organizations, identified as having an interest in advanced practice nursing. The first APRN Consensus Conference was held June 2004 and included representatives of 32 organizations connected to APRN practice, education, certification, licensure, or accreditation and provided a bellwether opportunity for an in-depth examination of issues related to APRN definition, specialization, subspecialization, and regulation.

As an outcome of this first consensus conference, the Alliance formed a work group composed of representatives from 23 organizations and issued a charge to develop a consensus statement that addresses the issues identified with the goal of envisioning a future model for regulation. As the APRN Consensus Work Group was beginning its work, the American Nurses Association (ANA), in collaboration with AACN, convened a second stakeholders' meeting in December 2004. The meeting reinforced the charge to the APRN Consensus Work Group and resulted in expansion of the work group representation. In addition, participation in the larger consensus group grew to more than 60 organizations that self-identified as having a stake in this national APRN consensus process. The ANA and AACN

reconvened this larger APRN stakeholder consensus group several times throughout the 5-year consensus building process to share and receive feedback on recommendations as they evolved.

### **A New Model Emerges**

In fall 2004, the APRN Consensus Work Group (the Work Group) began its activities. AACN, as coordinator of the process, enlisted Jean Johnson, PhD, RN, FAAN, Senior Associate Dean of Health Sciences at George Washington School of Medicine and Health Sciences, to serve as facilitator of the Work Group. Dr. Johnson is a CNP and academic administrator nationally recognized for her policy work. Originally envisioned as a 6- to 12-month project, Dr. Johnson maintained the role of facilitator for the APRN Consensus Work Group from 2004 through completion of the Consensus Report in July 2008.

The Work Group met regularly and frequently, in-person and through conference calls, between 2004 and 2007. The initial meetings focused primarily on sharing information, developing a common understanding of the four roles and regulatory issues, and building trust among the Work Group members. Information and issues placed on the table for discussion frequently were sensitive and impacted the mission and lifeblood of individual organizations; however, consensus slowly emerged. By late 2006, the Work Group had developed detailed recommendations for the definition of APRN and the individual roles, criteria for APRN recognition, definitions of specialty and subspecialty, and principles for the four prongs of regulation (licensure, accreditation, certification, and education).

During this same time that the APRN Consensus Work Group was having its discussions, the NCSBN APRN Advisory Panel (now the APRN Committee) was drafting a vision paper in an attempt to resolve many of these same APRN regulatory concerns. In early 2006, the NCSBN released the APRN Vision Paper, "The Future Regulation of Advanced Practice Registered Nurses." The paper and its eight recommendations stimulated a wide range of reactions across the nursing community and generated significant feedback to the Committee.

The APRN Consensus Work Group, which included an NCSBN representative, reviewed the NCSBN Vision Paper as part of its ongoing work. This review led to discussions regarding the implications of having two disparate statements and sets of recommendations on the future of APRN regulation. The APRN Consensus Work Group also began to consider new models for APRN regulation, which included regulation at the level of role preparation and population focus (e.g., adult, children, gender, across the lifespan). In June 2006, in an effort to reconcile the two national sets of recommendations, the larger APRN Consensus Group and the NCSBN APRN Committee agreed to join in a unified, national consensus process in the interest of advancing complementary recommendations in each group's final report. Following this mutual invitation and a joint meeting, the Work

