The APRN Compact: APRN Independent Practice Imposed on All Adopting States

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Those of us who are involved in state advocacy have witnessed numerous advocacy attempts by nurse anesthetists and advanced practice registered nurses (APRNs) in general to eliminate existing requirements for patient-centered, physician-led care. Many times, legislation or proposed regulatory language is obvious in its attempt to abandon the care team model, but sometimes ... well, sometimes an incremental approach takes such a long time to implement, the last steps in the process can be downright shocking. This is the case with the so-called APRN Compact.

We have been aware of the APRN Consensus Model for several years and have tried to inform ASA members about this dangerous trend. In a nutshell, the APRN Consensus Model is 2008 draft state legislative language developed by the National Council of State Boards of Nursing (NCSBN) that gives the APRN title to four roles of advanced practice nurses: nurse anesthetists, nurse practitioners, nurse specialists, and nurse midwives. Although it is usually touted by APRNs as simple name change legislation, nothing could be further from the truth. If you Google “APRN Consensus Model,” you can read the draft language yourself; the language increases scope of practice for APRNs – including nurse anesthetists – and makes them independent practitioners. The Consensus Model toolkit on the NCSBN website clearly states that APRNs are to be licensed as “independent practitioners with no regulatory requirements for collaboration, direction or supervision.”

Many states have enacted parts of the APRN Consensus Model, with most of them picking and choosing language and not changing their already-standing statutes or regulations regarding the team care model. A majority of states now lump all advanced practice nurses into the “APRN” categorization. You may be asking, “why does a name matter? What does it matter what we call advanced practice nurses?” It matters because even a small name change is a huge step in an incremental plan by APRNs to remove physicians as leaders of the care team.

Last year, the NCSBN approved draft legislation titled the “APRN Compact.” The compact would allow APRNs who hold a multistate license to practice in other compact states. The NCSBN says that in order to be considered a compact state, a state must pass the draft legislation without “any material differences.” Unlike the Federation of State Medical Boards’ Interstate Medical Licensure Compact, the APRN Compact seeks to automatically eliminate physician involvement requirements for APRNs who practice under a multistate license. Additionally, if one reads the entirety of the legislation, you’ll see that the term “APRN” is never defined. All the “simple name change” bills states have passed mean that nurse anesthetists automatically fall under the term “APRN” for the purpose of this compact.

Article III, Section (h) of the legislation says: “An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate licensure privilege.”

This means if an APRN (including a nurse anesthetist) receives a multistate license under the compact, he or she would be able to function independently, regardless of what the party state’s law says.

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Nurse anesthetists are a valued member of the anesthesia team, but removing physician involvement from anesthesia care makes no more sense than removing it from any other critical care location. We are not trying to keep advanced practice nurses from obtaining a multistate license, but we are opposed to it when the mechanism to do so usurps state laws pertaining to patient safety.

Other sections of the draft legislation say that the APRN Compact will govern licensing. This takes many decisions away from state boards of nursing and puts it in the hands of the NCSBN, who will govern the APRN Compact. An outside organization will have authority to say who should or should not receive an APRN license. The APRN Compact carelessly brushes aside laws and regulations crafted by states' democratically elected legislators or executive-appointed regulatory boards, all in the interest of gaining independent practice by any means necessary.

The APRN Compact fails to recognize the crucial difference between primary care and surgical anesthesia/critical care. Removing physician involvement (any physician, not just physician anesthesiologists) from anesthesia compromises patient safety. Nurse anesthetists are a valued member of the anesthesia team, but removing physician involvement from anesthesia care makes no more sense than removing it from any other critical care location. We are not trying to keep advanced practice nurses from obtaining a multistate license, but we are opposed to it when the mechanism to do so usurps state laws pertaining to patient safety. This is an underhanded attempt to eliminate the physician-led care team patients rely on in states where advanced practice nurses have not been able to do so via obvious legislative means.

The APRN Compact language says that only 10 states have to enact the compact into law to have it go into limited effect. So far during the 2016 legislative session, Idaho, Iowa and Wyoming saw the APRN Compact introduced, and Idaho and Wyoming signed it into law. Some have said, “my state is one of the four states that has independent practice for nurse anesthetists. What does it matter if we pass the Compact?” Please do your part to keep the APRN Compact from going into effect! With Idaho and Wyoming now Compact states, only eight states stand between APRNs gaining automatic independent practice in every Compact state under a multistate license. Even some state boards of nursing are acknowledging that the APRN Compact is over-the-top. During an April 2015 Texas Board of Nursing meeting, the board discussed the APRN Licensure Compact and noted their board should abstain from accepting Article III (h) “since such provision is not authorized under Texas law.” Article III, Section (h) is not authorized under 46 state laws and regulations!

For the remainder of this legislative session, and in preparation for the 2017 legislative session, determine the definition of “APRN” in your state. It’s also important to monitor regulatory boards to make sure they are not unilaterally changing definitions in state regulations, as well. We must vigorously oppose the APRN Compact in its current format in order to prevent the usurpation of state laws regarding patient safety. For more information about the APRN Compact and what you can do in your state, contact Jason Hansen at j.hansen@asahq.org, Erin Philp at e.philp@asahq.org or Ashli Eastwood at a.eastwood@asahq.org.

References: