REPORT OF THE VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS

Report on Advanced Practice Registered Nurses (Chapter 552, Item 309.C., 2021)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 18

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

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Members of the Senate of Virginia
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Members of the House of Delegates
c/o The Honorable Suzette Denslow

FROM: David E. Brown, D.C. David Brown (DAB)
Director, Department of Health Professions

DATE: October 29, 2021

RE: **Report on the oversight and regulation of advanced practice registered nurses (APRNs).**

Attached is the report requested by a language amendment to Item 309 of the budget bill adopted in the Special Session I of the 2021 General Assembly. The Department was required to study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs).

Should you have questions about this report, please feel free to contact me at david.brown@dhp.virginia.gov or at (804) 367-4450.

Virginia Department of Health Professions

REPORT ON ADVANCED PRACTICE REGISTERED NURSES: 2021 BUDGET BILL

OCTOBER 13, 2021

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TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

This Report is in response to a request in the 2021 Special Session I Virginia General Assembly Budget Bill, which reads, "*The Department of Health Professions (DHP) shall study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and regulations on practice and patient outcomes. The department shall report its findings to the Governor and General Assembly by November 1, 2021*."

Regulation of APRNs varies significantly from state to state. In 2008, the National Council of State Boards of Nursing developed the Consensus Model for APRN regulation, which presents recommendations for state legislatures and boards regarding the regulatory structure for APRNs (Certified Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists).

Virginia has been moving towards alignment with the APRN Consensus Model but differs in two significant ways:

1) Virginia does not grant all APRNs the ability to practice independently; and

2) Virginia does not regulate APRNs solely through the Board of Nursing.

DHP found a number of recent studies responsive to the impact of regulation on practice and patient outcomes. These studies indicate that granting APRNs independent practice authority may increase APRN supply without reducing quality of care.

Recommendations from DHP are to:

1) Amend statutory and regulatory definitions to conform to those in the APRN Consensus Model;

2) Consider amending Virginia laws and regulations to align with the APRN Consensus Model; and

3) Pursue participation in the APRN Licensure Compact.

II. ADVANCED PRACTICE REGISTERED NURSES OVERVIEW

Advanced Practice Registered Nurses (APRNs) are registered nurses who have completed graduate-level education and achieved national certification which qualifies them to provide direct care in a particular role at an advanced level. Each state has statutes and regulations which define APRN roles and their scopes of practice, resulting in significant statutory and regulatory variability. As APRNs became an integral part of the health care system, over 40 national nursing organizations met to consider the issues that contribute to this variability in APRN regulation among states and territories. In 2008, the National Council of State Boards of Nursing[1] (NCSBN) and the Advanced Practice Nursing Consensus Work Group developed the Consensus Model for APRN Regulation[2] (APRN Consensus Model) to guide all states toward a national standard for APRN licensure and practice. This model is currently endorsed by NCSBN and at least 48 national nursing organizations.

A. APRN Consensus Model:

The APRN Consensus Model presents strategies for state legislatures and regulatory boards to implement when establishing the appropriate licensure, accreditation, certification, and education of APRNs. According to this model, an APRN shall have completed an accredited graduate-level education program preparing him/her for one of four recognized APRN roles: Certified Nurse Practitioner (CNP), Certified Nurse Midwife, (CNM), Certified Registered Nurse Anesthetists (CRNA), or Certified Nurse Specialist (CNS). An APRN shall also have passed a national certification examination and obtained licensure. The NCSBN recommends that only those individuals who are licensed to practice as an APRN be allowed to use the APRN title. In addition to being educated in one of the four roles, the Consensus Model also recommends that APRNs be educated in at least one of six population foci: family-individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health.

The following chart paraphrases the definitions of the four APRN Roles and describes the recommendations regarding APRN practice, licensure authority, and prescriptive authority as outlined in the APRN Consensus Model:

[1] NCSBN an independent, not-for-profit organization through which nursing regulatory bodies act and counsel together on matters of common interest and concern affecting public health, safety and welfare, including the development of nursing licensure examinations.

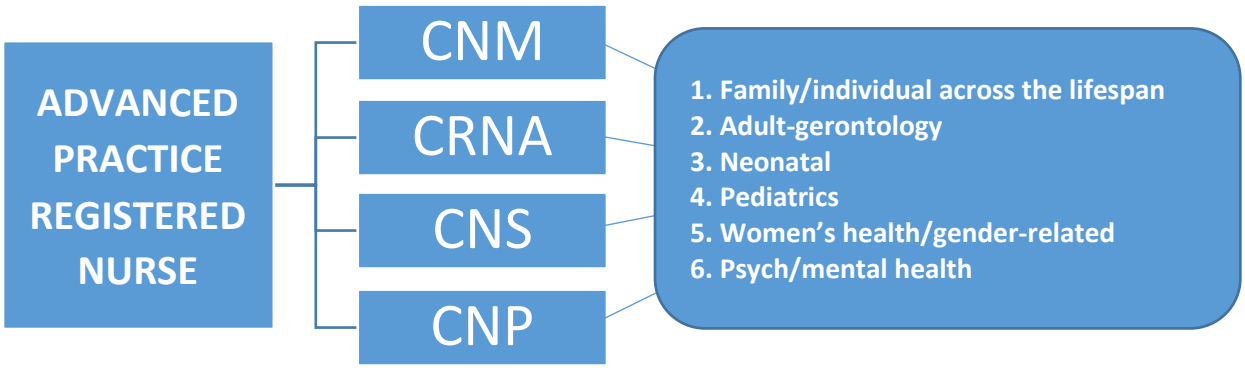
[2] APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, NAT'L COUNCIL STATE BDS. NURSING (Jul 2008).

	APRN	CNP	CNM	CRNA	CNS
Definition	A licensed independent practitioner who has completed a graduate-level education program preparing him/her for one of the four APRN roles; passed a national certification examination; and provides direct care to patients.	Practices autonomously as primary care CNPs and acute care CNPs, which have separate competencies and certification processes; prepared to treat patients with undifferentiated symptoms or established diagnoses.	Provides a full range of primary health care services to women including gynecologic, family planning, preconception, prenatal, postpartum, childbirth, and newborn care and treats male partners of their female clients for STDs.	Provides the full spectrum of patients' anesthesia care and anesthesia-related care for individuals, including those with immediate, severe, or life-threatening illnesses or injury.	Integrates care across the continuum and through three spheres of influence: patient, nurse, system; primary goal of the CNS is continuous improvement of patient outcomes and nursing care.

