CE: Continuing Education Independent Study

“What’s a Nurse Practitioner?”

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Purpose: This activity will enable the learner to examine and define the role, education, certification and practice of advanced nurse practitioners.

Objectives: After completion of this continuing education activity, learners will be able to:

1. Define the role, scope of practice, and categories of APRNs.
2. Analyze contributing factors that cause practice barriers and inconsistencies.
3. Compare the state of Michigan regulations to other states in the country.

A total of 1.0 contact hour will be awarded for successful completion of this study.

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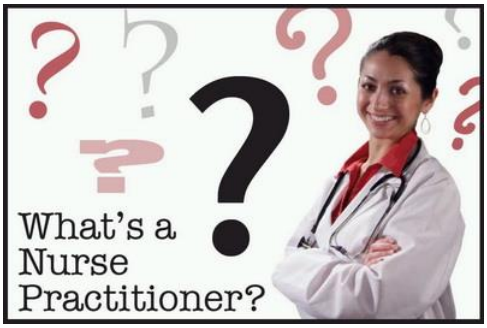


In our increasingly complex and expensive American health care industry, advanced practice nurses (APRNs) are playing an important component. These past few years have highlighted the role of APRNs due to the Affordable Care Act, the 2011 Institute of Medicine (IOM) report on the future of nursing, and predicted physician shortages. In many underserved areas, both urban and rural, nurse practitioners may be the only healthcare providers available and help meet the demand for primary or specialty healthcare practitioners. This is an opportune time to explore the role, positive outcomes, barriers, and challenges facing advanced practice nurses. What exactly are advanced practice registered nurses? What do they do and where can they practice? These are just a few questions healthcare consumers and even healthcare professionals may have.

APRN Definition

An Advanced Practice Registered Nurse (APRN) is a nurse who has a master's, post-masters, or doctoral degree in a nursing specialty and can generally (depending on the state) practice medicine *without the supervision* of a physician. APRNs are prepared with advanced didactic and clinical education, knowledge, skills, and scope of practice in nursing.[1]

Advanced practice nursing has four categories and includes certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history but shares the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards governed by state regulations and statutes are the final arbiters of who is recognized to practice within a given state.[2]

The most common type of APRN is a nurse practitioner (NP), representing well over half of advanced practice nurses, according to the U.S. Department of Health and Human Services. NPs are qualified to provide a range of both primary and acute health care services. They can diagnose and treat medical conditions and perform many of the same tasks as a physician, including writing prescriptions in most states. Nearly all states license NPs, and their official designation depends on the state and includes titles such as Advanced Registered Nurse Practitioner (ARNP), Advanced Practice Registered Nurse (APRN), Advanced Practice Nurse (APN), Certified Nurse Practitioner (CNP), Certified Registered Nurse Practitioner (CRNP), and Licensed Nurse Practitioner (LNP). All states, except California, Kansas, and Indiana as of 2012, also require that NPs be certified by one of the national certifying organizations for nurses.[3]

History

In the late 1950s and early 1960s, physicians began mentoring and collaborating with nurses who had clinical experience. In addition, increasing specialization in medicine led a large number of physicians out of primary care, creating a shortage of primary care physicians and leaving many areas, especially rural areas, medically underserved. In 1965, the Medicare and Medicaid programs provided health care coverage to low-income women, children, the elderly, and people with disabilities. The sudden availability of coverage increased the demand for expanded primary care services. Because physicians were unable to meet this demand, nurses "stepped into the breach."[4] Nursing leaders believed that nurses were qualified to expand their roles and meet the need. In 1965, Loretta Ford and Henry Silver, a nurse and a physician, created the first training program for nurse practitioners. The curriculum focused on health promotion, disease prevention, and the health of children and families.[5] According to Ford, society's demand for primary care services and nursing's potential to meet the need were the reasons for the development of nurse practitioners; the physician shortage merely provided the opportunity.

Nurse practitioners were created in an environment of informal training, a lack of credentialing processes, and opposition. In response to these challenges, nurse practitioners began to define and validate their profession. In the 1970s, they *documented* that they increased the availability of primary care services and that patients and physicians were satisfied with their care.[6-11] The physician shortage became a surplus in the early 1980s, and employers focused on controlling the skyrocketing cost of care. To address this new issue, nurse practitioners conducted studies of increasing scientific rigor to establish their value.[12-16] A 1994 article in the *New England Journal of Medicine* concluded that, "When measures of diagnostic certainty, management competence, or comprehensiveness, quality, and cost are used, virtually every study indicates that the primary care provided by nurse practitioners is equivalent or superior to that provided by physicians. These findings promoted increased utilization of nurse practitioners and would prove vital to their credibility. [17]

Nurse practitioners continued to grow in number and autonomy in response to an expanding need for accessible, cost-effective care.[18] As their impact on health care increased, nurse practitioners sought greater professional and economic recognition. In an attempt to clarify the scope of practice and to meet federal regulations for reimbursement, advanced-practice nursing organizations began offering voluntary certifications and titles.[19] The result was a confusing list of titles and credentials that led to even more confusing scopes of practice and forms of reimbursement. The National Council of State Boards of Nursing ultimately defined advanced-practice nursing, established the master of science in nursing degree and licensure as a registered nurse as the minimum standards for certification, and recommended licensure as the preferred method for regulating the profession.[20- 22]

Between 1973 and 1985, at least 11 nurse practitioner organizations centering on clinical specialties or practice settings were created.[23] Nurse practitioner leaders appreciated the diversity offered by the specialty organizations but condemned the lack of unity on key issues.[24] 1993 saw the formation of the National Nurse Practitioner Coalition (NNPC), a lobbying organization. Shortly thereafter, the coalition became the American College of Nurse Practitioners (ACNP). The ACNP proved to be a critical organization in the nurse practitioner community giving them identity and strength necessary to unite the profession and move the campaign forward.[25] Later, the Primary Care Health Practitioner Incentive Act, which passed the House and Senate, was signed by President Clinton as the Balanced Budget Act of 1997.

Role Confusion and Inconsistency

The lack of clarity regarding key terms such as *advanced practice nursing, advanced nursing practice, scope of practice, extended practice*, and the variability in how these terms are used has created significant confusion in healthcare policy development. This lack of clarity is problematic for nurses, other health professionals, consumers, educators and policy makers, especially with the mobility of the nursing workforce.[26] Confusion related to what constitutes an APRN, role misperceptions, misuse of titles, inaccurate job descriptions, and lack of knowledge by both health care and consumer groups contribute to misunderstandings. As previously stated, the National Council of State Boards of Nursing defines an advanced practice nurse as an RN who has completed an accredited graduate level nursing program in one of the four recognized APRN roles: Nurse Practitioner, Nurse Anesthetist, Nurse Midwife, or Clinical Nurse Specialist. These nurses must pass a national certification examination that measures the APRN role, and population-focused competencies. This is a direct patient care role requiring advanced clinical knowledge and skills, i.e., a greater depth and breadth of knowledge, the ability to synthesize data, and the hallmark-autonomy in nursing practice.[27] These nurses are prepared to assume the responsibility and accountability for health promotion and/or maintenance including the use and prescription of pharmacologic and non-pharmacologic interventions. However role definitions, titles, scopes of practice, prescriptive authority, and physician oversight are inconsistent across all fifty states!

All 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands have boards of nursing that collectively form the membership of the National Council of State Boards of Nursing (NCSBN). The NCSBN administers the National Council Licensure Examinations that all states require as part of the state licensing process. California, Georgia, Louisiana, and West Virginia have two boards, one for Registered Nurses and one for LPNs or LVNs. One state, Nebraska, has a separate board for advanced practice registered nurses.[28]

How State Nursing Licensure Works [29]

State legislatures pass Nursing Practice Acts (NPAs) that establish state regulation of nursing. The NPA lays out the requirements for licensure and defines the scope of nursing practice. State boards of nursing then put the NPA into practice by setting administrative rules and regulations that add details to further define the qualifications for licensure and the scope of practice. Rules must be consistent with the NPA and can't go beyond the law. When the rules go into effect, they carry the same weight as law (Michigan does not have a NPA).

