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Certification and education as determinants of nurse practitioner scope of practice: An investigation of the rules and regulations defining NP scope of practice in the United States

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Abstract

Purpose and background: In 2008, a consortium of advanced practice nursing organizations authored the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education*. The document's aim is to provide guidance for states to adopt uniformity in the regulation of advanced practice registered nurse roles. Despite a target date to complete that work by 2015, there remains an extensive amount of variation in how states define the scope of practice (SOP) for nurse practitioners (NPs).
Data sources: Based on the National Council of State Boards of Nursing online database, state ($N = 51$ [includes the District of Columbia]) NP practice acts and/or rules and regulations documents were examined for language describing SOP for NPs consistent with the language of the advanced practice registered nurse (APRN) Consensus Model.
Conclusions: Results indicated that 18 states and the District of Columbia (37%) had specific regulations defining NP SOP by certification and/or educational preparation while 23 (45%) did not. The remaining nine states (18%) had SOP regulations that were interpreted as being ambiguous in relation to certification and/or educational preparation.
Implications for practice: The findings suggest much work is needed to ensure NP SOP accurately reflects NP board-certification and graduate educational preparation.

Introduction

The role of the nurse practitioner: Scope of practice

Nurse practitioner (NP) education (at both the masters and doctoral levels) focuses on advanced preparation of nurses in a specialty area of population focus. NP programs generally prepare NPs for entry-level practice in a primary care role (e.g., family nurse practitioner [FNP], adult NP [ANP], geriatric nurse practitioner [GNP], adult-gerontology primary care nurse practitioner [AGPCNP—a new and evolved role reflecting the combining of the GNP and ANP credentials by the American Association of Nurse Practitioners and American Nurses Credentialing Center, the two bodies that offer this credential], women's health nurse practitioner [WHNP], and pediatric nurse practitioner [PNP]), acute care role (e.g., acute care nurse practitioner [ACNP], adult-gerontology acute care nurse practitioner [AGACNP], or pediatric acute care nurse practitioner [PNP-AC]), or in psychiatric/mental health (e.g., psychiatric mental health nurse practitioner [PMHNP] with a focus on adult-gerontology or family mental health). In addition to this specialized education, each population-focused NP role has specific scope of practice (SOP) standards provided by professional organizations and role-specific board certification examinations designed in accordance with role delineation studies that survey current practice environments. Completion of a formal graduate program of study allows the graduate to sit for the national board certification examination that matches his or her educational preparation. For example, a graduate from an FNP program is eligible to become certified as an FNP through the appropriate certifying body.

Completing the formal foci-specific graduate-level education in addition to passing the foci-specific board

certification leads to the appropriate credentialing of an NP within the population foci of his or her education. Despite the pairing of certification to an NP's education, state nurse practice acts and/or rules and regulations often do not tie certification and/or educational preparation to licensure and/or SOP. Keough, Stevenson, Martinovich, Young, and Tanabe (2011) examined where NPs ($n = 1216$ NPs) practice and compared their actual practice sites to their area of national certification. The majority of respondents were ACNPs ($n = 399$, 42%). Among the FNP ($n = 20$, 5%) and ANP ($n = 27$, 7%) respondents, 65% and 56%, respectively, worked in high-acuity intensive care units.

While many professional NP organizations have role-specific SOP standards (e.g., the American Association of Colleges of Nursing has specific competency documents for adult-gerontology primary care [2010] and acute care [2012] NPs), the ultimate authority for defining an NP's SOP is the state regulatory board. Because state processes of establishing NP SOP may vary widely (Chrisitian, Dower, & O'Neil, 2007; Kleinpell, Hudspeth, Scordo, & Magdic, 2012; Yee, Boukas, Cross, & Samuel, 2013), much debate occurred within the nursing profession that provided impetus for policy directives from professional advanced practice nursing organizations through a document entitled the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education* (APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, 2008).

Consensus model for APRN regulation: Licensure, accreditation, certification, and education (APRN Consensus Model, 2008)

The *APRN Consensus Model* was authored by a number of national professional advanced practice nursing organizations and was created to provide guidance for states to adopt uniformity in the regulation of advanced practice registered nurse roles (National Council of State Boards of Nursing [NCSBN], 2014b). The document establishes an APRN regulatory model based on the essential elements of licensure, accreditation, certification, and education (LACE). Thus, while the *APRN Consensus Model* includes elements of LACE, NCSBN (2010) defines LACE as, "a communication network to include organizations that represent the licensure, accreditation, certification, and education components of APRN regulation" (p. 4).