Licensure Authority	APRNs are to be licensed solely by Boards of Nursing (except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives).
Independent Practice	Responsible for complying with rules established by the Boards of Nursing and recognizing the limits of their knowledge and experience, and shall consult or refer to other health care providers as appropriate.
Independent Prescriptive Authority	Boards of Nursing shall grant prescribing, ordering, and dispensing authority through the APRN license.

Two recommendations are particularly relevant for this Report. First, the APRN Consensus Model recommends that APRNs be solely licensed by Boards of Nursing. It is important to note here that, although specialization is an option, APRNs are to be licensed at the level of role and population foci. The following graphic illustrates NCSBN's recommendation for APRN licensure:

ROLE POPULATION FOCUS



Second, the APRN Consensus Model recommends that all APRNs be granted independent practice and independent prescriptive authority as part of their licensure as an APRN.

Independent Practice is defined as requiring no collaborative agreement with a physician, supervision by a physician, or conditions for practice.

Independent prescriptive authority is defined as the ability of APRNs to prescribe, without limitation, legend (prescription) and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies.[3]

States have promulgated vastly diverse rules regarding prescriptive authority. For example, a board may grant independent prescriptive authority to APRNs who have been supervised by a physician after a limited period of time, or may restrict independent prescriptive authority to certain schedules of drugs. In some states, prescriptive authority is granted to some APRN roles, but not all of them. For the purposes of this report, states will be considered as granting independent prescriptive authority if APRNs may become eligible at any point for independent prescriptive authority.

B. APRN Compact:

In August 2020, the NCSBN adopted a Model Act which serves as the basis for state legislation to enact the APRN Compact. Once seven states have enacted this legislation, the APRN Compact will go into effect. In order to be eligible for a multi-state license, an APRN must be a legal resident of a compact state and meet the Uniform Licensure Requirements for a multi-state license. The home state maintains the authority over the license, and a remote state may take adverse action against a licensee's privilege to practice within that remote state.

Currently, North Dakota and Delaware have passed legislation to join the APRN Compact. Compacts make it possible for licensees to practice across state lines outside their home state without applying for a separate license therefore eliminating any delay in providing care to patients. An APRN's ability to practice across state lines increases access to care through expansion of workforce. Military spouses currently enjoy the benefits of the Nurse Licensure Compact and are likely to find the APRN Compact a useful mechanism through which they can maintain their licensure and continue to work when they are uprooted to different states.

[3] APRN Prescribing Law: A State-by-State Summary (last visited October 7, 2021) https://www.medscape.com/viewarticle/440315

In discussions on HB793 in the summer of 2021 Virginia's Board of Medicine and Board of Nursing both recommended that Virginia "Adopt the Criteria for APRN practice as outlined in the NCSBN APRN Compact". The APRN compact criteria for multistate licensure are provided in the following table:

APRN COMPACT UNIFORM LICENSURE REQUIREMENTS

FOR MULTI-STATE LICENSURE

1. Conduct criminal background checks for applicants for initial APRN licensure or APRN licensure by endorsement.
2. Meet home state's requirements for obtaining and retaining a single state license, in addition to meeting the following Uniform Licensure Requirements (ULRs):
   - Graduates from a graduate-level accredited education program or an approved foreign APRN education program
   - Passes an English proficiency examination (applies to graduates of an international education program not taught in English or if English is not the individual's native language)
   - Passes a national certification examination that measures APRN, role and population-focused competencies and maintains continued competence as evidenced by recertification in the role and population focus through the national certification program
   - Holds an active, unencumbered license as a registered nurse and an active, unencumbered authorization to practice as an APRN
   - Has successfully passed an NCLEX-RN® examination or recognized predecessor, as applicable
   - Has practiced for at least 2,080 hours as an APRN in a role and population focus congruent with the applicant's education and training
   - Has submitted to state and federal fingerprint-based criminal background checks
   - Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state, federal, or foreign criminal law
   - Has no misdemeanor convictions related to the practice of nursing (determined on a case-by-case basis)
   - Is not currently a participant in an alternative program *(i.e., Virginia Health Practitioners' Monitoring Program)*
   - Is required to self-disclose current participation in an alternative program
   - Has a valid United States Social Security number
3. An APRN multistate license is recognized as authorizing the APRN to practice in each party state, under a multistate licensure privilege, in the same role and population focus as in the home state.
4. An individual may apply for a single-state license, instead of a multistate license, even if otherwise qualified for the multistate license.

III. VIRGINIA REGULATORY MODEL

Upon the recommendation of the Virginia Board of Nursing, the General Assembly amended the *Medical* Practice Act in 1973 authorizing the Boards of Medicine and Nursing to regulate expanded nursing practice.

Virginia's joint-board regulatory structure[4] created an unusual legal landscape. Laws governing APRNs are housed in the Medical Practice Act, but Board of Medicine regulations do not contain any reference to APRNs. Regulations pertaining to APRNs are recommended by the Committee of the Joint Boards of Medicine and Nursing, must be approved by both the Board of Medicine and the Board of Nursing, and are housed under the Board of Nursing.

A. History of APRN Regulation in Virginia:

The regulations governing APRNs (referred to as "nurse practitioners") were initially promulgated in 1975 and included general NPs and CRNAs. The following year, regulations for CNMs were added. By 1986, Virginia certified NPs in these 3 roles (NP, CRNA, and CNM) according to 14 different population foci, and began registering CNSs in 1989. In 1988, regulations were amended changing the status of NPs from *certified* to *licensed*, and modifying the definition of supervision giving NPs less restrictive practice.

The General Assembly has steadily expanded licensed NP practice through amendments to the Virginia Code. From provisional practice status to legal changes enabling insurance reimbursement and expansion of prescriptive authority to include Schedule II drugs, the Commonwealth has incrementally grown closer to alignment with the APRN Consensus Model.

B. Recent Legislative Changes:

In 2018, HB 793 provided for nurse practitioners (CNP) with five or more years of clinical experience (9,000 hours) to submit an application for autonomous practice. The regulations went into effect January 7, 2019.

