Boards of nursing (BONs) have public protection as their primary mission. They do this chiefly by enforcing nurse practice acts (NPAs), which are statutes that give the board the authority to license and discipline nurses, accredit/approve schools of nursing programs that lead to licensure, and promulgate administrative rules and regulations consistent with the NPA. Nurse practice acts vary from state to state; it is nurses’ responsibility to be aware of the laws that govern their practice.

Although some BONs may state that no other nursing organization has the protection of the public as its primary mission, in fact, nursing certification programs share the same goal. For example, the mission of the AACN Certification Corporation (AACN CertCorp) contributes to consumer health and safety through comprehensive credentialing of nurses to ensure that their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

Traditionally, it has been thought that nursing licensure was mandatory and nursing specialty certification was voluntary—a credential to demonstrate additional expertise beyond licensure. However, both the increased dependence on advanced practice nurses to meet the nation’s health care needs, heightened public awareness of quality, and the resultant desire for assurance of continued competence beyond initial licensure have caused regulators to take a new look at the specialty certification credential and how it can be used to meet their public safety mission. This article will review the history and essential components of nursing licensure and how they parallel nursing specialty certification. The evolution of advanced practice nurse roles will be reviewed, and the implications of the new consensus model for APRN regulation (consensus model) on the education, certification, regulation, and practice of the nurse practitioner (NP) and clinical nurse specialist (CNS) in acute and critical care will be analyzed.

Slicing the Regulatory Pie
One of the hallmarks of a profession is self-regulation. The first professional group in the United States to seek licensure was physicians, not just for the purpose of public protection, but also to distinguish themselves from imposters. No
dependent practice, executing orders of other licensed practitioners. In 1955, the American Nurses Association (ANA) issued a model definition of nursing, which affirmed that physician supervision was not required for all nursing functions. It did, however, prohibit nurses from diagnosing and prescribing.  

**From Essays to State Board Test Pool Examination to National Council Licensure Examination**

The early BONs established the criteria for licensure as a combination of a board-prescribed course of nursing education followed by a board-constructed licensure examination. Most BONs had statutory authority to regulate the schools of nursing. Each state BON developed its own essay, multiple-choice, performance examinations, or any combination of these, with separate sections for testing, and set their own passing scores.

During this time, states also began to develop “reciprocity” agreements with other states; that is, if states believed that the licensure requirements were equivalent, they would allow nurses licensed in “reciprocal” states to practice between the 2 states. This practice ended with the introduction of a national licensure examination, but the terminology and the belief that this practice still exists continues to this day, resulting in many nurses failing to obtain licensure when they move to a new state. In 1997, in an effort to facilitate interstate mobility of nurses and accommodate new technologies, notably telehealth, the National Council of State Boards of Nursing (NCSBN) introduced the Nurse Licensure Compact. This is a more complex licensure process than a 2-state agreement and should not be confused with the old reciprocity agreements.

In 1944, the State Board Test Pool Examination (SBTPE) was created by the National League for Nursing (NLN) to relieve the individual states of the burden of examination development. The pool had 13 sections, including microbiology, communicable-disease nursing, foods, cookery, chemistry, and nursing arts, that were tested. States were free to select which sections to administer and to set their own passing standard. By September 1949, almost all states were using the SBTPE for licensure decisions but continued to set their own passing scores through the 1980s. Eventually, the examinations were reduced
to 5 “books”—medical, surgical, pediatrics, obstetrics, and psychiatric—administered over a 2-day period. Examinations had a scaled score of 350 required in each book to pass. However, California and New York required scaled scores of 500 on each book until the examination converted to the integrated National Council Licensure Examination (NCLEX) format in 1982. At that time, a standard score was required by all states using the examination. In 1985, because of misuse of examination scores by potential employers and educational admissions officers as predictors of employment success or educational prowess, the examination results were changed to pass/fail.

Foxes Guarding Henhouses
The relationships among the professional associations and licensing boards during the establishment of nursing as a regulated profession are notable. As BONs nationwide celebrate their centennials, their histories tell a story of close collaboration between the state nurses associations and the pioneers who established the early educational programs and regulatory boards. As the BONs struggled to establish and set standards for nursing education and practice, the state associations were their strongest advocates in influencing legislation to ensure that the board would have the statutory authority to advance their mission. It was only natural, then, that as the BONs formed a national organization, they would find their home as a special committee, later council, within the ANA. Although BONs retained the statutory authority to develop individual licensure examinations, they chose to contract with the NLN for use of the SBTPE because of both the high costs involved in examination development and the extraordinary legal exposure engendered in administration of licensure examinations.

In the early 1970s, issues of conflict of interest and criticism of BONs being too close to the profession they regulated began to surface. A rise in public scrutiny of government regulation led to consumers being appointed to boards, as well as licensed practical or vocational nurse members, who could not be members of ANA councils.

By 1978, the ANA was increasingly involved with the economic and general welfare concerns of nurses. Regulators became increasingly conflicted because regulation’s role was public protection, yet the professional organization was focused on benefits and protection for the membership. In addition, while the BONs met together as a council of the ANA, decisions about the structure and content of the examination were made. Although one can argue that the boards retained their autonomy, the fact that the ANA funded and staffed the ANA Council of Boards of Nursing and that membership on the council was limited to ANA members approved by the ANA Board of Directors raised questions of conflict of interest. The boards recognized that they needed to break from ANA in order to maintain the credibility of their mission.