All boards of nursing are responsible for evaluating nurse licensure applications, issuing and renewing nursing licenses, and taking disciplinary actions. Other responsibilities that a board of nursing might take on, depending on the state, include:

- Authorizing the use of licensing examinations
- Approving nursing education programs that meet established criteria
- Offering advice to the legislature about determining the legal scope of nursing practice
- Regulating nurse aides/nursing assistants and medication aides/assistants working in nursing home and home health care settings

State Nursing Boards and APRN Licensing [29]

Just as every state has its requirements for RN licensing, each state also sets its own requirements for licensing of APRNs, determines the legal scope of practice of an APRN in that state, and establishes the recognized roles and titles of APRNs in the state. Generally, the board of nursing is responsible for APRN licensing, but some states also have separate laws or boards that affect APRNs. In Michigan, nurse practitioner functions are under the Public Health Code definition of nursing.

MICHIGAN

Regulatory Structure: Restricted Practice
Regulatory Agency: Board of Nursing
Licensure Requirements: RN license and national certification.

Michigan has an act that regulates the practice of nursing, along with 25 other health occupations. Michigan does not have a stand-alone act called the Nurse Practice Act because in Michigan, we have a consolidated practice act that covers 25 health occupations and is formally titled the Occupational Regulation Sections of the Michigan Public Health Code, PA 368 of 1978.
Helpful Links:

- Article 15, Part 172 of the Public Health Code
- Article 7 for Advanced Practice Nurses
- Administrative Rules for the Board of Nursing

Although the standard requirements for APRN licensure are an RN license and completion of a graduate degree program in an advanced nursing specialty, some states require extra exams (such as national certification in a specialty) or additional professional experience.

Scope of practice for APRNs also varies by state. In some states, APRNs can work independently of physicians, in other states they cannot. Some states give APRNs independent prescription-writing privileges, others don't. The National Council of State Boards of Nursing (NCSBN is an independent, not-for-profit organization through which boards of nursing act and counsel together on matters of common interest and concern affecting public health, safety and welfare, including the development of nursing licensure examinations) maintains maps that show the titles used to represent APRNs in each state, the roles each state recognizes, the APRN education each state requires, the states where APRNs can practice independently, and the states where APRNs have prescriptive privileges.[29]

The variation in state laws for APRNs and the confusion it creates for both nurses and consumers led nursing organizations to develop of the *Consensus Model for APRN Regulation*, which is an attempt to standardize APRN licensure requirements and scope of practice. One aspect of the model regulation is that the board of nursing would be the only regulatory body that issues licenses and oversees APRNs. As of December 2012, only a few states have passed laws or have pending legislation that would implement the consensus model.[29]

Background of the Issue (to develop of the national *Consensus Model for APRN Regulation)*

When an RN engages in practice that is beyond the identified scope of nursing practice such as advanced practice nursing, legal authorization for that practice must exist. Any title, even if issued by a national certification body, carries legal status only if that title is recognized or authorized in statute or regulation.[30] Most states have a nurse practice act, however in Michigan, rules and regulations are determined in the Public Health Code which does not define or address all APRNs.

Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This of course creates barriers for APRNs to easily move from state to state.

Multiple articles confound the NCSBN's position on advanced practice licensure with the relationship to nurse practitioner certifying bodies. In 1993 NCSBN adopted a position advocating the licensure of advanced practice registered nurses (APRNs) on the basis that the level of care they provide and the autonomy of their practice are of such significance to consumers that, if provided incompetently or unethically, the public could be exposed to harm.[30]

The NCSBN position also advocates that regulatory jurisdiction for APRNs be solely under boards of nursing, a master's degree be required as minimum educational preparation and prescriptive authority be granted as appropriate to the practice area. Considerations for transition periods, such as grandfathering, are addressed in the model administrative rule language. The current status of this issue is that, as of Jan. 1, 1997, *all states regulate advanced practice nurses in some manner.* [30]

Consensus Model[30]

Because the regulations developed by individual state Boards over many years have been identified as inconsistent from one state to another, some certifying and accrediting bodies, along with many state Boards of Nursing believe that there are benefits to the adoption of a more consistent approach to certification and licensing. In 2008, the Consensus Model for APRN Regulation was published by the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee. The model had the support and input of more than 40 nursing organizations that believed that uniform regulations between states would improve advanced practice nursing nationwide. The model was developed in collaboration with certifying organizations, national nursing program accreditation agencies, regulators, and managing members of advanced practice professional organizations. The committee evaluated all variations in regulation and practice with the goal of developing a model that provided consistency so advanced practice nurses could practice in more than one location with the assurance that the standards of practice would be the same. The desired outcome is an increase in patient access to more cost-effective professional care by APRNs, who, under current laws, are often limited

in their scope of practice by regulations that prevent them from practicing within their full range of knowledge and abilities.