In 2021, the Virginia General Assembly brought the Commonwealth even closer into alignment with the national APRN Consensus Model upon enactment of three bills—HB1737, HB1747, and HB1817. Each of these bills included amendments to § 54.1-2957 of the Va. Code:

- **HB 1737** allows CNPs to apply for autonomous practice after *two* years (as opposed to the previously required *five* years) of full-time clinical experience. This law includes a "sunset" provision, meaning without further legislation, the law will revert back to the 5-year requirement on July 1, 2022.

[4] Virginia is one of three states with a joint board structure for APRNs; the others are Alabama and North Carolina.

- **HB 1747** changed the status of Virginia CNSs from registered to licensed. As of July 1, 2021, CNSs are now included in the definition of APRNs, and required have a practice agreement[5].
- **HB 1817** grants CNMs independent practice upon the Boards of Medicine and Nursing receiving an attestation that the midwife completed 1,000 hours of practice in accordance with a practice agreement with either a physician or a CNM with 2 or more years of clinical experience.

The current legislative landscape in Virginia is compared to the APRN Consensus Model in the following chart with areas in green denoting alignment with the Model:

	APRN	CNP	CNM	CRNA	CNS
Definition	In Virginia, 'APRN' as a term is not defined and is used only in the definitions of the 4 roles.	Virginia uses the term "licensed nurse practitioner" by regulation to refer to all APRNs. The definition of CNPs, CNM, CRNA, and CNS recommended by NCSBN's APRN Consensus Model are substantially equivalent to Virginia's definitions.			
Licensure Authority	The Consensus Model recommends licensure only by Boards of Nursing. In Virginia, all nurse practitioners are licensed by the Joint Boards of Medicine and Nursing.				
Independent Practice	APRNs are either supervised or must maintain a practice agreement upon initial NP licensure in Virginia.	In Virginia, licensed nurse practitioners (CNPs in the Model) must maintain a practice agreement with a physician for 2 years after which they may apply to the Boards to practice independently.[6]	In Virginia, CNMs must maintain a practice agreement with a physician or experienced CNM for 1,000 hours after which they may practice independently.	In Virginia, CRNAs are required to practice under the supervision of a physician, podiatrist or dentist. No mechanism exists for independent practice.	In Virginia, CNSs are restricted to consultation with a licensed physician in accordance with a practice agreement.
Independent Prescriptive Authority	Independent prescriptive authority is not granted by the designation as an APRN in Virginia.	Once granted independent practice (as described above), then LNPs (CNPs) and CNMs acquire independent prescriptive authority.		CRNAs may prescribe drugs during the periprocedural period.	CNSs may prescribe controlled substances in accordance with a practice agreement.

[5] Budget language in the 2021 Special Session II allows CNSs registered with the Board of Nursing immediately prior to July 1, 2021 to practice without a practice agreement if they practice without prescriptive authority. The budget provision expires after June 30, 2022.

[6] Va. Code § 54.1-2957 (C), (I) (effective until July 1, 2022); if not reenacted will require 5 years. While the law refers to "nurse practitioners," it also excludes CNMs, CNSs, and CRNAs.

In summary, Virginia laws have been moving toward alignment with the APRN Consensus Model while maintaining the unique joint-boards structure in the regulatory system.

The NCSBN assigns points to states and territories for alignment with the APRN Consensus Model. Virginia is one of nine jurisdictions that score 24 points, with 22 jurisdictions scoring higher and 24 scoring lower[7].

The Virginia regulatory model differs from the APRN Consensus Model in two significant ways:

1) Virginia does not grant all APRNs the ability to practice independently upon initial licensure, and 2) Virginia does not regulate APRNs solely through the Board of Nursing.

To understand specifically how Virginia compares with other states and territories, the next section examines each of the nationally-recognized APRN roles and how they are regulated. Legislative actions that are needed for Virginia to be in alignment with the APRN Consensus Model are then detailed in the Recommendations section of this Report.

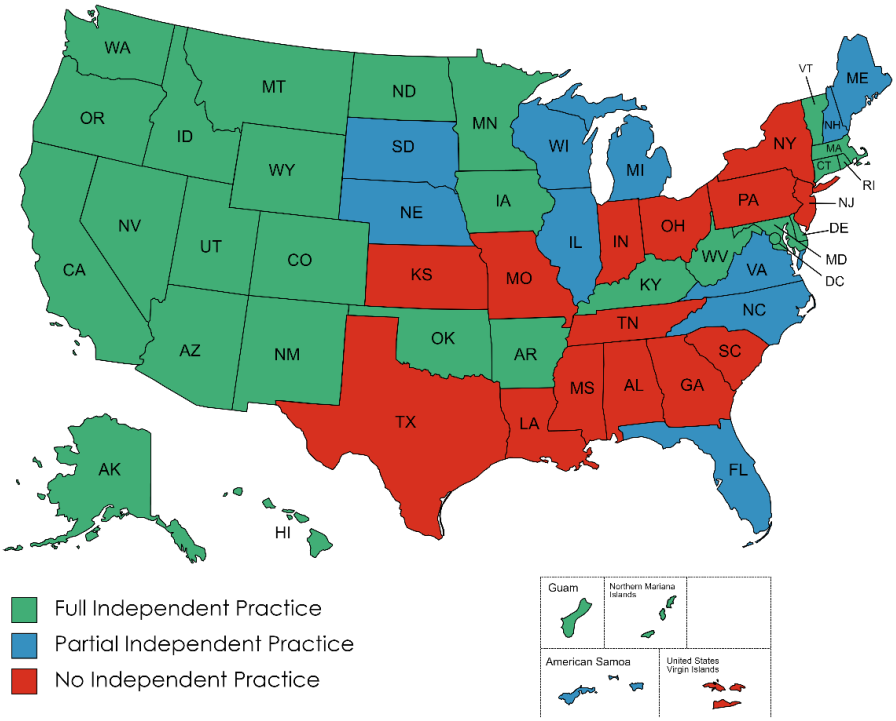
IV. APRN ROLES – HOW EACH ROLE IS REGULATED IN THE UNITED STATES AND TERRITORIES

While there continues to be significant national variation in state APRN regulatory structures, overall states and territories have collectively grown closer to conformity with the APRN Consensus Model. As of 2021, every U.S. state recognizes at least three of the four APRN roles. Only eight states do not use the "APRN" designation. Most states now require licensure by a regulatory board for APRNs to legally practice and are subject to disciplinary action by those boards. Nearly half (23) of U.S. jurisdictions authorize APRNs in all four roles to practice and prescribe independently (as previously defined on page 4) in their jurisdiction.

The following maps reflect an analysis of statutory data on APRN practice authority and APRN prescriptive authority by state-territory collected specifically for this Report and found in Appendix A.

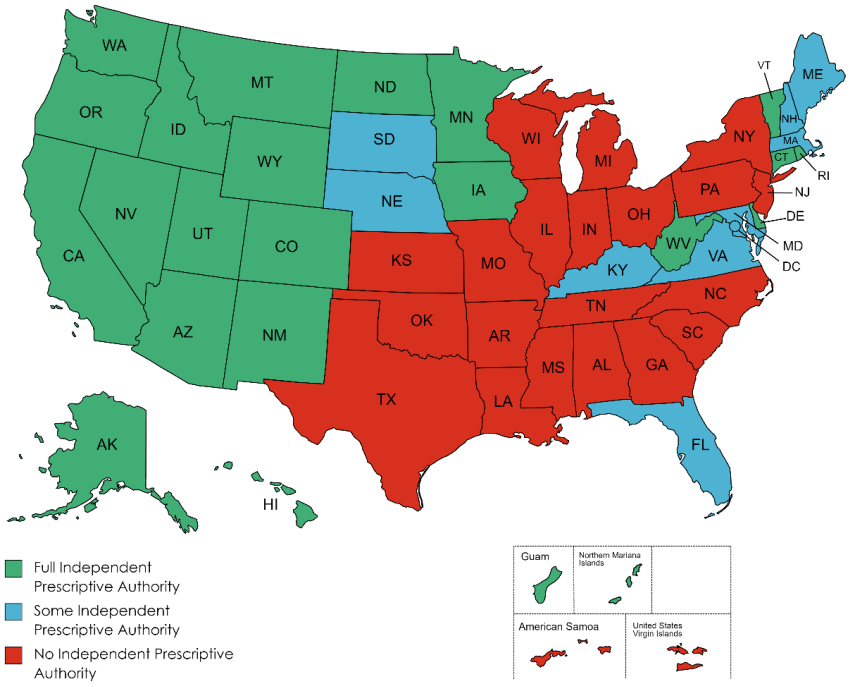
[7] https://www.ncsbn.org/5397.htm

APRN PRACTICE AUTHORITY



Most states allow full or partial independent practice; 15 jurisdictions do not allow independent practice options for any of the four roles.

APRN PRESCRIPTIVE AUTHORITY



This map indicates that there is greater division between jurisdictions regarding the granting of independent prescriptive privileges.

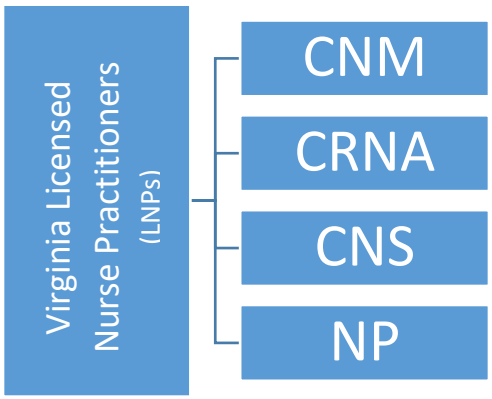
Due to the great variation among state regulatory structures for each APRN role, this section of the report will consider each role separately.

A. Certified Nurse Practitioner:

Consensus Model Definition: Certified Nurse Practitioner (CNP) – prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

National: The generic umbrella title of "nurse practitioner" has gradually phased out and been replaced with "advanced practice registered nurse" at the national level. "Certified nurse practitioner" was adopted in the APRN Consensus Model and many other states to refer to one of the four APRN roles. Some U.S. jurisdictions continue to use "nurse practitioner" to refer to all four APRN roles. Virginia is one such state as "nurse practitioner" and "licensed nurse practitioner" are used interchangeably in Virginia Code and regulations to denote an APRN who has been licensed by the joint Boards of Medicine and Nursing.

Virginia: In Virginia, it is particularly challenging to compare the NP role that corresponds to the CNP role as defined by the APRN Consensus Model to other states. Va. Code § 54.1-2957 requires the Boards of Medicine and Nursing to "jointly promulgate regulations governing the licensure of nurse practitioners". As a result, "nurse practitioner" refers to all four APRN roles jointly licensed by the Boards of Medicine and Nursing throughout the Code as illustrated in this diagram:



Unlike the CNM, CRNA, and CNS roles which are specifically defined in the Code according to education and certification, referring to the NP role requires the use of qualifiers by exception in Virginia Code -- "a nurse practitioner, other than a CRNA, CNM or CNS".