A similar potential for conflict of interest exists between professional nursing specialty associations and specialty certification organizations. The mission of the professional association is to set standards for practice, provide education and other resources for the practitioner in the interest of patients and families, and promote the profession. The mission of the certification organization is to protect the public. Legal considerations and accreditation requirements direct separate governance for the professional association and the certification organization. The certification board must have autonomy in decisions related to examination and certification renewal eligibility requirements, development, administration, or scoring of the examination, or determining the passing standard.

Membership in the professional association cannot be a prerequisite for certification, candidates cannot be required to participate in an educational offering provided exclusively by the professional association in order to qualify for certification, and the certification organization cannot provide or accredit review courses with the exception of sample examination questions to familiarize candidates with the format of the examination. Procedures are in place to safeguard the confidentiality of the examination.

Role of the NCSBN to Standardize Licensure
With the assistance of a $288,000 grant from the Kellogg Foundation, the NCSBN was formed in 1978. The mission of the NCSBN is to provide “education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.” Confusion exists within the nursing community about the decision-making
processes within the NCSBN. The governance structure of the NCSBN is composed of an elected board of directors, consisting of officers as well as 4 geographically representative directors and a director-at-large. The Delegate Assembly (voting body) convenes annually to discuss national issues, vote on board and committee recommendations and other items brought forward, set policy, and elect board and leadership succession committee members. The Delegate Assembly is structured like the US Senate; it consists of 2 representatives from each member BON.

Major actions of the Delegate Assembly, such as adoption of the Model NPA and Model Administrative Rules, are approved by a national vote. Individual BONs have the option of whether to incorporate any or all of the model legislative language into their own statutes or codes.

The majority of the work of the NCSBN is accomplished through the committee process; the APRN Committee works closely with NCSBN-recognized APRN certification organizations on issues related to regulatory sufficiency of certification examinations. An annual report is submitted to the APRN Committee each spring, detailing information such as the number of candidates and pass rates.

Once settled as an autonomous organization, the NCSBN began work on initiatives to standardize nursing licensure processes among the states to expedite the endorsement process, facilitate interstate endorsement, and allow BONs to better track disciplinary and practice problem data on licensees. Table 1 provides a timeline of NCSBN activities since the organization's inception.\(^\text{13}\)

**Evolution of Nursing Practice Roles**

**Nurse Practitioners**

Although nursing regulation was maturing and establishing standardized, collaborative practices among boards to facilitate interstate licensure and decrease the burden of regulation, a gradual expansion of nursing practice occurred during the 1960s because of a national shortage of primary care physicians. The first NP and physician assistant programs were developed in response to this physician shortage. In 1965, the first pediatric NP program was launched as a demonstration project at the University of Colorado; this 4-month program was designed to prepare RNs to manage childhood health problems. Pediatric NP programs were found to be able to successfully assess 75% of children in community health settings and increase the number of patients seen in private physician offices by 33%--a win-win for consumers and providers.\(^\text{14}\) Not all nursing leaders or educators were pleased with the introduction of the NP role; many considered the role to be a “siphoning off” of talented nurses into a form of medical practice.

Idaho was the first state to recognize advanced practice nurses in statute under joint control of the nursing and medical boards in 1971.\(^\text{15}\) The NP role gained a national champion in Health, Education and Welfare Secretary Elliott Richardson, who established the national Committee to Study Extended Roles for Nursing. This panel determined that to

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**Table 1: Activity Timeline of National Council of State Boards of Nursing Initiatives**

<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>All states using the NCLEX-RN examination agreed to use the same passing score for licensure, eliminating the New York/California difference.</td>
</tr>
<tr>
<td>1982</td>
<td>The Model Nurse Practice Act was adopted and the board appointed a committee to study issues related to the regulation of advanced practice nursing.</td>
</tr>
<tr>
<td>1983</td>
<td>Adopted Model Administrative Rules and Regulations</td>
</tr>
<tr>
<td>1986</td>
<td>Adopted position paper on advanced clinical nursing practice</td>
</tr>
<tr>
<td>1987</td>
<td>Changed NCLEX reporting to pass/fail</td>
</tr>
<tr>
<td>1993</td>
<td>Adopted a position paper titled “Regulation of Advanced Nursing Practice and Model Language on APRN incorporated into Model Act and Rules”</td>
</tr>
<tr>
<td>1994</td>
<td>Launched Computerized Adaptive Testing for NCLEX</td>
</tr>
<tr>
<td>1997</td>
<td>Nurse Licensure Compact adopted</td>
</tr>
<tr>
<td>1999</td>
<td>Adopted uniform core licensure requirements for RN/LPN</td>
</tr>
<tr>
<td>2000</td>
<td>Adopted uniform core licensure requirements for APRN</td>
</tr>
<tr>
<td>2002</td>
<td>Approved the Nurse Licensure Compact for APRNs</td>
</tr>
</tbody>
</table>

**Abbreviations:** LPN, licensed practical or vocational nurse; NCLEX, National Council Licensure Examination; RN, registered nurse.