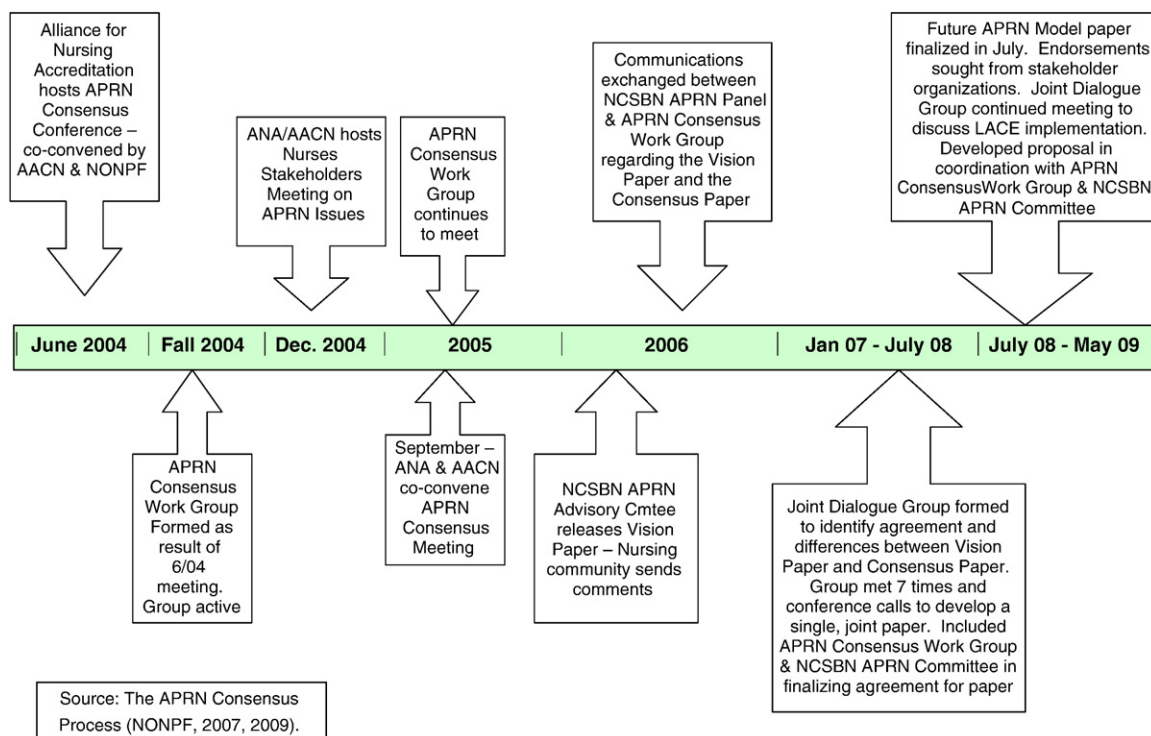
Group and the NCSBN APRN Committee agreed to create the Joint Dialogue Group, which included representation from the four APRN roles, education, accreditation, certification, and state boards of nursing, to serve on behalf of the two groups as a forum for dialogue and development of consensus recommendations around APRN regulation.

In the first quarter of 2007, the Joint Dialogue Group met frequently to contrast the two papers and identify areas of commonality and differences. As the work progressed, however, the Joint Dialogue Group concluded that a single paper from the collective work of both groups would be feasible and would have a greater impact on APRN regulation. The Joint Dialogue Group proceeded over the remainder of 2007 and into 2008 to blend the papers and to resolve areas of disagreement in an attempt to reach consensus around one model for the future regulation of APRNs. During this period, some of the most significant and difficult issues emerged, including defining the level of regulation for all APRNs and establishing criteria and congruence among all four roles regarding educational preparation. As the group agreed to regulation occurring at the level of role and population preparation, discussions ensued regarding the identification and definition of the population foci. The group also addressed differences and overlap in CNP preparation with either a primary care or acute care focus. By July 2008, these intense discussions within the Joint Dialogue Group, and subsequently with the Work Group and the APRN Committee, ultimately led to agreement around a new regulatory model and a diagram depicting this new model.

Since July 2008, the Joint Dialogue Group has continued to meet to consider a process and develop recommendations for implementation of the regulatory model. In consultation with Dr. Michael Bleich, Dean of the Oregon Health & Science University School of Nursing, the group crafted recommendations for the development of an ongoing Licensure, Accreditation, Certification, and Education (LACE) network to facilitate the implementation of the model. By June 2009, 44 national organizations had endorsed the model and are currently working to advance the recommendations contained in the consensus document and plans for implementation of LACE (see [Figure 1](#) for the timeline of the APRN consensus process).

### **Coming to Agreement**

Defining and reaching consensus were significant challenges throughout the process. Definitions for *consensus* do not provide clarity when they include both "unanimity" and "general agreement" in the same description. The Work Group recognized that unanimous agreement may be ideal but unrealistic when developing a paper addressing multiple issues and with so many participants. Instead, the Work Group decided to recognize consensus as two-thirds agreement on any issue, and this agreement was carried over into the work of the Joint Dialogue Group. Both groups also agreed that the final paper



**Figure 1.** Timeline of consensus discussions on APRN regulation (NONPF, 2007, 2009). Used with permission from NONPF.

should include only those areas where consensus was reached. Participants in the process found it difficult at times to move beyond a unanimous consent model, which perhaps reflected nursing's tradition of inclusion. Consequently, topics frequently would resurface for discussion after the group had previously reached a decision. In addition, as consensus materialized on one issue, questions regarding the impact on previous decisions or not previously considered would arise. The revisiting of topics allowed not only for different thinking by organizational representatives but also time for in-depth processing of issues and for new information to emerge, which informed decisions.