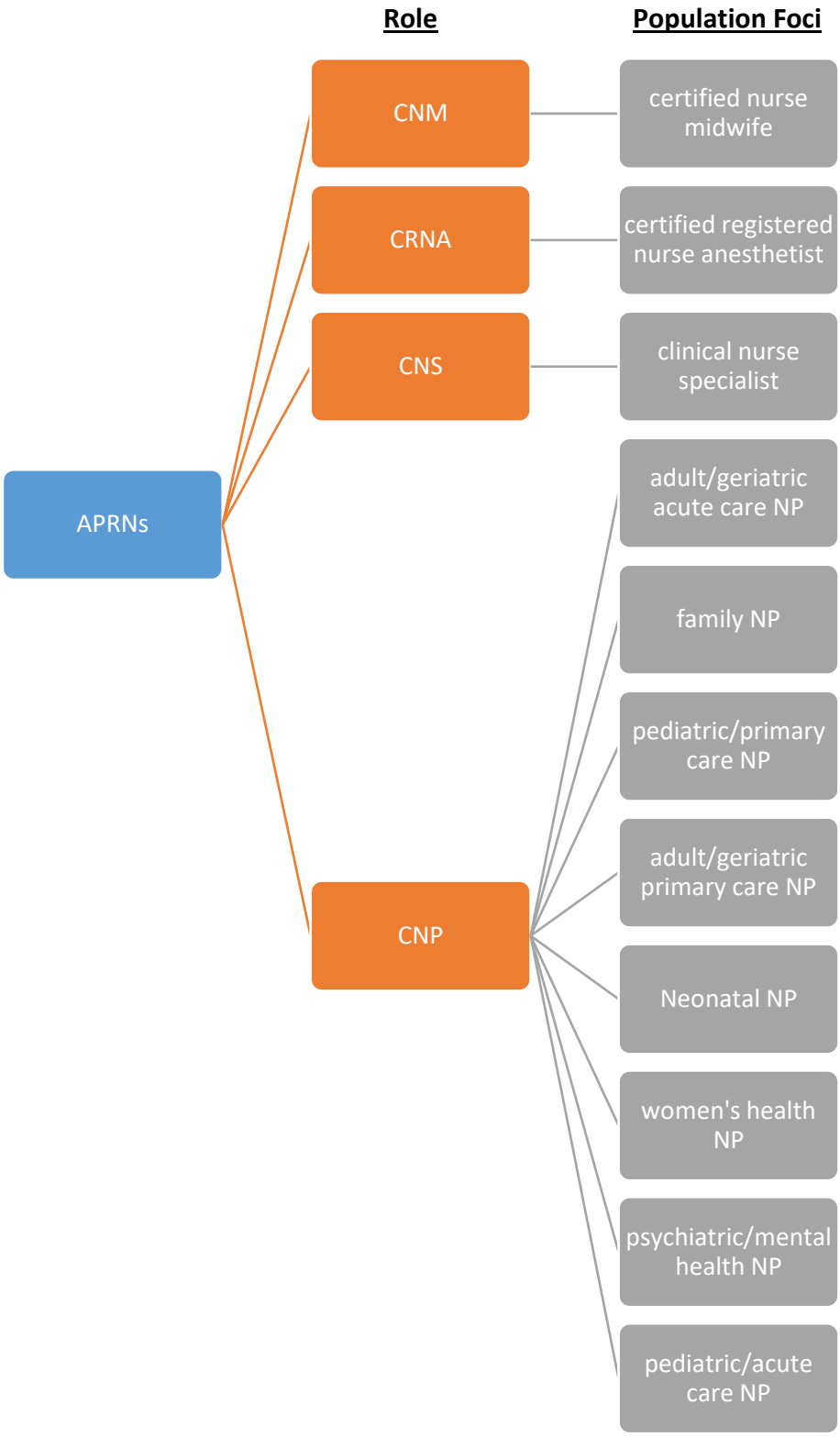
In other words, an NP in Virginia educated and certified in specialties other than nurse midwifery, nurse anesthesia, or clinical nurse specialist falls under what most states and the APRN Consensus Model refer to as Certified Nurse Practitioner (CNP).

Independent Practice: The NCSBN defines independent practice as requiring no collaborative agreement with a physician, supervision by a physician, or conditions for practice. Currently, independent practice authority is the legal/regulatory issue with the least amount of disparity between jurisdictions. Thirty-six jurisdictions (including Virginia) grant CNPs the ability to obtain independent practice authority either immediately upon licensure or via a transition to practice model.

Prescriptive Authority: The NCSBN considers an APRN to have prescriptive authority if they may administer, prescribe, or distribute controlled substances devices and equipment. Such authority is considered independent if there are no requirements that the APRN maintain a written collaborative agreement with a physician or be supervised in their prescriptive capacity.

There are 32 U.S. jurisdictions (including Virginia) that grant CNPs independent prescriptive authority exceeding that of any other APRN role.

If Virginia were to codify the term “Advanced Practice Registered Nurse” as a substitute for “Nurse Practitioner” as well as the term “Certified Nurse Practitioner” for the NP role as used in the APRN Consensus Model, the regulatory model in Virginia would look like this:


Role
Population Foci
APRNs
CNM
certified nurse midwife
CRNA
certified registered nurse anesthetist
CNS
clinical nurse specialist
CNP
adult/geriatric acute care NP
family NP
pediatric/primary care NP
adult/geriatric primary care NP
Neonatal NP
women's health NP
psychiatric/mental health NP
pediatric/acute care NP

B. Certified Nurse Midwife:

Consensus Model Definition: Certified Nurse Midwife (CNM) – provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted diseases and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

National: All jurisdictions recognize the CNM role. CNMs are regulated by both the Board of Medicine and the Board of Nursing in Virginia and North Carolina, while in New Jersey and Pennsylvania CNMs are regulated solely by their jurisdiction's Board of Medicine. CNMs in the other jurisdictions are regulated solely by the Board of Nursing, except in five states where they are regulated by the Department of Health or a Board of Midwifery.

Virginia: A "certified nurse midwife" is an APRN "who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing." All laws pertaining to the CNM are provided in Chapter 29 of the Virginia Code (Medicine and Other Healing Arts), with regulations in the Board of Nursing.

Independent Practice: Independent practice is defined by the NCSBN as having no requirements "for a written collaborative agreement…supervision, [or] conditions for practice." Recent legislation in Virginia allows CNMs to attain autonomous practice status after completion of 1,000 hours of clinical experience attested to by a CNM or physician who supervised such experience. Thirty-one states (including Virginia) plus D.C., Guam, American Samoa, and the Northern Mariana Islands allow CNMs the ability to obtain independent practice authority.

Prescriptive Authority: Nationally, there is great disparity between jurisdictions on the level of prescriptive authority held by CNMs. While CNMs have been granted the authority to write prescriptions in all fifty states and the District of Columbia, the level of authority varies from direct supervision limited to a practice agreement to independent authority with no physician oversight requirement. Thirty jurisdictions currently provide CNMs with independent prescriptive authority. Virginia provides independent prescriptive authority for CNMs who have attained autonomous practice status.

C. Certified Registered Nurse Anesthetist:

Consensus Model Definition: Certified Registered Nurse Anesthetist (CRNA) – provides the full spectrum of anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of practitioners such as surgeons, dentists, podiatrists and ophthalmologists.

National: In most U.S. jurisdictions the practice of CRNAs is governed exclusively by the laws governing nursing and Board of Nursing regulations. No jurisdiction other than Virginia includes the Board of Medicine in the regulation of CRNAs.