\(^\text{This timeline is based on reference 6.}\)
provide health care to all Americans, it was essential to expand nursing’s scope of practice.\textsuperscript{14,19} This sounds quite familiar in this current period of health care reform, as we are once again seeing APRNs as a key to the ability to incorporate more than 30 million new uninsured Americans in the nation’s already-strained system.\textsuperscript{16}

Coronary Care Units Revolutionize Nursing Practice
The rapidly emerging technology and advances in coronary care medicine of the 1960s and 1970s also had a profound effect on the emergence of advanced practice roles and collaborative practice that persist today. It may be hard to imagine what nursing was like before the development of coronary care units. In Critical Care Nursing: A History, Fairman and Lynaugh\textsuperscript{16} appropriately titled the first chapter “Inventing Critical Care Nursing” and described the intense desire of these early nurses to gain as much knowledge and expertise as possible, as quickly as possible, to meet the needs of their patients. It was not advanced practice per se, but it was not the dependent role of nursing delineated in most NPAs. It was a collegial practice based on mutual respect between nurses and physicians working together for positive patient outcomes, with each valuing the contributions of the other, and each learning from the other’s discipline in those small, isolated rooms packed full of technology and the most fragile patients.

The successes of the first coronary care units at Presbyterian Hospital in Philadelphia and Bethany Hospital in Kansas City, Kansas, soon spread across the country and throughout the hospital into other types of critical care units, increasing the demand for specialty-educated nurses with knowledge, skills, and abilities beyond the limitations of cardiovascular expertise.\textsuperscript{14}

Similar changes in practice were also occurring in other nursing specialties, resulting in the formation of the Emergency Department Nurses Association in 1971 and the Oncology Nurses Society in 1975. Universities began to develop graduate programs for CNSs in critical care and cardiovascular nursing. Staff nurses practicing in the newly established intensive and coronary care units were highly dependent on the clinical expertise, education, and mentoring provided by CNSs.\textsuperscript{14,15} Clinical nurse specialists oversee delivery of complex interdisciplinary care for a specific population. As a specialist, the CNS brings an expert body of knowledge—coupled with hands-on clinical expertise—to the care setting, enhancing delivery of highly complex, technical care. Clinical nurse specialists collaborate and consult with interdisciplinary providers; role-model expert nursing practice; troubleshoot complex patient care issues; provide education for patients, family members, and interdisciplinary staff; and continuously assess the results of interventions through the eyes of a clinical researcher.\textsuperscript{16} Role-modeling expert clinical practice ensures not only credibility but also respect for the CNS and makes a strong statement in support of advanced practice nurse roles.\textsuperscript{16}

Emergence of the Acute Care Nurse Practitioner
Although acute care facilities were exploding with new technologies, the nation’s focus turned to primary care, with more physicians specializing in family medicine. This shift resulted in a shortage of house staff and specialized physicians to care for acutely ill patients. Extensive growth in NP programs led to increased federal support for family, adult, and neonatal NP programs. The solution to the loss of house staff was to use adult NPs, family NPs, or both as role substitutes. Oftentimes, they were selected nurses who had experience in acute or critical care before entering their NP program. However, these individuals were not educated in acute care in graduate programs and did not possess the necessary knowledge, skills, and abilities to care for this population, nor would they have had the legal standing to provide care at an advanced practice level.

Unfortunately, this situation continues today, putting practitioners at risk as they continue to assume roles for which they are legally unqualified. From this patient care need rose the impetus for the development of the acute care nurse practitioner (ACNP).\textsuperscript{21} In 1993, AACN published Standards for Educational Programs: Preparing Advanced Practice Nurses for Acute Care. This document was the product of a consensus group tasked with providing guidance to educational programs interested in developing ACNP programs and to provide a starting point for the development of a certification program. At the same time, the American Nurses Credentialing Center (ANCC) was exploring the development of an ACNP certification program. The 2 groups collaborated on the development of a joint Standards of Clinical Practice and Scope
of Practice document for the ACNP, which was published in 1994. Subsequently, AACN Cert-Corp and ANCC entered into a joint venture to develop a certification examination program for ACNPs. The examination was launched in December 1995.

How to License the Certified?
Boards of nursing were using a variety of regulatory scenarios to address APRN roles. Some statutes specifically stated that boards could only approve or accredit nursing programs that led to initial licensure, so the board had no jurisdiction over APRN programs if the APRNs did not receive a second license. Some states provided a certification status for APRNs, which was in addition to the RN license. In Missouri, APRNs continued to practice on their RN license, which resulted in a landmark state Supreme Court case recognizing the advancements in the scope of RN practice over the recent decades and the inevitable overlap between medicine and nursing as practice roles evolved.

Throughout the country, other BONs were experiencing similar difficulties with finding the best way to incorporate the APRN scope of practice into existing statutes and rules. Using the NCSBN as a data clearinghouse, BONs began to dialogue about difficulties being encountered with the patchwork quilt of educational preparation of applicants, the myriad specialty programs that were offered, and the variations among states, which made interstate endorsement a nightmare for applicants, employers, and the boards themselves. Boards had become comfortable with the relative uniformity of prelicensure educational programs and a national examination, which was handled by the NCSBN staff and committees. APRN regulation engendered feelings of chaos and loss of control with 4 APRN roles, educational preparation ranging from certificate programs through master’s degrees, and certification examinations being provided by national nursing organizations with no input from the boards.

Lack of National Licensure Examinations
One of the components of the NCLEX contract includes a provision allowing each member board the opportunity to review actual examination forms and provide comments. In addition, all boards have the opportunity to provide volunteers for the NCLEX examination development process, so any board member or staff person may participate in all steps of constructing the licensure examination. In contrast, boards were being asked to approve external NP, CNS, certified registered nurse anesthetist (CRNA), and certified nurse midwife (CNM) examinations as the proxy measure for APRN designation or licensure sight unseen; this was beyond the comfort zone for many. Some boards were uneasy about the legal defensibility and psychometric soundness of the external certification examinations. These issues were raised at NCSBN area and national meetings.