The consensus decisions reflected in the final paper represent the votes of the Joint Dialogue Group, Work Group, and Advisory Committee; however, the consensus-building process provided numerous opportunities and mechanisms for the larger stakeholder community to weigh in on issues and recommendations. As noted previously, ANA and AACN convened the larger stakeholder group a number of times between 2004 and 2008. The frequent reporting back to this stakeholder group, as well as in other venues, for example, Alliance and APRN Roundtable meetings, elicited feedback and comments considered in the consensus process. In addition, the Joint Dialogue Group and the Work Group invited targeted stakeholders to participate in discussions focused on topics specific to their constituencies to ensure adequate representation on key issues. Although not all stakeholder groups had direct representation in either the APRN Work Group or the Joint Dialogue Group, all have had opportunities to shape the process and the final consensus report. In July 2008, the

final report was disseminated to the larger stakeholder community (see <http://www.aacn.nche.edu/education/pdf/APRNReport.pdf>).

The focus for all stakeholders participating in this process and producing the final report remained true to the goals of the consensus process:

- To strive for harmony and common understanding in the APRN regulatory community to promote quality APRN education and practice;
- To develop an agreed-to vision for APRN regulation, including education, accreditation, certification, and licensure;
- To establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and
- To produce a written framework that reflects consensus on APRN regulatory issues and strengthens the APRN position within the health care system.

### Challenges and Implications of the Consensus Process

Developing a single regulatory model for the four APRN roles is a huge milestone for the nursing profession. At times, it seemed unlikely that one model could bridge the uniqueness of each role. Use of APRN as an umbrella term was challenging due to real or perceived variations, among the roles in education, certification, accreditation, and licensure. Prior to the consensus paper, no common definition succinctly linked the four roles. Many times, participants suggested that a single model could not accurately encompass each role—when it worked for one role, it did not work for another. Yet, the process

prevailed and the model defines APRN and how the CRNA, CNM, CNP, and Certified Nurse Specialist (CNS) roles fit together under this umbrella.

The success of the process reflects the perseverance and commitment of the participants and the organizations they represented. A core of participants, supported by their respective organizations, served on one or more of the groups for the duration. In addition, the process relied on leadership and staff support from AACN and NCSBN. Without the time-limited structure of a funded project, the work extended to 5 years, resulting in revisiting issues and changes in decisions and consensus along the way. Arguably, the work might have been completed sooner had more resources been available; however, the end product may not have been as valuable or far reaching. Perhaps, the communities of interest needed time to hash out the issues before reaching agreement on moving forward. One thing is definite—the process allowed for in-depth discussion of every detail of the model, and the report reflects a comprehensive analysis of the issues linked to each recommendation within the APRN regulatory model.

### Consensus Model for APRN Regulation

The consensus model for APRN regulation is the model of the future. Its purpose and goal are to standardize APRN regulation across the country to ensure mobility for APRNs and access to quality health care for the public. The model provides the framework for APRN education, accreditation of education and certification programs, independent competence assessment through national certification, and legal authority to practice through the process of licensure.

#### Education and Accreditation

Based on this model, APRN education will be broad-based graduate education. The APRN program will be

grounded on three separate, comprehensive graduate-level courses in advanced physiology/pathophysiology, advanced health assessment, and advanced pharmacology (APRN core). The program also must prepare the graduate with nationally vetted core competencies for a specific APRN role (nurse practitioner, nurse-midwife, nurse anesthetist, or CNS). Lastly the program must address the nationally vetted core competencies for one of six specific population foci, specifically family/across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender related, and psychiatric-mental health (see Figure 2). In addition, the program must provide sufficient clinical experiences in the role and population focus to prepare the graduate to obtain certification for licensure and to practice in the APRN role and population focus.

All education programs will be nationally accredited based on the consensus framework. New education programs must go through a preapproval, preaccreditation, or accreditation process prior to admitting students. All APRN graduates must be eligible for national certification and state licensure.

Preparation in a specialty area of practice, more narrow than the population focus, is optional. However, if included in the APRN education program, preparation in the specialty must build on a comprehensive curriculum that prepares the graduate with the APRN core, role, and population-focused competencies.

#### Certification

Upon completion of the education program, the graduate will sit for a psychometrically sound, legally defensible competence assessment examination. The examination will be based on a practice analysis and must assess the national competencies for APRN core, role, and at least one population-focused area of practice.