Virginia: A "certified registered nurse anesthetist" is an APRN who is "certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957." This definition comes from Chapter 29 of the Virginia Code (Medicine and Other Healing Arts), while regulations reside with the Board of Nursing.

Independent Practice: CRNAs are allowed to practice independently in 36 jurisdictions. In Virginia, a CRNA "shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry."

Prescriptive Authority: Nationally, there is great disparity between jurisdictions on the level of prescriptive authority held by CRNAs. Twenty-seven jurisdictions currently allow CRNAs to obtain independent prescriptive authority. While able to prescribe, CRNAs do not have independent prescriptive authority in Virginia due to the supervisory requirement.

D. Clinical Nurse Specialist:

Consensus Model: Clinical Nurse Specialist (CNS) – integrates care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity.

Virginia began registering CNSs in 1989 and only began licensing CNSs in July 2021. Notably, common functional role competencies for CNS practice were not delineated until 1998, which may explain the delay on the part of Virginia and other states in shifting CNS regulation from certification to full licensure.

National: CNSs are regulated by boards of nursing in nearly every jurisdiction. Idaho and Michigan primarily regulate CNSs via boards of nursing but allow some regulation of CNSs by the boards of pharmacy relevant to the prescriptive authority of each APRN role. The only U.S. jurisdictions which do not recognize the CNS role are American Samoa, Mississippi, and New Hampshire.

Virginia: In Virginia, a "clinical nurse specialist" is an APRN who is "certified in the specialty of clinical nurse specialist and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957." No other jurisdictions follow this regulatory model.

Independent Practice: Thirty-four (34) jurisdictions allow CNSs to practice independently. CNSs in Virginia are required in § 54.1-2957 (J) to practice in "consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician." Across all U.S. states and territories, the CNS role is the least likely among all roles to obtain independent practice or independent prescribing.

Prescriptive Authority: Twenty-five (25) jurisdictions grant CNSs the authority to prescribe medicine independently. Virginia does not authorize CNSs to independently prescribe. However, CNSs holding a license for prescriptive authority may prescribe Schedules II through VI controlled substances, but in accordance with any prescriptive authority included in a practice agreement.

V. IMPACT OF LEGISLATION AND REGULATION ON APRN PRACTICE & PATIENT OUTCOMES

As part of this report, DHP was asked to "review research on the impact of statutes and regulations on practice and patient outcomes". Provided below are brief summaries of articles that are most responsive to this request.

- The results of a systematic review of the literature on state NP regulation and patient outcomes in 2021[8] "indicate that expanded state practice regulations were associated with greater NP supply and improved access to care among rural and underserved populations without decreasing care quality."

[8] Bo Kyum Yang, et al., *State Nurse Practitioner Practice Regulations and U.S. Health Care Delivery Outcomes: A Systematic Review*, 78 MED. CARE RESEARCH & REV. 183 (2021).

- The study by Kurtzman, et al., Does *the Regulatory Environment Affect Nurse Practitioners' Patterns of Practice or Quality of Care in Health Centers*[9]*,* used data from community health centers to compare NP-delivered care in states with and without NP practice restrictions. No significant differences in quality were detected, although patients of NPs in states with prescriptive independence received more educational services and medications. NPs in states with practice independence were more likely to refer to physicians.
- Ortiz et al.*[10]* studied clinical outcomes of older rural adult patients by state to determine if variability exists based on level of NP practice autonomy. The authors concluded that, while there was no significant relationship between APRN scope of practice and patient outcomes, there were "strong indications that the quality of patient outcomes is not reduced when the scope of practice is expanded."
- Martsolf et al.[11] studied the issue of the geographic variation in anesthesia provider supply (lower per capita in rural areas) to see if state policy on CRNA regulation was related to CRNA supply in rural areas. By measuring the degree to which states allowed CRNA services without physician supervision, and whether or not the state "opted out" of Medicare requirements for physician supervision, it "found opt-out status was correlated with greater CRNA supply per capita in rural counties although findings seem to suggest that opt-out may not lead to more CRNAs; rather, states may respond to the current supply of CRNAs in the state by opting out".
- A 2016 analysis, *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*[12]*,* estimated the association between state scope of practice laws related to the autonomy of CNMs, access to midwife-attended births and childbirth-related procedures and outcomes. It concluded that "states with regulations that support autonomous midwifery practice have a larger midwifery workforce, and a greater proportion of midwife-attended births" and that "autonomous practice was associated with lower odds of cesarean delivery, preterm birth, and low birthweight."

[9] Ellen Kurtzman, et al., *Does the Regulatory Environment Affect Nurse Practitioners' Patters of Practice or Quality of Care in Health Centers?* 52 HEALTH SERVICES RESEARCH 437 (2017).
[10] Judith Ortiz, et al., *Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes*, 6 HEALTHCARE 65 (2018).
[11] Grant Martsolf, et al., *Relationship Between State Policy and Anesthesia Provider Supply in Rural Communities*, 57 MED. CARE 341 (2019).
[12] Y. Tony Yang, et al., *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*, 26 WOMEN'S HEALTH ISSUES 262 (2016).

VI. CONCLUSIONS

The national landscape of APRNs is one with great regional variation. A number of states, especially in the South and Midwest, do not allow independent APRN practice; Virginia does, for some APRN types and with some restrictions. Similarly, Virginia allows some degree of independent prescriptive authority, joining over half of the states that allow full or partial authority. Virginia is one of only 3 states in which APRNs are regulated using a joint board (medicine and nursing) structure.

One way to look at the status of advanced practice nursing in Virginia is to see how Virginia compares to the NCSBN-supported Consensus Model for APRN Regulation (page 8 of this report). Virginia is aligned in some but not all areas.

An alternative way is to see how Virginia compares with other United States' jurisdictions (pages 9 – 16 of this report); again, Virginia is positioned in the middle, with alignment in some but not all areas.

Research to date on the impacts of regulation of advanced practice nursing indicates that autonomous practice may lead to a greater supply of APRNs, and while there may be differences in practice, there do not appear to be significant differences in quality of care.