The *APRN Consensus Model* (2008) delineates SOP to "at least one population focus as defined by nationally recognized role and population-focused competencies" (p. 8). The APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee (2008) identified the six population foci for the APRN as: (a) family/individual across lifespan, (b) adult-gerontology, (c) neonatal, (d) pediatrics, (e) women's health/gender related, (f) psychiatric/mental health.

Moreover, The *APRN Consensus Model* (2008) makes a clear distinction between acute care and primary care practice preparation, noting that acute care focused and primary care focused NP programs have distinct competencies based on the consensus model as well as specific certification processes. The regulatory model also stipulates that NP educational programs can prepare NPs for practice in both acute and primary care settings; but those programs must meet consensus-based competencies for both roles. NPs wishing to practice across the primary acute care continuum must also be certified in both primary and acute care according to the model. Accordingly, licensure of NPs should occur at levels of role and population foci. The "Timeline for Implementation of Regulatory Model" (2008) indicates 2015 as the target date for full implementation.

Literature review

NP SOP

To date, few studies have focused on the regulatory language of state nurse practice acts and/or practice rules and regulations related to SOP of NPs as defined by certification and/or education (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). The few experts who have worked in this area have indicated that clarification of NP SOP as it pertains to the acute care setting is needed nationwide and that there remains a need to support NP SOP regulations "based on educational preparation, licensure, certification, and focus of practice" (p. 11).

Keough et al. (2011) studied current practice environments in a survey of FNPs, ANPs, and ACNPs board certified through the American Nurses Credentialing Center (ANCC) to determine congruency of practice with area of certification. The researchers compared the NP respondents' practice descriptions and the definition of their SOP standards, with standards operationalized by an expert panel consisting of NP faculty and other national nursing leaders familiar with national consensus competencies for FNPs, ANPs, and ACNPs. They found that the NP's current practice activities and scope did not always match their certification focus. In fact, 10% of NPs reported working in nontraditional practice settings.

The American Association of Critical Care Nurses (AACN, 2012) asserts that ACNPs' population focus "includes patients with acute, critical, and/or complex chronic illnesses who may be physiologically unstable, technologically dependent, and highly vulnerable to complications" (p. 7). Conversely, in primary care NP graduate program

education, NP students are not exposed to education or clinical immersion with patients that would be of this high level of acuity. Instead, the competencies for these roles outlined by the National Organization of Nurse Practitioner Faculties (2013) emphasizes care of "common acute and chronic physical and mental illness" (p. 15). To further emphasize the major competency differences between NPs educated in the acute and primary care roles, the *APRN Consensus Model* (2008) asserts that primary care NPs and ACNPs "have separate national consensus-based competencies and separate certification processes" (p. 9).

These data suggest there could remain a large amount of discrepancy between the educational preparation and certification of NPs and their SOP. This indicates that more study is needed to examine the legal state definitions of SOP for NPs on a national level and how SOP is defined through education and/or certification state-by-state.

Methods

Purpose of study

The purpose of this study was to assess the nurse practice act and/or documents pertaining to practice rules and regulations of each state and the District of Columbia ($n = 51$) to determine whether or not NP SOP was specifically defined through board-certification and/or graduate educational preparation.

Sample

Using the National Council of State Boards of Nursing (2014a) online database, each state's nurse practice act and/or rules and regulations documents were accessed ($n = 51$). This online database includes links to full web-based nurse practice act documents and other pertinent legal documents that contain regulatory language pertaining to the state's legal descriptions of NP SOP.

Data collection and treatment

Data were collected from each state's nurse practice act and/or nursing practice rules and regulation documents over a period of approximately 30 days between the months of March and April of 2014. Each document was read thoroughly by both the primary investigator and an additional NP faculty member who served as an outside expert consultant. In addition, all data pertaining to NP SOP, initial licensure requirements, and any other descriptive language pertaining to NP practice setting and state requirements for practice within specific settings were extracted. These documents were assessed to determine whether or not NP SOP was defined by NP education and/or certification, consistent with the LACE recommendations within the *APRN Consensus Model* (2008).