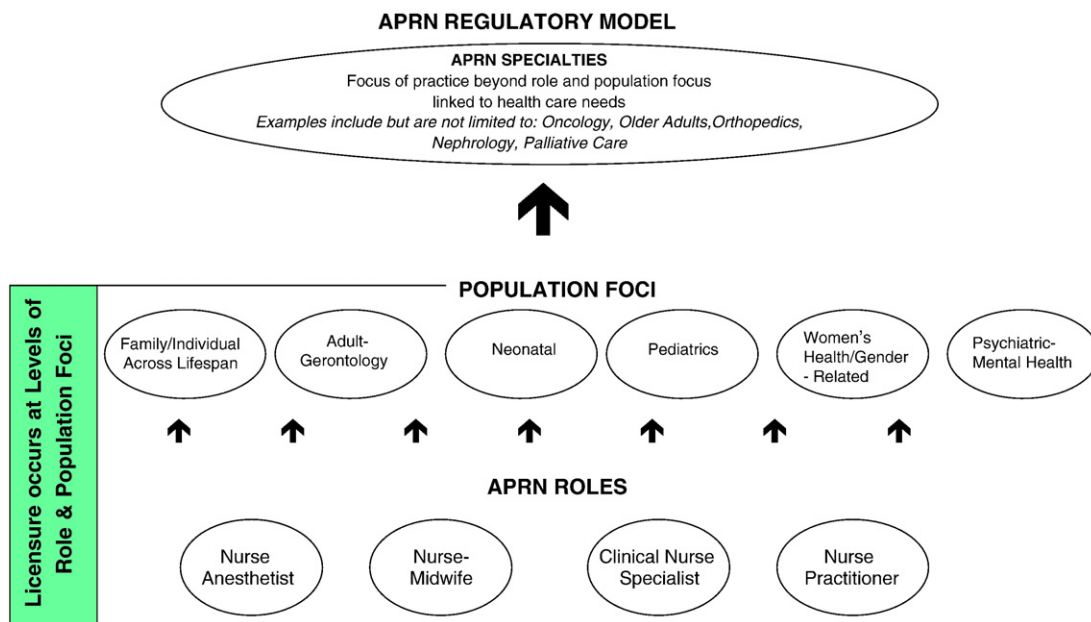


Figure 2. APRN regulatory model (APRN Consensus Work Group & NCSBN APRN Advisory Committee, 2008).

APRN certification programs will be accredited by a national certification accrediting body.

### Licensure

Individuals will be licensed as independent practitioners in one of the four APRN roles and in at least one of the six population foci. Education, certification, and licensure must all be congruent in role and population.

The title APRN is the licensing title that will be used to designate the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in the four roles. The title, APRN, is a legally protected title, and under the consensus model, individuals must legally represent themselves, including in legal signature, as an APRN and by the role. He or she may indicate the population as well. Only those licensed as an APRN may use the APRN title.

### Implementing the New Regulatory Model

One significant difference in this new regulatory model is that it is broad-based and not focused on a single nursing role or specialty. The model recognizes the interface between licensure, accreditation, certification, and education and ensures congruence across each of these components. The new model also places responsibility for the education and demonstration of competence in a specialty area of practice with the nursing profession.

The model creates significant implications for education programs, accreditors, certification entities, and state boards of nursing. National accrediting bodies will need to revise processes and standards to reflect the framework of the new model, and accreditation will apply to degree-granting and postgraduate certificate programs. A preapproval process for reviewing all APRN programs prior to enrolling students will be established. Accreditation standards and processes will assess programs based on the APRN core, role core, and population core competencies and other nationally recognized curricular guidelines. Accreditation visiting teams will include an APRN on the team.

APRN education programs will need to carefully review and revise the curriculum to ensure it reflects the APRN core, role core, and population core. This is particularly important for CNP and CNS programs transitioning from an adult or gerontology to the merged adult–gerontology focus. In addition, psychiatric–mental health CNP and CNS programs must expand curricula to include preparation across the lifespan. Both didactic and clinical coursework must encompass preparation in the role and across the population focus. All APRN programs must ensure that graduates are prepared for national certification and state licensure in the role and population. New programs will need to obtain preapproval or preaccreditation prior to admitting students. Official graduation documentation (e.g., the transcript) will need to clearly specify the role and population in which the graduate was educated. Faculty qualifications will also need to match the framework of the new model with expertise in the APRN core, role core, and population core competencies. Faculty will need to consider whether

the inclusion of specialty content in addition to the role and population focus fits with the program's purpose and goals. This is a significant change particularly if there has been a long-standing history and recognition of specialty programs offered.

APRN certification examinations will need to evaluate and remediate examination content based on the new model to assure congruence, psychometric soundness, and legal defensibility. Requirements to sit for the examination must reflect and be congruent with the concepts of the new model as well. For example, the new adult–gerontology certification examinations must encompass a comprehensive assessment of competence across the entire young adult to frail older adult population. Likewise, the psychiatric–mental health certification must assess preparation to practice across the lifespan.