VII. RECOMMENDATIONS

1. **Amend select definitions to conform to those used in the APRN Consensus Model endorsed and promoted by the NCSBN.**
   - Amend the definition of "nurse practitioner" to "advanced practice registered nurse" in Va. Code §§ 54.1-2900 and 54.1-3000 and regulation when referring to all 4 APRN roles.
   - Amend the definition of "licensed nurse practitioner" in regulation to "certified nurse practitioner (CNP)"

2. **Consider amending Virginia laws and regulations to align with the APRN Consensus Model.**

   Additional actions required to align with the Model include:
   - Grant all APRNs in Virginia independent practice authority.
   - Grant all APRNs in Virginia independent prescriptive authority.
   - Regulate APRNs solely under the Board of Nursing

3. **Pursue participation in the APRN Licensure Compact.**
   - Adoption of the Compact by Virginia and other states, especially our border states, would increase mobility for APRNs and potentially increase access to care through expansion of workforce across state lines.

APPENDIX A

This appendix was created by the Department of Health Professions' staff and was used to create the maps on page 10 of this report.

Key:

- ✓ - independence (practice or prescriptive authority) granted for all roles
- × - no independence for any roles
- ✓* - at least one APRN-role is granted independence

Board	Independent Practice	Independent Prescribing	Citations
Alabama	×	×	§ 34-21-86; § 34-21-90 ; Ala. 540-X-80.08
Note: Laws for CNS practice are very restrictive (may not prescribe at all or engage in collaborative practice). "Certified registered nurse practitioners and certified nurse midwives are subject to collaborative practice agreements with an Alabama physician. Certified registered nurse anesthetists and clinical nurse specialists are not subject to collaborative practice agreements with an Alabama physician and are not subject to the requirements of Sections 34-21-82, 34-21-83, and 34-21-85 to 34-21- 92, inclusive, and are prohibited from engaging in any of the acts or functions of a certified registered nurse practitioner (CRNP) or a certified nurse midwife (CNM) as established by this article and regulations adopted under this article."			
Alaska	✓	✓	AS 08.68.100; 12 AAC 44.440; 12 AAC 44.380
American Samoa	✓*	×	A.S.C.A. 31.0442 through 31.0447
Arizona	✓	✓	Ariz. Stat. 32-1601; R4-19-508 ; R4-19-511; R4-19-512 ; R4-19-513
Arkansas	✓	×	Ark. Code Ann. S 17-87-310; Ark Admin Code 067.00.3-VIII
Note: Map chart indicates that CNPs do have independent prescriptive authority; I reviewed the regulations and did not find language separating CNPs from the other APRN roles, and all APRNs with prescriptive authority must apply for it, complete training, have preceptorial experience, and be restricted to the formulary guidelines outlined in a collaborative practice agreement with a physician. CNMs are independent but must have written agreement if providing intrapartum care.			
California	✓2023	✓2023	Cal. Bus. & Prof. Code 2836.1; 2837.104.
Not currently independent, but AB 890 approved bill granting full practice authority by 2023 to nurse practitioners.			
Colorado	✓	✓	C.R.S. 12-20-204(1), 12-255-107(1)(j), 12-255-112, 12-38-111.6; R. 1.15; 12-255-111.
APRNs are registered but not licensed; implicit independent practice.			
Connecticut	✓	✓	Conn. S. 20-87a
Delaware	✓	✓	Del. Code S. 1934; R. 8.14

Board	Independent Practice	Independent Prescribing	Citations
District of Columbia	✓	✓*	5709.1; 5710; 5710.1; 5710.2; 5910.1; 5910.2;
*CNP is restricted to protocol for prescribing (5910.1); Certified nurse practitioner: a registered nurse trained in an educational program and certified by a recognized national certification organization to provide healthcare services who, when functioning within the authorized scope of practice, is qualified to assume primary responsibility for the care of patients. (Title 17, Rule 5999.1).			
Florida	×*	×*	Fla. Stat. 464.012; Fla. Admin. Code 64B9-4.010
Florida only allows CNMs the ability to obtain independent practice or independent prescriptive authority.			
Georgia	×	×	GA.R. 410-11-.14
Georgia's law seems to be confusing; it keeps referring to "when an APRN is authorized to use a protocol," but I am not finding any language which suggests that APRNs are always required or at any point required to practice in a dependent manner. To the contrary, S. 43-34-25 (j) states, "Nothing in this Code section shall be construed to apply to the practice of a certified registered nurse anesthetist."			
Guam	✓	✓	3-12-10 Guam Code Ann. § 12313
Hawaii	✓	✓	Chapter 457 S. 457-8.5; 457-8.6
"§457- Application of National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. (a) In accordance with chapter 91, the board shall adopt the provisions of the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules relating to the scope and standards of nursing practice for registered nurses, licensed practical nurses, and advanced practice registered nurses and shall adopt any subsequent modifications adopted by the Delegate Assembly of the NCSBN; provided that the board shall not be required to adopt rules or provisions that the board finds are inappropriate or inapplicable."			
Idaho	✓	✓	R. 315
Illinois	✓*	×	225 ILCS 65/65-40; Ill. Admin. Code 1300.430; Tit. 68 Section 1300.465 Full Practice Authority
*CRNAs do not have the ability to obtain full practice authority, but CNMs, CNPs, and CNSs all do.			
Indiana	×	×	848 IAC 5-1-1 (prescriptive authority); IC 25-23-1-19.4 (practice authority)
Iowa	✓	✓	655 IAC 7.4
Kansas	×	×	K.S.A. 65-1130; Kan. Admin. Regs. § 60-11-101
NCSBN marked CRNA as independent practice			
Kentucky	✓	✓*	K.R.S. § 314.042
* APRNs have the ability to obtain independent prescriptive authority after 4 years of prescribing pursuant to a practice agreement. Subsections 8 through 10 describe this transition.			
Louisiana	×	×	LAC 46:XLVII.4513.D
Maine	✓*	✓*	32 M.R.S.A. 2102; CMR 02-380-008

