
REGULATION OF EMERGENCY NURSE PRACTITIONERS BASED ON EDUCATION AND CERTIFICATION

There are currently over 205,000 nurse practitioners (NPs) in the United States and nearly 6% (>12,000) report practicing in emergency care settings (AANP, 2014). These settings include, but are not limited to, emergency departments (EDs), urgent/fast track units, observational units, ambulatory urgent care settings, and correctional care facilities. Nurse practitioners have staffed emergency care settings since the 1980's; however, formal educational programs to prepare NPs to work in EDs were not available until the 1990's with some programs adapting acute care curricula and others family nurse practitioner (FNP) curricula. Among NPs working in emergency care a recent snowball sample of 164 NPs surveyed in 2014 found 78% reported being certified as an FNP while only 10% reported certification as acute care (Ramirez, 2014). Presently there are seven graduate emergency nurse practitioner programs in the United States. Five of these programs are based on an FNP curricula: Emory University, Jacksonville University, Loyola University-Chicago, Rutgers University, and University of Texas-Houston. Vanderbilt University offers a dual FNP, acute care adult-gerontology emergency program, and the University of Maryland offers an adult-gerontology acute care/clinical nurse specialist program. Emergency NP educational preparation incorporates the medical model but is distinct from curricula used to prepare emergency medicine physicians and physician assistant colleagues. Domains of advanced practice nursing in emergency care include critical care, urgent care, primary care, behavioral medicine, public health, and social medicine (Chan & Garbez, 2006). The ENP role is distinct in that it spans population and acuity continuums. Emergency care focuses on potentially life-threatening conditions irrespective of the patient's initial chief complaint or reason for seeking care. This perspective is unique and is the foundation for how health care is provided in EDs. In order to remain present and competitive in this workforce, the ENP role must be clearly understood by the inter-professional team in which we practice, by those in positions of hiring for ENP positions, by regulatory agencies including the National Council of State Boards of Nursing, by educational accreditation bodies such as the American Association of Colleges of Nursing, and by graduate NP educational organizations including the National Organization of Nurse Practitioner Faculties.

Family Nurse Practitioners as ENPs

Justification for preparing and utilizing FNPs in EDs is based on ED demographic data and census trends. According to the CDC, more than 136,000,000 individuals visit EDs within the United States (CDC, 2011a). ED visit rates increased 26% from 1994-2004 and continue to increase at a rate of 3% annually (Kellerman, et al., 2015). This has led to a critical manpower gap where ENPs are vitally needed and important. ED visits are also increasing among sicker, older patients having complicated medical conditions requiring complex work-ups and medical decision making (Kellerman, et al., 2015). This demands that ENPs are prepared to provide acute resuscitation and stabilization for medically unstable patients. Additionally, roughly 20- 25% of all ED visits are pediatric patients (CDC, 2011a; Chamberlin, Krug & Shaw, 2013) who, 90% of the time, present in general, non-specialty EDs (Chamberlin, Krug & Shaw, 2013). This data supports that ENPs must be educated to care for patients across the lifespan.

According to the CDC (2011b), only 10% of patients seen in EDs have emergent, life-threatening conditions. Instead, the majority of patients who visit EDs have less urgent conditions and are discharged home (CDC, 2011b; Morganti et al., 2013). Additionally, fewer than 50% of Americans see a primary care provider for a new onset acute care problem (Pitts, et al., 2010). Instead, ED providers manage 28% of all acute care visits for insured patients and two-thirds of acute care visits for the uninsured (Pitts, et al., 2010). This data supports that ENPs must be prepared to manage primary care as well as critical care conditions. Although FNPs are prepared to care for primary care conditions, their education does not include management of complex medically unstable conditions. Similarly, while acute care NPs are prepared to care for either medically unstable adults OR children, their education does not prepare them to care for patients with primary care problems or to care for patients across the lifespan. These educational gaps have led to the development of innovative FNP curricula incorporating didactic and clinical content in the care of urgent and life-threatening emergencies. Family NPs may also obtain additional training in emergency care by completing an emergency medicine fellowship program. FNP/ENPs who receive additional educational preparation in emergency care and acute stabilization and resuscitation of medical unstable patients across the lifespan are well -prepared to provide safe, high quality care in emergency care settings.

Emergency NP Scope of Practice and Board Certification

The initial scope of practice & standards of care for the ENP were written in 2000. In 2004, the Emergency Nurses Association (ENA) established an NP Validation Committee. In 2006, role delineation and instrument development was furthered with the development of an NP treatment competency instrument for emergency practice. These steps culminated in publication of the *Nurse Practitioner Delphi Study: Competencies for Practice in Emergency Care* (ENA, 2010). In conjunction with American Association of Nurse Practitioners (AANP), individuals on this committee led stakeholders to develop entry-level competencies for NPs in emergency care. The competencies were endorsed by the American Nurses Association (ANA) and by the National Organization of Nurse Practitioner Faculties (NONPF). These competencies are the basis of ENP curricula nationwide.