At the 1982 Delegate Assembly, a report indicated that 30 to 35 states either had a type of law or statute regulating advanced practice or were in the process of developing a mechanism to do so. A great deal of variation persisted in the manner in which states were regulating APRNs, with no clear best practice identified.

By 1992, 50 boards had some type of language addressing advanced practice; 16 boards were licensing APRNs. Some BONs expressed concern about the regulatory sufficiency of advanced practice certification examinations being used as a proxy measure in licensure decisions. Concerns were related to the examinations not being designed to measure entry-level practice as recommended by the NCSBN. The nursing specialty certification examinations in effect at the time were never designed or intended to measure practice of an experienced APRN in the same fashion as the generalist certification examinations measure the competence of a nurse with 2 years of experience.

When considering regulatory sufficiency, one must understand that regulatory examinations limiting individuals’ opportunities to practice their chosen profession are considered to be “high-stakes” examinations. An example of a high-stakes examination is the NCLEX-RN examination. It is essential that high-stakes examinations are legally defensible and psychometrically sound, to protect the assets of the licensing or certifying organization from legal challenges by unsuccessful candidates. Regulatory examinations must (1) be targeted to entry-level practice; (2) measure only job-related knowledge, skills, and abilities; (3) require demonstration of competence at the minimum
level necessary for safe and effective practice; and (4) be psychometrically sound. 

Variations Among APRN Educational Programs

Boards also expressed frustration with the variations among educational programs for NPs and CNSs. From the origins of nursing licensure, BONs prescribed the educational content of nursing programs. Licensure consisted of board-approved education and successful completion of a board-created or board-endorsed licensure examination. In the 1970s, APRN programs proliferated, aided in part by support from health, education, and welfare. Colleges and universities were encouraged to develop new and innovative programs in order to secure funding. Oftentimes, these APRN programs were formatted without any consideration as to whether graduates would be qualified to achieve APRN designation or licensure. Boards of nursing, for the most part, did not regulate APRN educational programs unless the programs led to licensure, so the boards had no approval authority over new program development or curriculum content.

The issue was referred to the Nursing Practice and Standards Committee with directions to develop a position paper. The paper, released in 1986, was widely disseminated to nursing stakeholders. By this time, approximately 42 states were recognizing advanced practice in some fashion. Recommendations for APRN regulation included the following: (1) regulation should be in response to a clear regulatory mandate; (2) education should be a minimum of a master's degree in a clinical nursing specialty; (3) use of a national certification examination is satisfactory if the examination is based on the acquisition of additional knowledge, skills, and abilities acquired through the master's program in the clinical nursing specialty; and (4) the preferred mechanism of regulation is designation/resignation, because it is the least restrictive.

Boards were also concerned with variability in NP educational program curricula, including differences in the length of programs, curricula for specialty areas of practice, number of required clinical hours, faculty qualifications, and inconsistent application of examination eligibility requirements by some certification agencies. In 1993, the NCSBN issued a second position paper on APRN regulation calling for licensure as the mechanism of choice for APRN regulation. The rationale for licensure was that level of care provided by APRNs and the autonomy of their practice are of such significance to consumers that, if provided incompetently or unethically, the public could be exposed to severe harm. Also included in the recommendations were independent scope of APRN practice without supervision, protocols, formularies, or practice agreements, and clear authority for prescribing and dispensing legend drugs, controlled substances, and therapeutic devices. Model rules were proposed, establishing standards for approval of national certification examinations and included criteria for credential review, testing processes, certification renewal, and communication with BONs. Grandfathering currently practicing APRNs was recommended.

Standardization of NP Curriculum and Certification

The nursing community reacted strongly and negatively to this position paper, believing that the second licensure was too restrictive and that the requirement of a master's degree would eliminate too many from practice, as all APRN roles did not require a master's degree at that time. After much debate, the position paper titled Regulation of Advanced Nursing Practice and model language on APRN practice was incorporated into Model Act and Rules in 1993. The 1994 NCSBN Delegate Assembly authorized a feasibility study for the development of a “core” NP certification examination and a study to identify NP core competencies.

During 1995 and 1996, representatives from the ANCC, National Certification Board for Pediatric Nurse Practitioners and Nurses (NCBPNP/N), National Certification Corporation for women's health specialties, and American Academy of Nurse Practitioners met with NCSBN members to determine whether certification examinations would meet BON standards for regulatory sufficiency. When negotiations among the organizations stalled, the Delegate Assembly authorized the conduct of the first phase of a job analysis of NP practice. Ultimately, all parties struck a compromise for third-party review of examination processes. The APRN certification organizations agreed to attain accreditation for their examination programs by the National Commission for Certifying Agencies (NCCA).

In response to complaints of inconsistency among NP programs, from 1995 to 1997, appointed organizational representatives from
American Academy of Nurse Practitioners, the American Association of Colleges of Nursing (AACN-Colleges), ANCC, National Association of Neonatal Nurses, National Association of Nurse Practitioners in Reproductive Health, National Association of Pediatric Nurse Associates and Practitioners, NCBPNP/N, National Certification Corporation, NLN, and the National League for Nursing Accrediting Commission collaborated to (1) develop standardized criteria for evaluation of NP programs; (2) pilot test the criteria as a self-study document; (3) develop an implementation/dissemination plan for the criteria; and (4) seek endorsement of the criteria from participating organizations and other selected nursing organizations. The Task Force came to consensus on a draft document initially in July 1996.