Next, states' NP SOP definitions were categorized as either being (a) defined by education and/or certification, (b) not defined by education and/or certification, or as being (c) ambiguous. An ambiguous classification indicated that a state's SOP regulatory language included data related to education and/or certification, but it did not include language strictly restricting an NP's work to his or her specific area of education and/or certification.

Also, if a state's regulatory language allowed for SOP to be defined by an NP's education and/or certification but also allowed for continuing education and/or experience to expand the SOP beyond initial education and/or certification, it was also categorized as ambiguous. Finally, in states where SOP was defined by education and/or certification, specific state statute numbers were collected for future points of reference. Data were input into an Excel spreadsheet and were analyzed using descriptive statistics. Table 1 lists each state and District of Columbia and identifies which classification its NP SOP was categorized.

Results

States defining SOP by NP education and/or certification

Eighteen of the 50 states and the District of Columbia (37%) had regulatory language defining NP SOP specifically by an NP's education and/or certification (see Table 2). These states included Alabama, Alaska, Arizona, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Missouri, Nevada, New York, North Carolina, Oklahoma, Texas, Virginia, Washington, and Wyoming. In the District of Columbia, Kansas, Louisiana, New York, North Carolina, and Texas, NP SOP was defined only by educational preparation. For example, in the District of Columbia, NPs must complete postbasic nursing education from an accredited program specific to the NP's area of practice (DC Municipal Regulations and DC Register, 2002). Maryland, Oklahoma, Washington, and Wyoming defined SOP based on certification foci but did not include educational preparation. For example, in Maryland, NPs can practice only in the area in which they are certified (Maryland Board of Nursing, 2002).

States not defining SOP by NP education and/or certification

Twenty-Three states' (45%) NP SOP definition was completely void of any description based on certification and/or education. These states included Arkansas, California, Colorado, Connecticut, Delaware, Florida,

Table 1 NP SOP categorization by state and the District of Columbia

State	SOP Defined by Certification/Education
Alabama	Yes
Alaska	Yes
Arizona	Yes
Arkansas	No
California	No
Colorado	No
Connecticut	No
Delaware	No
District of Columbia	Yes
Florida	No
Georgia	No
Hawaii	No
Idaho	No
Illinois	Ambiguous
Indiana	No
Iowa	Yes
Kansas	Yes
Kentucky	Yes
Louisiana	Yes
Maine	Yes
Maryland	Yes
Massachusetts	Ambiguous
Michigan	No
Minnesota	No
Mississippi	No
Missouri	Yes
Montana	No
Nebraska	No
Nevada	Yes
New Hampshire	Ambiguous
New Jersey	No
New Mexico	Ambiguous
New York	Yes
North Carolina	Yes
North Dakota	Ambiguous
Ohio	No
Oklahoma	Yes
Oregon	Ambiguous
Pennsylvania	Ambiguous
Rhode Island	No
South Carolina	No
South Dakota	No
Tennessee	No
Texas	Yes
Utah	No
Vermont	No
Virginia	Yes
Washington	Yes
West Virginia	Ambiguous
Wisconsin	Ambiguous
Wyoming	Yes

Table 2 States defining SOP by NP education and/or certification

State	State Statute	Reference
Alabama	610-X-5-.02	Alabama Board of Nursing Administrative Code (2007)
Alaska	12 AAC 44.430	Alaska Statutes and Regulations: Nursing (2014)
Arizona	R4–19—501	Arizona State Board of Nursing (2013)
District of Columbia	Chap 17 5904.1	DC Municipal Regulations and DC Register (2002)
Iowa	655 IAC Chap. 7	Iowa Board of Nursing (2009)
Kansas	65–1130	Kansas Board of Nursing (2013)
Kentucky	201 KAR 20:057	Kentucky Board of Nursing (2009)
Louisiana	Title 46, Part XLVII	Louisiana State Board of Nursing (2005)
Maine	Chap 8, Sec 3	Maine Board of Nursing (2010)
Maryland	Chap .02	Maryland Board of Nursing (2002)
Missouri	20 CSR 2200–4.100	Missouri State Board of Nursing (2014, 2005)
New York	Article 139: §6902	New York State Education Department (2010)
North Carolina	21 NCAC 36.0802	North Carolina Board of Nursing (2004)
Oklahoma	485: 10–15–6	Oklahoma Board of Nursing (2013)
Texas	§221.13	Texas Board of Nursing (2013)
Virginia	18 VAC 90–30–10 et seq. Statutory Authority: §§ 54.1–2400 and 54.1-2957	Joint Virginia Boards of Nursing and Medicine (2005)
Washington	WAC 246–840–300	Washington State Legislature (2000)
Wyoming	Chap 2, Sec 2a	Wyoming State Board of Nursing (2014)