The model also provides strategies for the implementation of legislative changes that would bring a state into alignment with major elements of the model. As of 2012, 35 state and US territory Boards of Nursing have *enacted* the consensus model, and another five are pending. Only 11 (Michigan being one) have yet to propose any legislation concerning the implementation of the model.

Nurse Practitioner Certification[29]

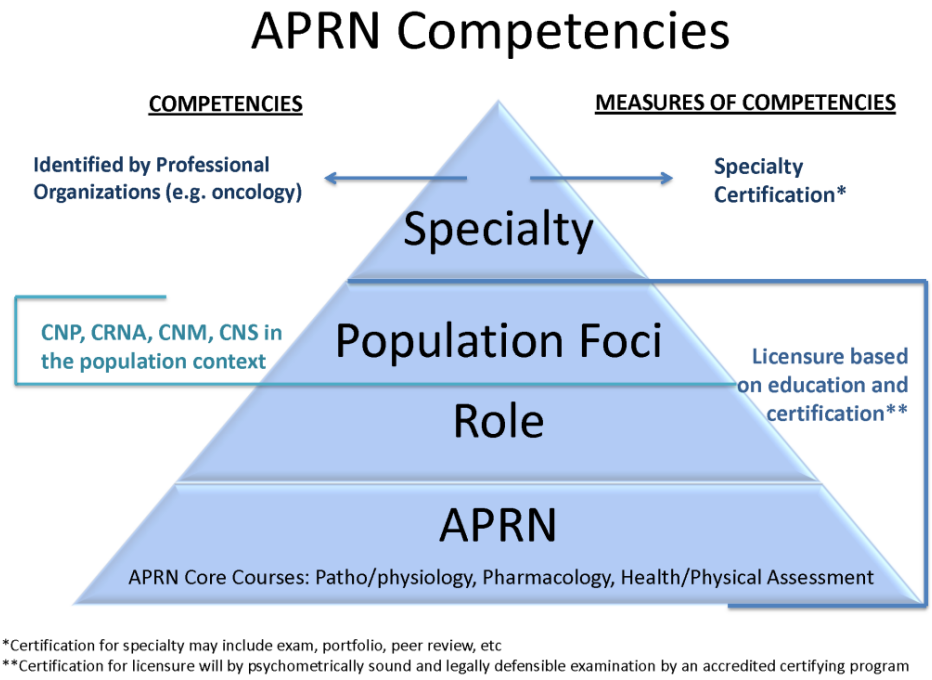
Certification is available to all graduates of any *accredited* masters, post-graduate, or doctoral nurse practitioner program within the chosen population focus. At this time, only California, Indiana, and Kansas will recognize nurse practitioners without national certification.

Because considerable differences in certification and state Board licensing policies have been a challenge to many advanced practice nurses, the proposed APRN Consensus Model recommends a certification process that will be more uniform between state jurisdictions. One significant change contained in the model is that new certification and licensing policies will focus on the nursing role first, then the population focus. This means that a role-specific certification exam will test in one of the six population foci: 1) neonatal, 2) pediatrics, 3) adult-gerontology, 4) women's health, 5) family/across the life span, and 6) psychiatry/mental health. For example, the certification exam requirement for NPs serving the pediatric population would be the Pediatric Nurse Practitioner exam.