State boards of nursing will need to review current statutes and regulations regarding licensure of APRNs for any changes needed to implement the new model. Changes may include revisions to the APRN title, definition of APRNs, implementation of independent practice, and issuance specifically of a license. Changes may be required through the state legislative process or the rule-making process. Licensure by state boards of nursing is the level of legal authority under this regulatory model. Many state boards currently do not recognize all four APRN roles, and some boards do not issue a second APRN license in addition to the RN license. Under this model, a nurse could practice as a nurse under one's RN license even if the APRN license was withdrawn. In addition, APRN representation on state boards of nursing and use of an APRN advisory panel are foundational changes required under this new consensus model. APRN is a legally protected title, common across all states, with licensure of all four APRN roles in at least one population defined by the model.

Successful implementation of the regulatory model will involve the commitment, coordination, and continued collaboration of *all* nursing stakeholders, including academic institutions, professional organizations, certification and accreditation bodies, and state boards of nursing. Implementation is the responsibility of each of these entities and has already been put into motion at a variety of levels. However, communication among the four regulatory entities and across all four roles is critical to implementation. The LACE communication network, described in the final report, will provide a platform for the LACE entities to communicate and continue this collaborative effort. Stakeholder groups have made a long-term commitment to working together to ensure the success of the consensus model.

### The Consensus Model and Health Care Reform

Reform is not a luxury that can be postponed, but a necessity that cannot wait ([President Barack Obama, May 2009](#)).

The consensus model for APRN regulation clarifies the licensure, accreditation, certification, and education requirements for all APRNs. Increased APRN mobility across states and greater access to APRN services will only be realized through full and timely implementation of the consensus model. Individual components of the model, including creation of six population foci and establishment of broad APRN education criteria, will better prepare graduates to address the complex health care needs of this country. These include an increased number of APRNs with expertise to address the special health care needs of a growing, older adult population and enhancing the ability of all APRNs to lead change within systems and in the policy arena.

Congruence across APRN regulatory components provides a strong national voice, which is vital during this time of health care reform. The consensus process has established a model for ongoing communication and transparency among the four regulatory entities and across all four roles. At the same time, meeting the challenges and opportunities presented by health care reform requires flexibility and nimbleness as well as the ability to respond rapidly and with a unified approach. The APRN community must embrace this historic agreement and move forward with timely implementation of the Consensus Model to place APRNs in a position to achieve the goals of health care reform.

### Lessons Learned

The stakes are high in ensuring the full inclusion of APRNs in health reform models. Reaching consensus around a standardized model for all APRN regulation is a significant accomplishment for the APRN community. However, for the consensus model to be effective in achieving the desired outcomes, full implementation of the model is critical. One of the most important lessons for the APRN community has been the need for open communication and transparency. Much of the 4 years it took to develop the model was spent educating ourselves and others in the APRN community regarding the myriad of issues surrounding licensure, accreditation, certification, and education as well as the interplay among these entities. As implementation moves forward, we cannot assume the public, nor the rest of the profession, has a clear understanding of these same issues just because the consensus model has been finalized and disseminated. Although important steps, we simply do not have another 5 years to engage in an education campaign or a discussion regarding how components of the model should be implemented. Instead, the APRN community needs to recognize that time is of the essence and that we must move forward now to capitalize on having reached consensus on APRN regulation and on the events that are occurring in the political arena.

Building consensus among diverse entities or organizations is rarely easy. This laudable goal is particularly challenging within a community that in the past has perceived more advantage to preserving unique differ-

ences than moving toward unity. The consensus process requires sustained commitment by all participants and the ability of each participating organization to tolerate the push-and-pull phenomena that occurs during the process. This tenacity, supported by a culture of open communication, is what allowed each participant to state his or her position or understanding and to push an agenda, but ultimately pull back when necessary and appropriate, to reach a common ground. Finding the balance to accommodate differing viewpoints without missing out on achieving meaningful consensus is essential. At any point, the process can begin to unravel when a party does not believe it has been heard or its perspective recognized in the document. A separate challenge is overcoming the fear or attitude that the end product is a compromise and therefore not the "best" decision. Because the definition of *consensus* itself is unclear, some can easily assume that anything less than unanimous consent is compromise. It is critical that participants in the process not adopt this attitude but continue to work through the issues to reach a common agreement that addresses not only the concerns and needs of individual organizations but is the best decision for the profession.

Implementation of the model is the responsibility of each individual organization, but ongoing communication and transparency of actions and decisions are critical. As we move forward with implementation of the consensus model for APRN regulation, time will tell if the APRN community was successful in reaching true consensus that has a lasting impact on the nursing profession.

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