Following an external review process, a pilot study, and self-studies using the newly developed criteria, recommendations were made to the Task Force to strengthen the evaluation criteria. The criteria were presented as part of the report of the National Task Force on Quality Nurse Practitioner Education titled Criteria for Evaluation of Nurse Practitioner Programs. The criteria were subsequently endorsed by 23 national nursing organizations, including the NCSBN, and serve as an important resource for entities that play a role in the preparation, credentialing, and licensing of NPs.

Concurrently in 1996, AACN-Colleges published the Essentials of Master’s Education for Advanced Practice Nursing. This landmark document defined the essential curricular elements of master’s education for advanced practice as a CNS, CRNA, NP, and CNM. Of particular importance in this document were the establishment of the Graduate Nursing Core Curriculum and the Advanced Practice Core Curriculum.

The purpose of the advanced practice nursing core curriculum is to prepare a graduate for health promotion, assessment, diagnosis, and management of client problems including the prescription of pharmacologic agents within a specialty area. A strong emphasis is placed on developing sound clinical decision-making skills including diagnostic reasoning. The content in the advanced practice nursing core must build upon the content included in each of the 3 areas listed as advanced practice nursing core. The content also must be integrated throughout all courses. To ensure sufficient depth and focus, separate core courses are developed for the advanced practice nursing core: advanced health/physical assessment, advanced physiology/pathology, and advanced pharmacology. The Master’s Essentials also established criteria for clinical experience. A minimum of 500 hours of clinical experience was established, noting that specialities such as family NP programs, which prepare practitioners to care for patients from more than 1 age group, may need more hours of experience.

Standardization of CNS Competencies
The National Association of Clinical Nurse Specialists (NACNS) began development of competencies for the first edition of the Statement on CNS Practice and Education with a national call for CNS job descriptions from members of NACNS and AACN. More than 80 job descriptions were received. The job descriptions addressed a multitude of specialties. Approximately 70 of the job descriptions contained substantive information regarding CNS competencies for which the CNS was responsible; these were used in the initial competency development. A panel of CNS experts began by conducting a content analysis of the 70 detailed CNS job descriptions. The panel developed a draft of the core competencies from the job descriptions, literature, and expert knowledge of the CNS role. The content analysis revealed several common tasks and a few common core competencies. The product of this work was a list of identified core competencies needed by the CNS.

First-tier validation was accomplished by soliciting review and comment from a select validation panel of more than 100 CNS educators and practitioners who were NACNS members. Second-tier validation was accomplished through extensive external review from stakeholders, employers, and organizations. Requested external reviewers included 51 national nursing leaders and CNSs in 9 national nursing organizations representing a variety of specialties and practice settings. Additional feedback was received from NACNS members. More than 8000 copies of the first Statement were disseminated to practicing CNSs, graduate students, schools of nursing, employers, state BONs, and other national groups.

In 2003, the Education Committee of NACNS conducted a study of CNS programs nationally to identify characteristics and trends...
in CNS education. Key findings are presented in Table 2.

By 1997, BONs and the NCSBN expressed satisfaction with changes made by APRN certification examinations to meet regulatory sufficiency and achieve NCCA accreditation for existing examination programs. During the next several years, BONs continued to debate “Uniform APRN Licensure/Authority to Practice Requirements,” specifically, what came to be known as the “alternative mechanism element” or an alternative to a certification examination for advanced practice nurses who were educated in a specialty in which there was no certification examination available. Boards continued to be concerned about the proliferation of specialty APRN educational programs for which no certification examination was available. In 2002, the NCSBN issued another position paper on the Regulation of Advanced Practice Nursing. At this time, the NCSBN also developed the Criteria for APRN Certification Programs, the review criteria for all new APRN certification programs to be considered for use by BONs.

**AACN CertCorp and APRN Certification**

**ACNP Certification**

After dissolution of the joint ACNP certification examination venture with ANCC in 2001, AACN CertCorp launched its own ACNP certification examination program in November 2007 on the basis of a national job analysis of currently practicing ACNPs conducted to determine the knowledge, skills, and abilities necessary to test for certification as an ACNP. The ACNPC certification program has met the NCSBN Criteria for APRN Certification Programs and has received NCCA Accreditation. AACN CertCorp has requested approval of the ACNPC certification examination program by all state BONs.

As of this date, the BONs that have approved either the examination itself as a certifying examination acceptable to the board or AACN

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### Table 2: Key Findings of Clinical Nurse Specialist Program Study by NACNS

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>The majority of CNS role options were in adult health (52.9%), followed by community health (29.3%), pediatrics (22.3%), gerontology (20.4%), psychiatric/mental health (19.1%), acute care (14.6%), and home health (11.7%). Less than 10% of the programs offered specialty options in critical care, family, maternal/child, oncology, or perinatal nursing. In addition, 36.7% of the respondents indicated that they offered a CNS post-master’s certificate program.</td>
<td></td>
</tr>
<tr>
<td>The majority of CNS programs (91%) based their curriculum on semester hours. Quarter hours were used by 13 (8.3%) of the programs, and 1 school (0.6%) used a system other than semesters or quarters. The mean total number of credit hours for the semester programs was 41.4 hours and 52.2 hours for the quarter-system programs.</td>
<td></td>
</tr>
<tr>
<td>Clinical/practical clock hours ranged from 6 to 768, with a mean of 416.2 hours.</td>
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<tr>
<td>Increases in didactic credits were planned by 13.9% of the respondents, and 31.1% planned to increase clinical credits. Only 2.6% planned to decrease didactic credits, and even fewer (0.7%) planned to decrease clinical credits. Finally, 31.3% planned no changes in the allocation of credit hours.</td>
<td></td>
</tr>
<tr>
<td>Content areas most frequently taught in separate core courses included research methods, measurement, and research use; theoretical foundations; advanced pharmacology; advanced pathophysiology; and health policy, organization, and finance.</td>
<td></td>
</tr>
<tr>
<td>Content that was most frequently integrated within 1 or more other courses included human diversity, specialty-focused content, teaching and coaching, intervention design and development, and evaluation methodologies.</td>
<td></td>
</tr>
<tr>
<td>The most frequent content that was not included in CNS programs included selection, use, and evaluation of technology and devices; advanced pharmacology; advanced physiology; assessments to diagnose disease for which pharmacologic interventions are used; and advanced pathophysiology.</td>
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</tr>
</tbody>
</table>

67.3% of the programs were preparing graduates for prescriptive authority. The most common course used to prepare students was advanced pharmacology. Other courses mentioned included advanced health assessment and pathophysiology.

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**Abbreviation:** CNS, clinical nurse specialist.

**National Association of Clinical Nurse Specialists.**

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CertCorp as an authorized certification body acceptable to the board, depending on how their particular statute or administrative rules require approval to be accomplished, are listed in Table 3.

CNS Certification
In 1999, AACN CertCorp launched a certification examination for adult, pediatric, and neonatal CNSs in acute/critical care. The original educational eligibility criteria for this examination were a master’s degree in nursing and evidence of expertise in critical care nursing to be demonstrated by possession of the CCRN credential, publication in the field, or educational presentations to meet specified parameters. Applicants who did not have 500 clinical hours of practice within the educational program were allowed to obtain the hours after graduation. In April 2002, AACN published the Scope of Practice and Standards of Professional Performance for the Acute and Critical Care Clinical Nurse Specialist. Education criteria included advanced health/physical assessment, advanced physiology and pathophysiology, advanced pharmacology, and a minimum of 500 hours in direct clinical practice during their educational program.

In August 2002, the NCSBN Delegate Assembly voted to remove the “alternative mechanism option” granting APRN licensure by methods other than the use of a national certification examination, such as evaluation of a portfolio or clinical practice from the APRN uniform core requirements. In the core requirements, advanced practice licensure could now be obtained only through the use of an approved certification examination. In October 2003, the Commission on Collegiate Nursing Education Board of Commissioners approved an amended version of its Standards for Accreditation of Baccalaureate and Graduate Nursing Programs. The revised standards, effective January 1, 2005, required Commission on Collegiate Nursing Education–accredited graduate nursing programs to use the Master’s Essentials as the foundation for curricula.

For the CCNS certification examination by individual BONs for APRN status to be approved, the examination program had to be reviewed by the NCSBN APRN Advisory Group for compliance with the Criteria for APRN Certification examinations. The NCSBN APRN Advisory Group invited AACN CertCorp to have the CCNS Certification Examination program reviewed in October 2003. The APRN Advisory Group indicated that the substitution of practice as a CNS after graduation for the required 500 supervised clinical hours was not acceptable and agreed to re-review the CCNS program in January 2004 if this eligibility requirement was removed.

In November 2003, the AACN CertCorp Board of Directors voted to eliminate the substitution of CNS practice in lieu of a formal CNS clinical education option and to require either 500 supervised clinical hours within the master’s program or, until March 1, 2006.

### Table 3: State Boards of Nursing That Approved the ACNPC Examination as a Certifying Examination or Approved AACN CertCorp as an Authorized Certification Body

<table>
<thead>
<tr>
<th>State</th>
<th>Approved ACNPC Examination</th>
<th>Approved CertCorp as an Authorized Certification Body</th>
</tr>
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*At this time California, Colorado, Indiana, Michigan, Nevada, New York, and Oregon do not require certification for NPs; regulatory change is pending in Colorado and Oregon.*
deficient hours may also be earned as a transcribed clinical practicum from a CNS program. An extension to this deadline until December 2006 was granted. The new requirements were now congruent with the AACN CNS Scope and Standards and include a master’s degree or higher in nursing from an accredited program with specific delineated coursework. The 500 clinical practice hours in all roles of the CNS caring for acute/critically ill patients within the master’s program is also required. Following achievement of NCSBN recognition, the CCNS examination has been approved by BONs in every state that recognizes the CNS as an APRN in specialties other than psych/mental health and requires certification for APRN status.

New APRN Regulatory Model: Defining the Future of Advanced Practice Nursing

In March 2004, the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties submitted a proposal to the Alliance for APRN Accreditation, now named the Alliance for APRN Credentialing (APRN Alliance), to create a national forum to develop a consensus statement on the education, certification, and regulation of advanced practice nurses. The purpose of the endeavor was to provide a set of uniform expectations that can be used by educators, credentialers, and employers to ensure access to high-quality, effective advanced practice nurses. This consensus also would address issues related to specialization/subspecialization in advanced practice and mechanisms that would support evolutionary growth in nursing, while ensuring accountable practice.