Accredited certification examinations test graduate students on multiple components of a nurse practitioner's intended area of practice. Testing has been developed to evaluate knowledge and clinical competence in all facets of patient assessment, diagnosis, treatment, and evaluation. Exam content also includes relevant knowledge and clinical competence in anatomy, pathophysiology, disease symptomatology, diagnostic testing, differential diagnosis, and epidemiology. Additional areas covered include research and evidence-based practice, interviewing techniques, counseling, educational theories, and biopsychosocial theories. Treatment knowledge should include pharmacologic, non-pharmacologic, and complementary therapies and protocols. Two additional areas of testing include strategies for health promotion and knowledge on the legal and ethical aspects of practice.

For clarification, it is important to fully understand the definitions of three key certification terms as defined by the APRN Consensus Model:

- Role – Appropriate clinical and didactic experiences of the 4 APRN Roles: Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), or Certified Nurse-Midwife (CNM).
- Population Foci – Competency in at least 1 of 6 population foci: family/individual across lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psychiatric/mental health.
- Specialty – Focus of practice beyond role and population focus and linked to health care needs, including (but not limited to) oncology, orthopedics, nephrology, and palliative care.



Nurse Practitioner Scope of Practice

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 programs require that students successfully complete professional clinical experience in performance of direct patient care in the role the individual has selected.[31]

A nurse practitioner's *Scope of Practice* represents the full range of practice privileges allowed by certification and licensure. It incorporates the needs of the patient population with regard to evaluation and treatment, including the capacity to be paid for services rendered and the limitations of practice. For example, an NP is able to order diagnostic testing and prescribe medications, which is typically broader in scope than that of an RN. In addition to the practice privileges accorded for core certification within a population focus, specialty certifications can expand scope of practice through added competency and education in a specialized area of practice.

Because a nurse practitioner (APRN) utilizes theoretical knowledge and scientific process in practice, the APRN has a unique combination of skills that provide a broad range of practice options. The more commonly recognized responsibilities of an APRN include health care provider, educator, consultant, researcher, and administrator. Since APRNs have consistently focused on health promotion and ways to reduce the impact of disease, their services have become well-respected by patients and physician colleagues.

For new APRNs, the scope of practice will now extend to the medical diagnosis and treatment of patients with acute, episodic, or chronic medical conditions. Many nurse practitioners working in specialty areas, and especially primary care, must become skilled at using and interpreting a wide range of diagnostic tools. While APRNs do not perform complex surgical procedures, some can perform specified treatment procedures.

Because an APRN can work in primary or specialty health care, skills that blend nursing and primary care services can be utilized in a wide variety of settings from large healthcare organizations to small free clinics. Nurse practitioners also provide care in independent and collaborative practices, hospitals, specialty clinics, long-term facilities, surgical centers, family planning clinics, school health centers, hospices, home care agencies, and health maintenance organizations.

Standards of Practice refer to the clinical practice aspects of patient care. A nurse practitioner should follow national standards of care that are appropriate for practice in a particular setting, such as an ambulatory, acute, or long-term care facility. There are five primary practice standards for patient care, each with several important components: 1) Assessment, 2) Diagnosis, 3) Development of treatment plans, 4) Plan implementation, 5) Evaluation of plan.

Additional responsibilities include health education and promotion, patient advocacy, quality assurance, and collaborative responsibilities. Other standards can include the practitioner's obligation for staying current within the practice area, (continuing

education requirements) self-management of quality issues, and alignment with practice guidelines and legislative policies.

Quality standards of care are determined and monitored by several agencies, including governmental agencies. Examples include the Joint Commission on Accreditation of Healthcare Organizations (now known as the Joint Commission, formerly JCAHO), the Agency for Health Care Research and Quality (AHRQ), the National Committee for Quality Assurance (NCQA), professional societies, and licensing boards. Some states include select standards of care in their laws. These standards can be general in scope and relate to maintaining skill levels, or they can be specific, as in the case of the Montana requirement that 5% of all charts be reviewed by a physician and a peer practitioner. [29]

Advanced Practice Nurses perform these general functions:

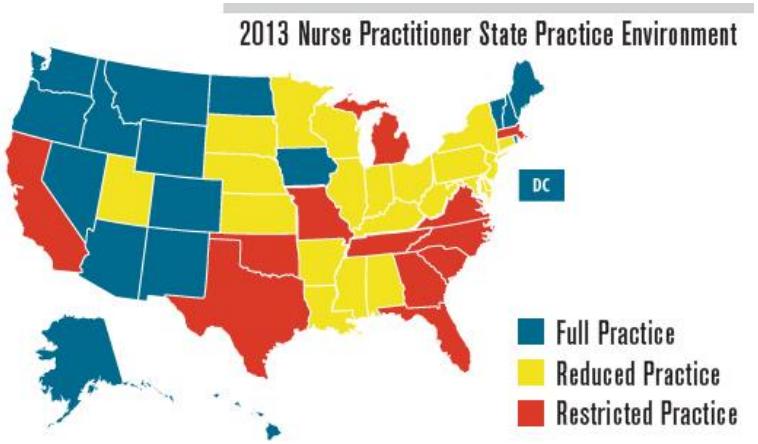
- Obtain health histories and perform comprehensive physical examinations, including psychosocial, functional, and developmental assessment
- Order and interpret lab results and other diagnostic studies
- Develop differential diagnoses
- Develop/order therapeutic plan of care
- Maintain patient records
- Evaluate patient's response to plan of care and modify as needed
- Provide patient/family counseling and education
- Arrange for patient referrals/consultations
- Participate in research studies

Prescriptive Authority [29]

Following the certification process, the new nurse practitioner must apply for the state Board's prescriptive authority that governs the prescribing of medications. Typically, the advanced pharmacology education needed before this authority can be granted is completed within the academic program. There may be variations from state to state, but the application process usually requires that the state Board receive proof of pharmacology education, an application form, and a fee. While differences in state prescribing laws have diminished in recent years, variations in authority still exist. Some states require an APRN to be in collaborative practice with a physician and need a written agreement from the physician before providing prescriptive authority. Now only four states have no controlled substances authority: Alabama, Florida, Hawaii and Missouri. While most states have collaborative terminology, 13 states, which includes Michigan, still use the term "supervise."

APRNs in these states are allowed to prescribe from schedules II through V unless otherwise noted.

Who are they?	Approx. No.	What do they do?
Nurse Practitioners (NPs)	160,000 MI - 4865	Take health histories and provide complete physical exams; dx & treat acute and chronic illnesses; prescribe &manage medications; order & interpret lab tests and X-rays; provide health teaching and supportive counseling
Clinical Nurse Specialists (CNSs)	60,000 MI – no data	Provide advanced nursing care in hospitals & other clinical sites; provide acute & chronic care management; develop quality improvement programs; serve as mentors, educators, researchers, & consultants
Certified RN Anesthetists (CRNAs)	35,000 MI - 2162	Administer anesthesia & related care before and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as pain management. Settings include operating rooms, outpatient surgical centers, & dental offices
Certified Nurse Midwives (CNMs)	18,500 MI- 292	Provide primary care to women, including gynecological exams, contraceptives, prenatal care, management of low-risk labor &delivery, & neonatal care. Practice settings include hospitals, birthing centers, & community clinics
CNS not included in MI Public Health Code	MPHI data 2014	Sources: AARP Public Policy Institute, Center to Champion Nursing in America. Preparation and Roles of Nursing Care Providers in in America. Washington, DC, 2010



Full Practice: State practice and licensure law provides for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice: State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

Restricted Practice: State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.

Evidence to demonstrate APRNs deliver safe, effective, quality care

Studies demonstrate that consumers receive safe and effective health care from APRNs. Research shows no difference in outcomes of primary care delivered by an NP or a physician, including patient satisfaction, health outcomes, the number of prescriptions written, return visits, or referrals to other providers.[32] A systematic review of APRN outcomes found comparable—*and in some cases better*— outcomes of care delivered by NPs, certified nurse midwives (CNMs), and clinical nurse specialists in collaboration with physicians, compared with care provided by physicians alone.[33] In fact, no study establishes a basis for requiring physicians to supervise APRNs.[34] There is no evidence that APRN care is better in states with more restrictive physician oversight. There is also no evidence that physicians make less money in states in which APRNs have an expanded scope of practice.[35]

Barriers to Practice [36]

