



## **Position Statement - Full Practice Authority for Advanced Practice Registered Nurse (APRN)**

Full practice authority is generally defined as the APRNs' ability to practice nursing at the full extent of their knowledge, skills, and clinical judgment based on their education and training. APRNs are prepared at the graduate level and are deemed competent clinicians upon graduation and passage of national certification. Each APRN is personally accountable for his or her practice, to the patients, the respective licensing board, the nursing profession, and society. Individual accountability extends to legal liability; It is inappropriate to expect physicians, or any other providers, to accept responsibility or liability for care in which they have not been directly involved.

It is within an APRN's professional judgment and responsibility to assess and treat patients within the bounds of his or her legally authorized scope of practice. Decades of research have established the safety and effectiveness of care by APRNs, and that body of evidence has led institutions and organizations from the IOM to the NGA to AARP to call for the lifting of barriers to APRN practice. Current Oklahoma State Statute requires APRNs to have supervision of prescriptive authority as well as limits their ability of prescriptive rights to legend drugs and Schedule III to V. Other barriers include insurance companies and facility regulations.

As of June 2016, twenty-one states currently grant full practice authority to one or more APRN roles upon licensure and/or certification. This makes Oklahoma one of twenty-nine states with barriers to APRNs to practice at the full extent of their education and training. The Oklahoma Nurse Practice Act follows the national Consensus Model for APRN Regulation defining the four APRN roles as: certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), and clinical nurse specialist (CNS).

ONA and ANA's strategic goals have always included advocacy for a health care system where RNs and APRNs can practice to the full extent of their knowledge and professional scope of practice.

**THEREFORE it is the position of** the Oklahoma Nurses Association that it supports full practice authority for Advance Practice Registered Nurses in Oklahoma;

ONA and its members will advocate state legislation to provide full practice authority for Advance Practice Registered Nurses in Oklahoma. In addition, ONA and its members will advocate state legislation to allow APRNs with prescriptive authority to a write Schedule II – V drugs in accordance with their role's scope of practice.

ONA also supports credentialing of Advance Practice Registered Nurses by insurance companies and facilities.

### **Background**

With the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), now more than ever there is a growing sense of urgency for states to increase the number of health care providers, particularly primary care providers. Supported by a growing body of evidence on the safe and cost-effective provision of care by APRNs, there is a [national call to remove all barriers to full practice authority](#) from organizations such as the [Institute of Medicine \(IOM\)](#), the [National Governors](#)

[Association](#) (NGA), the [Federal Trade Commission](#) (FTC), the [Bipartisan Policy Center](#), and the [Veteran's Health Administration](#), among others.

**ONA and ANA strongly supports full practice authority for all APRN roles.** “Full practice authority” is generally defined as an APRN’s ability to utilize knowledge, skills, and judgment to practice to the full extent of his or her education and training. The American Association of Nurse Practitioners has offered a definition of full practice authority as “the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing” (Issues At-A-Glance: Full Practice Authority, 2014).

As of June 2016, Twenty-one states and the District of Columbia currently grant full practice authority to one or more APRN roles ***upon licensure and/or certification***. Several of these states have passed full practice authority legislation or made similar regulatory changes since passage of the ACA in 2010. The National Council of State Boards of Nursing (NCSBN) maintains the [APRN map project](#), which provides an overview of each state’s implementation of the Consensus Model for APRN Regulation, including independent practice (defined as “no requirement for a written collaborative agreement, no supervision, no conditions for practice”).

While many are working to obtain full practice authority for APRNs through legislative and regulatory efforts, analysis has revealed a disturbing trend in state legislation requiring a supervised post-licensure practice or transition period, often referred to as “transition to practice” requirements, further delaying APRN full practice authority. In several states (see table below), legislation has been enacted with the intention of moving closer to full practice authority for one or more APRN roles, yet the legislation includes new requirements for a supervised practice period following licensure and/or certification. These legislative restrictions are modeled in concept after the state of Maine’s 1995/2007 legislation, a supervised practice provision of 24 months. Discussion with stakeholders reveals that these changes have not been based on evidence but are the result of political compromise. As demonstrated in the table, states have unique time periods and standards for this “transition to practice,” none of which are supported by the evidence or research.

As states begin to implement these requirements, there is a growing realization of the potential impact on the workforce and access to care. In a report published in November 2014, the [Nurse Physician Advisory Taskforce for Colorado Healthcare](#) (NPATCH) described how it evaluated perceived barriers created by the legislation passed in that state: employers are reticent to hire new graduates because they are unable to prescribe independently, supervision requirements create an unnecessary burden for preceptors and mentors, and APRNs are often unable to be empaneled and bill for services independently. The Taskforce generally found the barriers to be real and made recommendations to streamline the process for APRNs to obtain prescriptive authority, including reducing the transition requirement to six months’ full-time or 1,000 practice hours.

National APRN organizations have provided information and guidance for their memberships on this issue through position statements and briefs, which are referenced in this document. Continued and increasing variability in state practice requirements for APRN full practice authority does not bring the nation toward consensus, but institutes additional layers of unnecessary regulatory constraint and costs.

ANA and our constituent and state nurses associations (C/SNAs) are committed to working with other national nursing organizations and key stakeholders to remove barriers to APRN practice in order to ensure patients have access to safe and effective care from the providers of their choice.

### States with “Transition to Practice” Barriers

State	Year Legislation Passed	Transition Requirement	APRN Role Affected	Oversight Requirement/Comments
Maine	1995/2007	24 Months	CNP	Physician or CNP
Colorado	2009	3,600 Hours	CNP, CNS, CNM, CRNA	Required when seeking independent prescriptive authority; physician or physician and APRN
	2015	1,000 Hours	CNP, CNS, CNM, CRNA	Hours reduced for prescribing mentorship with a physician or APRN required when seeking autonomous prescriptive authority
Vermont	2011	24 Months and 2,400 Hours	CNP, CNS, CNM, CRNA	Collaborative Agreement with an APRN or physician
Nevada	2013	2 Years or 2,000 Hours	CNP, CNS, CNM	Required when seeking independent CS II prescriptive authority; collaborating physician-approved protocols for CS II prescribing
Minnesota	2014	2,080 Hours	CNP, CNS	Collaborative Agreement with an APRN or physician
Connecticut	2014	3 Years and 2,000-Hours Minimum	CNP, CNS	Collaborative Agreement with a physician
New York	2014	3,600 Hours	CNP	Collaborative Agreement with a physician; attestation of collaboration requirement
Nebraska	2015	2,000 Hours	CNP	Transition-to-Practice Agreement with a supervising provider (MD, DO, or NP)
State	Year Legislation Passed	Transition Requirement	APRN Role Affected	Oversight Requirement/Comments
Maryland	2015	18 Months	CNP	An applicant who has never been certified by Maryland or another state shall consult and collaborate with a physician or CNP mentor (who has at least 3 years’ experience )
Delaware	2015	2 Years and 4,000 Full-time Hours Minimum	CNP, CNS, CNM, CRNA	Collaborative Agreement with a hospital or integrated clinical setting (“Independent Practice”)
West Virginia	2016	2 Years	CNP, CNS, CNM, CRNA	Collaborative Relationship and Agreement with a qualified collaborating health care professional (physician or APRN) when seeking full autonomous prescriptive authority

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