Invitations were sent to 50 nursing organizations that were APRN stakeholders to attend an educational/organizational consensus meeting in July 2004. On the basis of recommendations from the participants at the initial meeting, a 23-member APRN work group was formed with representation from APRN regulation, accreditation, certification, education, and practice. The CRNA, CNM, NP, and CNS roles were represented. The charge to the group was to develop a consensus statement of how practice scopes evolve, how to define the distinction between specialization and subspecialization, and how to resolve the need for evolution in the credentialing process. This would provide clarity to the consumer and the employer regarding the expertise held by an APRN and how this expertise can be appropriately validated.

Other desired outcomes noted by participants at the initial consensus meeting included the development of a consensus model for advanced practice nurse credentialing that would be forward-looking; meet the future needs of patients; provide clarity and uniformity to facilitate interstate mobility of practitioners; standardize curricula so that graduates would be eligible for NCSBN-endorsed CNS certification examinations; create a graphic representation of the model that is clear for all stakeholders to articulate the similarities and differences among APRN roles and specialties; assure BONs of the regulatory sufficiency of the certification and accreditation processes; and prohibit the development of new “creative” educational programs that would not qualify students for APRN status upon graduation.

The APRN Consensus Work Group (Work Group) started this project in October 2004. A parallel project had been undertaken by the NCSBN’s APRN Advisory Group. One of the issues of particular concern to the NCSBN was the lack of broad general education in NP programs that resulted in some NPs practicing beyond the scope of their educational preparation.

In 2006, the NCSBN APRN Advisory Group released a Vision Paper: The Future Regulation of Advanced Practice Nursing. Because the NCSBN had been hearing from some CNSs that their preference was to practice in the RN role under the RN practice act, one of the recommendations of the Vision Paper was to eliminate the CNS from the category of APRN. A secondary recommendation was for education and regulation of a generic NP only, who might later then “specialize” in areas such as acute care. The AACN/AACN CertCorp response to the NCSBN relative to the role of the CNS, and “possible” future supply of ACNPs, provided a compelling argument for CNSs to have advanced practice designation by BONs. The letter can be viewed on the AACN Web site.

The NCSBN Vision Paper evoked a strong reaction from the nursing community and provided a catalyst for further dialogue and movement toward resolution of outstanding APRN issues. In 2008, the Work Group and the NCSBN APRN Advisory Group decided that they had more issues in common than differences and formed a joint dialogue group to
collaborate on the development of 1 consensus paper. The final product of these groups, the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, was released July 7, 2008, and has been endorsed by 44 nursing organizations.

**Implications of the APRN Consensus Model**

The recently endorsed consensus model provides a definitive foundation for nurses who want to pursue the advanced practice credential. The comprehensive document has far-reaching impact on licensing boards, accreditation agencies, certification organizations, and educational programs (see Figure 1).

**Overview**

In the new APRN Regulatory Model, there are 4 roles: CRNA, CNM, CNS, and certified nurse practitioner (CNP). These 4 roles are given the title of APRN. Education, certification, and licensure of an individual must be congruent in terms of role and population foci.

The term critical care does not appear in the new regulatory model. AACN and AACN CertCorp believe that “critical care” is inseparable from “acute care” and that patient needs must govern competencies when APRNs care for acutely and/or critically ill patients. Therefore, to fulfill the organizational missions of patient safety and optimal nursing care, AACN and AACN CertCorp established a strong advocacy position to preserve the role of the ACNP as a regulated APRN and to ensure that all CNSs would be educated, evaluated, and regulated through acute care competencies. Under the new regulatory model, APRN “specialties,” which are indicated on the uppermost level of the graphic representation of the model, have no prescribed educational criteria, are not mandated to have their...
educational programs or certification examinations nationally accredited, and do not require state BON oversight. AACN and AACN Cert-Corp believed that acutely and critically ill patients and their families deserve comprehensively educated, thoroughly evaluated, and professionally accountable NPs and CNSs. Therefore, ACNPs caring for the adult-gerontology and pediatric populations will be educated and regulated as NPs, and all CNSs will be educated, and competencies will be assessed from wellness through acute care. This is indicated on the regulatory model in the footnotes labeled with + and ++ (Figure 1).

All CNPs will be educated and assessed through national certification processes across the continuum from wellness through acute care under the new APRN regulatory model. In addition, gerontology content will be added to the adult population focus for CNS programs, so adult CNS programs will be required to change their curriculum to include gerontology content, competencies, and clinical practice experience and acute care didactic content, competencies, and clinical practice experiences for CNSs caring for the adult through geriatric population. Adult acute care CNS programs will be required to include gerontology didactic content, competencies, and clinical experiences as well as wellness didactic content, competencies, and clinical experiences for CNSs caring for the adult through geriatric population. Pediatric CNS and neonatal CNS educational programs will also be required to add didactic content, competencies, and clinical practice experiences in acute care for the relevant age group.

Licensure
APRN's will be licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Licensure will be required, because these APRNs will be practicing in a role beyond that of the registered professional nurse.

The CNP is prepared with acute care CNP competencies and/or the primary care CNP competencies. The terms primary care and acute care apply to patient needs and competencies of NPs, not to geographic or patient care settings.

APRN's may specialize but cannot be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci. Examples of specialties include oncology, orthopedics, nephrology, palliative care, and cardiology.

CNP or CNS. In addition, all APRNs in any of the 4 roles, including CRNAs and CNMs, providing care to the adult population (eg, family or gender specific), must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

All APRNs must be educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions, whether or not they have the need or desire to do so.