- Outdated laws, regulations, and organizational policies keep APRNs and other skilled providers from practicing to the full extent of their education and training
- Laws that require nurse practitioners who diagnose, treat and prescribe medication to have some degree of physician involvement or supervision
- Regulations that increase costs and duplicate and/or delay care for consumers
- Private insurance companies do not reimburse nurse practitioners for services
- Hospital Bylaws such as prohibiting admitting/clinical privileges, and staff membership
- Existing and proposed state regulations that have anticompetitive effects without contributing to the health and safety of the public
- Lack of legislative change at various levels of government
- "Turf wars" and fear of economic repercussions by physicians

Benefits

- Expanding consumer choice and access to care
- Improving continuity of care
- Increasing cost-effectiveness (decreased re-hospitalizations, decreased medication errors, fewer C-sections, decreased duplication of services, to name a few)
- Improved inter-professional collaboration and team care
- Improved education of other professionals regarding APRNs
- Increased survivorship in multisystem, chronic disease, and complex cancer patients

- Decreasing patient stressors, especially for older, obstetric, and pediatric patients
- Providing models for hospitals to use for credentialing APRNs
- Using available health care workforce most efficiently to coordinate and deliver care

Michigan[37]

The MI Board of Nursing certifies qualified registered nurses to work within nursing specialties in the state. These specialists are commonly known as advanced practice registered nurses (APRNs).
Before applying for nurse specialty certification in Michigan, you must hold a Michigan RN license.
The Board recognizes three nurse specialty certifications: Nurse Anesthetist, Nurse Midwife, and Nurse Practitioner (the Board accepts Clinical Nurse Specialist certification for Nurse Practitioners)
Prior to receiving nurse specialty certification, you must obtain at least a master's degree in nursing with a concentration in advanced practice nursing or a certificate in advanced practice nursing.

The Michigan Board of Nursing places responsibility for ensuring you have the proper advanced practice education on the national certifying organization that offers certification in your specialty role. It is, therefore, not necessary to send transcripts to the Board, as the onus for making sure that you have completed the necessary advanced nursing education is placed upon your national certification agency.

- *Nurse Anesthetist:* your graduate nurse anesthetist program must be accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs to meet the standards of the National Board of Certification & Recertification of Nurse Anesthetists.
- *Nurse Midwife:* your graduate nurse midwifery program must be accredited by the Accreditation Commission for Midwifery Education to meet the standards of the American Midwifery Certification Board.
- *Nurse Practitioner*: your graduate nursing program must be accredited by one of the national accreditation agencies for nurse education schools recognized by the U.S. Department of Education, such as the National League for Nursing Accrediting commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE). This will ensure that the program meets the standards of one of the following national certification organizations that are recognized by the Michigan Board of Nursing: American Nurses Credentialing Center (ANCC),

Pediatric Nurse Certification Board (PNCB), National Certification Corporation (NCC), American Academy of Nurse Practitioners (AANP), or the Oncology Nursing Certification Corporation (ONCC).

Certification Programs

You must obtain national certification in order to obtain Michigan certification as an APRN. These national certification agencies are approved by the Michigan Board of Nursing to set standards for the respective APRN generalist and specialty roles:

- ANCC (American Nurses Credentialing Center):
  - Acute Care Nurse Practitioner
  - Adult Nurse Practitioner
  - Family Nurse Practitioner
  - Gerontological Nurse Practitioner
  - Pediatric Nurse Practitioner
  - Family Psychiatric Mental Health Nurse Practitioner
  - Adult Psychiatric Mental Health Nurse Practitioner
  - Pediatric Nurse Practitioner
  - Adult Health Clinical Nurse Specialist
  - Adult Psychiatric & Mental Health Clinical Nurse Specialist
  - Child & Adolescent Psychiatric & Mental Health Clinical Nurse Specialist
  - Gerontological Clinical Nurse Specialist
  - Pediatric Clinical Nurse Specialist
- ONCC (Oncology Nursing Certification Corporation):
  - Advanced Oncology Certified Nurse Practitioner
  - Advanced Oncology Certified Clinical Nurse Specialist
- AANP (American Academy of Nurse Practitioners):
  - Adult-Gerontology Primary Care NP
  - Adult Nurse Practitioner
- NCC (National Certification Corporation):
  - Neonatal Nurse Practitioner
  - Women's Health Care Nurse Practitioner
- PNCB (Pediatric Nurse Certification Board):
  - Pediatric Nurse Practitioner – Acute Care
  - Pediatric Nurse Practitioner – Primary Care
- AMCB (American Midwifery Certification Board):
  - Certified Nurse Midwife
- NBCRNA (National Board of Certification & Recertification of Nurse Anesthetists):
  - Certified Registered Nurse Anesthetist

Criminal History Background Check

When you apply for nurse specialty certification in Michigan, you do not need to undergo a criminal history background check. You should already have already submitted to one when you applied for your Michigan RN license.