Board	Independent Practice	Independent Prescribing	Citations
*NCSBN says that CRNAs are subject to supervision and thus are not independent, but as I read the regulation, it appears to me that such supervision is only required "for aspects of anesthesia practice that require execution of the medical regimen." * CNPs, CNMs, and CRNAs are granted prescriptive authority, but under Sec. 7 of the regulation, only CNMs and CNPs may prescribe drugs perioperatively, while CRNAs are restricted to prescribing drugs only during the preoperative period and the immediate postoperative period and must use the institution's DEA number, whereas the CNM and CNP are required to maintain their own DEA numbers. CNSs are not granted prescriptive authority.			
Maryland	✓	✓*	Independent Practice: COMAR 10.27.27 (CNS); 10.27.06 (CRNA); 10.27.05 (CNM); 10.27.07 (CRNP or NP); Prescriptive Authority: COMAR 10.27.05.11 (CNM); 10.27.07.07 (NP or CRNP) (no language for CRNA or CNS)
* Prescriptive authority for CRNAs and CNSs is defined by statute or regulation and thus is not considered by the NCSBN to be "independent."			
Massachusetts	✓	✓*	244 CMR 4.06 (independent practice); 244 CMR 4.07 (prescriptive authority)
* Pursuant to emergency regulations adopted in June, CRNAs, CNPs, and psychiatric CNSs have the ability to obtain independent prescriptive practice after 2 years of prescribing under supervision. CNMs have independent prescriptive authority, and CNSs (the non-psychiatric kind) do not have any independent prescriptive authority.			
Michigan	×*	×	MCL 333.17211a
* CRNAs may practice independently in certain sites only.			
Minnesota	✓	✓	MINN. STAT. 148.171 (2021)
Mississippi	×	×	30 Miss. Code R. § 2840
Missouri	×	×	334.104.2 RSMo; 20 CSR 2200-4.200
Montana	✓	✓	Mont. Admin. R. 24.159.1461, 1464 (prescriptive authority); 1470 (practice authority)
Nebraska	✓*	✓*	Neb. Rev. Code 38-613, 618(CNMs restricted to practice agreement; CNMs excluded from independent practice); 2315; 2322 (authorizing transition to independent practice to the nurse practitioner role); 901-910 (no CNS statute grants independent prescriptive authority or independent practice)

Board	Independent Practice	Independent Prescribing	Citations
* 618 states that nothing in the Certified Nurse Midwifery Act should be interpreted as granting independent practice. However, the acts which govern all nurse practitioners grant independent practice after 10,000 supervised hours. Therefore, all roles may obtain independent practice, except for CNMs which are subject to the interpretation that they are excluded from independent practice. The CNS statutes do not mention anything about a practice agreement or independent practice or independent prescriptive authority. Ask NCSBN why they marked CNS as "NS,' what that means, and where in statute they interpreted CNS authorities.			
Nevada	✓	✓	Nev. Rev. Stat. § 632.237, 259; Nevada Admin. Code § 632.2595
* Nevada doesn't recognize the CNS role.			
New Hampshire	✓*	✓*	N.H. Rev. Stat. §§ 326-B:2.I (practice authority), 326-B:11.III (prescriptive authority)
New Jersey	×	×	N.J.A.C. 45:11-49(b) (practice authority), (c) (prescriptive authority)
New Mexico	✓	✓	N.M. § 61-3-23.2(B)(2)
New York	×	×	§ 6910 (CNP); § 6911 (CNS); § 6951 (CNM)
*In New York, midwifery is a separate profession.			
North Carolina	✓*	×	21 NCAC 36.0228 (CNS practice); 21 NCAC 36.0226 (CRNA practice); 21 NCAC 36. 0802 (NP scope of practice); 21 NCAC 36.0809 (NP prescriptive authority)
* NP is the term used for all APRN roles.			
North Dakota	✓	✓	N.D. Admin. Code § 54-05-03.1-01
Northern Mariana Islands	✓	✓	Commonwealth Admin. Code § 140-60.1-415 (prescriptive authority), 420 (practice authority)
Ohio	×	×	Ohio Rev. Code § 4723.43 (practice authority); Ohio Rev. Code § 4723.481; Ohio Admin. Code R. 4723-9-10 (prescriptive authority)
Oklahoma	✓	×	Ok. Stat. Ann. 567.3a; Ok. Admin. Code 485:10-15-6 (CNP), 15-7 (CNS), 15-8 (CNM), 15-9 (CRNA), 16-5 (prescriptive authority)
Oregon	✓	✓	Or. Rev. Stat. § 678.390 (prescriptive authority); Or. Admin. R. § 851-050-0004 (practice authority)
Pennsylvania	×	×	21 Pa. Code § 107.12a
Rhode Island	✓	✓	216 Rhode Island Code of Regulations 40-05-3.7 (APRNs), 23 (licensed nurse midwives)
*APRNs include CNPs, CNSs, and CRNAs; licensed nurse midwives are recognized separately under laws and regulations governing midwifery.			
South Carolina	×	×	S.C. Code Ann. 40-33-20;40-33-34

Board	Independent Practice	Independent Prescribing	Citations
South Dakota	✓*	✓*	SD. Stat. Ann. 36-9A-12;17; ARSD 20:48 (CRNAs & CNSs), 62 (CNPs & CNMs)
*CNSs are restricted to a collaborative agreement for practice and supervision for prescribing.			
Tennessee	×	×	Tenn. Code Ann. 63-7-123; Tenn. R.R. 1000-04-.04
Texas	×	×	T.A.C. 222.4(a)(1)(A)
Utah	✓	✓	Utah Code Ann. § 58-31b-102 (practice authority), 803 (prescriptive authority)
Vermont	✓	✓	26 V.S.A. §§ 1572 (prescriptive authority), 1613 (practice authority)
Virgin Islands	×	×	27 V.I.C. § 101a
Virginia	✓*	✓*	Va. Code § 54.1-2957 (practice authority), 2957.01 (prescriptive authority)
* CRNAs are restricted to supervision, by definition. CNSs are restricted to a collaborative agreement with a physician.			
Washington	✓	✓	WAC 246-840-300 (independent practice), 400 (prescriptive authority)
West Virginia	✓	✓	W.Va. § 30-7-1
Wisconsin	✓*	×	Wis. Stats. 441.16 (2); Wis. Admin. Code N 4 (nurse midwives), N 8.10 (APN prescribers).
* Scope of practice for nurse-midwives: required to "collaborate with a consulting physician pursuant to a written agreement," and shall not "independently manage those complications that require referral pursuant to the written agreement." My interpretation of the law is that CNMs do not have independent prescriptive authority, but the NCSBN has marked down that CNMs do have independent prescriptive authority.			
Wyoming	✓	✓	Wyoming Admin. R. Chapter 3 §§ 2, 3