Georgia, Hawaii, Idaho, Indiana, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Jersey, Ohio, Rhode Island, South Carolina, South Dakota, Tennessee, Utah,

and Vermont. While a graduate degree with educational preparation as an NP was required by all these states, that area of education did not define the NP's SOP. For example, in Florida, NPs must be both nationally certified and hold at minimum a masters degree in nursing preparing them as an NP. However, beyond that requirement for licensure, SOP was not defined by educational preparation and/or certification. While board certification is not a licensure requirement in California, Kansas, or New York (Fitzgerald, 2013), both Kansas and New York define SOP by an NP's area of educational preparation (see above).

States with ambiguous regulatory language

Nine states' (18%) NP SOP definition was interpreted as being ambiguous. This indicated that regulatory language allowed for SOP to be defined by an NP's education and/or certification but also allowed for experience, continuing education, and training to expand the SOP beyond initial education and/or certification. States that were classified as ambiguous included Illinois, Massachusetts, New Hampshire, New Mexico, North Dakota, Oregon, Pennsylvania, West Virginia, and Wisconsin. For example, in Illinois, regulatory language pertaining to SOP includes the NP's "education, training, and experience" (Illinois General Assembly, Compiled Statutes: Nurse Practice Act, 2014, Sec. 65–30).

Discussion

Implications for practice

The purpose of this study is not to suggest which practice environments are appropriate for NPs. Rather, it is hoped the findings will contribute to the scant advanced practice nursing literature that has examined the relationship between education and certification in the definition of NP SOP policies within the United States. In addition, one of the major points of emphasis of the *APRN Consensus Model* (2008) is ensuring that NPs practice to the full scope of their ability, defined by their educational preparation and certification foci. Defining precisely which practice environments are appropriate for NPs with varying educational preparation and certification has been met with uncertainty (Kleinpell et al., 2012). However, NPs need to take responsibility for the decisions they make regarding the practices in which they choose to work; and they need to consider practice boundaries in accordance with their educational preparation and certification foci. For example, Klein (2005) asserts:

> Professional licensure and certification reflect validation that the provider has met criteria for practice in a focused, rather than broad scope of practice. A lack of congruence between the practice environment and level of expertise results in a decreased level of safety for the patient and increased risk of liability for the NP (p. 6).

NP educators must also recognize the SOP definitions provided by professional nursing organizations and ensure that clinical practice experiences of NP students accurately reflect these definitions. Finally, nurses need to work closely with their regulatory boards to encourage implementation of the *APRN Consensus Model* (2008) and advocate for SOP policies that allow NPs to work to the fullest extent of their abilities, which should be validated by their educational preparation and certification foci.

Study limitations

The only major limitation of this study pertains to the ever-changing nature of the legislative documents from which the data were collected. While legislative data sources accessed were the most recent found through various Internet and literature searches, it is important to consider that legislative documents are dynamic and fluid and are in constant states of change. Therefore, it is possible that these documents could have been updated after data for this study were collected or during the time the manuscript was under review or in press.

Conclusions

The findings from the data from this study are similar to other studies that have examined SOP issues across the United States. While this study is unique in that it is the only one to exhaustively assess every state's SOP regulatory language as it relates to education and certification, studies conducted by other authors suggest that uniformity in NP SOP continues to be a major challenge for the profession. With the *APRN Consensus Model* implementation goal date of 2015 nearing, it is imperative that states' boards of nursing take stronger initiative to assure that NP SOP is defined in ways that are consistent with an NPs educational preparation and foci area of certification. Nursing is a politically active profession, and nurses should be proactive in assisting policymakers and regulatory agencies in implementing the LACE recommendations within the *APRN Consensus Model* (2008). Ultimately, patient safety deserves the utmost emphasis. Ambiguity regarding NP SOP can be a potential source of confusion for employers; and NPs that lack the proper credential and formal educational preparation to treat the patients they are caring for could be more vulnerable to claims related to malpractice (Buppert, 2014). With NPs taking on a bigger role in the healthcare system within the United States, the profession must

advocate for patients by ensuring that NPs are practicing within the boundaries of their appropriate education, certification, and expertise.

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