Collaborative Practice Agreement/Prescriptive Authority

The state of Michigan does not require APRNs to have a collaborative practice agreement with a physician on file in order to be able to practice. However, if in your APRN role you are requesting prescriptive authority, you must have a written authorization established with a supervising physician who practices within your specialty. This authorization must be kept on file at the physician's practice and at your practice. It must contain the effective date, any limitations on your prescriptive authority that have been established, and must be reviewed by both parties and updated annually.

Scope of Practice

The Michigan Board of Nursing has not developed a scope of practice for APRNs. However, you must abide by the following scopes of practice, as determined by Michigan law for registered nurses as well as by your national certification organization:

Nurse practitioner: Because a NP is a licensed RN in Michigan, there is not a separate written scope of practice for NPs in Michigan law. Anything beyond the RN scope of practice must be supervised by a physician (such as performing surgeries, invasive procedures, ordering physical therapy, and prescribing medications). The duties of a NP may include:

- Treating common and chronic illnesses
- Health maintenance
- Disease prevention
- Counseling and patient education
- Providing primary care services

Nurse anesthetist: The role of a NA includes care for basic anesthesia needs of the patient before, during and after surgery or labor and delivery. Under Michigan's scope of practice for NAs, (as there is no written scope of practice beyond that of a RN), all activities and/or medical functions must be performed under the supervision of a qualified physician.

Nurse midwife: Under the scope of practice of the American College of Nurse Midwives, NMs may manage women's health care, pregnancies, childbirth, postpartum period, newborn care, and family-planning and gynecological care of women. This scope of practice is followed in Michigan as well.

Conclusion

Some physician groups have expressed concerns about the safety of care delivered by nurse practitioners, *but fail to provide any evidence to support their claims.* In contrast, the Institute of Medicine (IOM) and the National Governors Association as mentioned previously, cite decades of convincing evidence demonstrating that nurse practitioners provide safe, effective care whether or not they are supervised by physicians.

The Federal Trade Commission released a staff paper urging state legislators and policy makers to be mindful when evaluating proposals that limit access to care provided by APRNs. The paper found that "mandatory" physician supervision and collaborative practice agreement requirements are likely to impede competition among health care providers and restrict APRNs' ability to practice independently, leading to decreased access to health care services, higher health care costs, reduced quality of care, and less innovation in health care delivery."[38]

The IOM report, *Crossing the Quality Chasm* (2001), stresses that the health care system as currently structured does not, as a whole, make the best use of its resources. The aging population and increased client demand for new services, technologies, and drugs contribute to the increase in health care expenditures, but also to the waste of resources. Recommendations in the report call on all health care organizations and professional groups to promote health care that is safe, effective, client-centered, timely, efficient, and equitable.[39]
With so much potential for change and the higher level of recent activity on the legislative front, the nursing profession, and specifically APRNs, need to seize this opportunity to promote our agenda. There are various new ways of delivering cost-effective care and increasing access to qualified healthcare providers for patients and their families. Advanced practice registered nurses are grounded in theory and research, work in collegial capacities with physicians, are clinically prepared to diagnose and treat patients with acute and chronic illnesses and can safely prescribe medications. These responsibilities require nursing professionals who are as smart and as they are caring[40] ARRNs can and should be one of the solutions to our countries' healthcare woes.

National organizations continue to work at all levels to reform scope of practice laws and regulations in addition to promoting the APRN Consensus Model. Various "campaigns" will also work at the state level to require third party payers to directly reimburse APRNs in an effort to expand access to care and help contain health care costs. MNA will continue to seek to remove outdated barriers to care that prevent patients from receiving the care they need.

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