An educational program may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute care and primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Education
In the model, it is proposed that APRNs are educated in an accredited graduate-level education program in 1 of the 4 roles and in at least 1 of 6 population foci: family/individual across the life span, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. This means that there must be a match between the title of the educational program/degree awarded and the certification examination.1

The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology
Certification

All APRNs must pass a national certification examination that measures APRN role and population-focused competencies and maintain continued competence as evidenced by certification renewal in the role and population through a national certification program.

APRN practice builds on the competencies of RNs by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy. Performing a nursing assessment and establishing a nursing diagnosis are delineated as being within the scope of practice of the professional RN in most NPAs and in the NCSBN Model Practice Act. Advanced practice is practice beyond the RN license, which is the rationale for the requirement of a second license.

Some confusion arose during the development of the consensus model as to who should be included in the definition of advanced practice nurse. The word advanced seems to indicate that this is a category for nurses with advanced degrees, and that any nurse who has attained a master’s degree and a certification should also be considered an advanced practice nurse. The issue, however, is that this is a regulatory model, and the only reason that the model was needed was to provide a legal framework and protection for those nurses who were practicing beyond the scope of their RN license. Advanced practice reflects a legal status. The defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals. Because the charge to the work group was to develop a model for APRN regulation, the focus of the project was on practitioners whose educational preparation and legal scope of practice exceeded that of the RN.

Implications of the New APRN Regulatory Model

Licensing Boards

Those BONs that do not authorize the full role of the CNS as an APRN other than the CNS in psych/mental health will need to make statutory changes in order to come into compliance with the model. Other revisions in some states may be necessary to place all categories of APRN under the regulation of the BON and to remove physician supervisory language in order to conform to the model. Boards must also make determinations regarding grandfathering and the health care needs of the residents of their states.

Accreditation Agencies

Accreditors will essentially be running 2 parallel programs, assisting educators in phasing out existing curricula, and incorporating new models. The new regulatory model also requires a preaccreditation process to prevent the development of inappropriate APRN programs. Although this procedure serves to protect potential students from entering a program for which they will never be able to achieve licensure, it also places an additional burden on these agencies at a time when they will be striving to provide extra services to programs.

Certification Organizations

Certification organizations must conduct job analyses, which will result in legally defensible, psychometrically sound certification examinations reflective of the roles now defined in the new APRN model and have these examinations available for launch when the model is ready to be implemented, so that there will be no interruption in the supply of qualified APRNs to meet the nation’s burgeoning health care needs. At the same time, they must continue to administer their current examination and certification renewal programs to meet the needs of active practitioners and those students currently enrolled in existing programs.

AACN CertCorp expects to have new CCNS examinations ready to launch in adult-gerontology, pediatric, and neonatal from wellness through acute care by late 2012 or early 2013. The same target date has been set for the Adult-Gerontology ACNPC. AACN CertCorp will continue to offer the current examinations for students who are enrolled in existing programs through 2015. American Nurses Credentialing Center will also need to add acute care content to its adult and pediatric CNS examinations if it expects to continue to administer them under the new regulatory model.

Educational Programs

Curriculum changes may be necessary to separate the “3 Ps” courses (advanced physiology/pathophysiology, physical assessment, and pharmacology) if they are still integrated with other
course content. Adult programs must incorporate gerontology content. All CNS programs must incorporate didactic and clinical content to provide comprehensive care for the designated population from wellness through acute care competencies. All graduates must be educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and nonpharmacologic interventions.

Implementation
Implementation of the model, which is slated for 2015, is being accomplished through a consensus group known by the acronym of LACE (Licensure, Accreditation, Certification, and Education), including representative stakeholders from each of these groups. This group meets periodically to provide progress updates on the key issues outlined earlier, to resolve unforeseen issues arising from the model, and to ensure that communication is consistent. Plans are proceeding for the development of an electronic network to facilitate communication among all APRN stakeholders. The ultimate goals of common understanding of APRN roles, uniformity in APRN education, ease in interstate endorsement, and most of all patient safety are closer than ever before. Open and frequent communication is the key to achieving the desired outcomes, and all stakeholders are encouraged to engage in helping to reach this goal.

Conclusion
Educators are working collaboratively with BONs, accreditors, and certification organizations to incorporate required curriculum changes in order to conform with changes brought about by the model. Certifiers are conducting job analyses now to prepare the examinations that will be needed for model implementation. Boards of nursing are preparing statutory and/or administrative rule changes necessary to comply with the uniform requirements for licensure.

If you are currently practicing in an APRN role, check with your BON to be sure that you will meet new regulatory requirements. You may be interested in participating in an advanced practice committee or legislative advocacy efforts taking place in your state. If your state does not currently require certification for your APRN role or recognize your role as an APRN, find out how you can advocate for legislative change through your state nurses association or other professional organization.

If you are considering enrolling in an APRN program, check to see whether the program is making changes so that curriculum will conform to the new consensus model. It is crucial for your future practice that your education will qualify you for national certification examinations and for interstate licensure, and you should explore these issues before you enroll in a program.

The consensus model for APRN regulation is not associated with the doctorate in nursing practice. However, over time, as graduates from generic DNP programs enter the workforce in significant numbers and begin to influence practice, these changes will be reflected in the job analyses, which drive the test plans of the national APRN certification examinations.

For too long, nursing has let complex APRN issues confound and divide us. It has been a long but necessary journey toward uniformity and consensus. Patient needs and public protection have been the deciding factors when making tough decisions. We believe that relentless communication will be crucial in making this historic transformation and hope that you will use this resource as a starting place to get involved in this effort.

REFERENCES