In 2013, the American Nurses Credentialing Center (ANCC) established emergency nurse practitioner board certification (ENP-BC) via portfolio. Certification as an ENP requires two years or 2000 hours of emergency clinical practice within the past 3 years, certification in a population foci (FNP, AGNP, PNP, ACNP), completion of 30 hours of continuing education in emergency care, and demonstrated exemplary performance in two of five professional development and leadership categories. The applicant must also submit self and peer performance evaluations and submit a written exemplar that shows expertise as an emergency care clinician.

American Academy of Emergency Nurse Practitioners

In 2014, the American Academy of Emergency Nurse Practitioners (AAENP) was established from a core group of NP leaders in emergency care. The mission of AAENP is to "promote high quality, evidence based practice for NPs providing emergency care for patients of all ages and

acuties in collaboration with an interdisciplinary team" (AAENP, 2014). Since the establishment of AAENP, members have been asked to participate on committees outside of the organization and are working on collaborative initiatives with the American College of Emergency Physicians, the American College of Osteopathic Emergency Physicians, physician assistant colleagues, and other nurse practitioner groups to promote quality educational preparation for ENPs to improve emergency patient care within the United States.

CONGRUENCY WITH THE APRN CONSENSUS MODEL

In 2008, the Advanced Practice Registered Nurse Consensus model (also referred to as the “LACE model”) was adopted nationally as the regulatory framework for NP licensure, accreditation, certification, and education. The model delineates advanced practice nursing (APN) based on role (nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist) and population focused competencies (family/individual across the life span, adult-gerontology, pediatrics, neonatal, psych/mental health, and women’s health/gender specific) (ANCC, 2008).

Nurse practitioner educational preparation further differentiates population focused competencies based on primary or acute care needs. Although patient care is not setting specific, NPs who are prepared as primary care providers have different competencies than those prepared for acute care roles. These unique educational differences govern an NP’s scope of practice. In addition to educational preparation based on role, population and acute or primary care focus, NPs may become specialty providers. Competencies and certification at the specialty level are determined by specialty organizations (i.e. cardiology, emergency, gastroenterology, oncology, orthopedics, etc.). Competencies for the ENP were initially published in 2008 and are now currently being updated by AAENP.

SUMMARY/CONCLUSION

NPs working in EDs are currently facing challenges obtaining and maintaining employment in emergency care settings as state Boards of Nursing and hospital organizations struggle to interpret and develop policies consistent with national LACE guidelines. The ENP specialty, whose educational preparation and scope crosses populations and acuties, does not fit easily into a narrow interpretation of the LACE guidelines. Although most state boards of nursing require certification based on population foci, consistency regarding certification type related to specialty practice is lacking. Confusion in the interpretation of the LACE model, with regard to specialty competencies, has resulted in competent ENPs being removed from their current positions due to misinterpretations of what types of NPs are “competent” to work in hospital environments; specifically who is competent to work in emergency care settings where care can range from primary care to acute resuscitation and stabilization of life threatening conditions. Current initiatives for preparing NPs in attaining established ENP core competencies include establishing educational curricular standards for academic, graduate education of ENPs, supporting the practice of current ENPs through appropriate post-graduate continuing education, updating ENP core competencies, and exploring potential partnerships with nursing and medical organizations to improve continuing education, recruitment and retention of qualified ENPs.

Since ENP certification by portfolio is poorly understood and is not accessible to many NPs entering the emergency workforce, this places NPs working in emergency care settings in a vulnerable position. Additionally, to require FNPs to obtain acute care pediatric AND acute care adult gerontology certification is not feasible or necessary. FNPs can obtain knowledge and skills in the acute resuscitation and critical skills required for safe practice in an ED by completing an ENP graduate program, by attending a structured emergency fellowship program, or by obtaining continuing education in critical care while working within EDs. Ultimately, NPs working in emergency settings must demonstrate ENP competencies through certification.

The Congressional Budget Office estimates that 42 million individuals still lack health care coverage and that ED visits have risen since the implementation of the Affordable Care Act (AHA, 2015). Americans rely heavily on the 24-hour access to care provided by EDs. These visits have increased by nearly 20% in the past 10 years (AHA, 2015). Emergency care providers are the safety net of care. With the existing manpower gaps that are threatening the delivery of emergency care services nationwide it is critical that FNPs currently working in the ED be grandfathered in their current positions and encouraged to obtain board certification as ENPs. Additionally, it is recommended that FNPs graduating from academic ENP programs and fellowships be recognized as having the knowledge, skills and competencies to begin entry level practice in the ED and be considered as board-eligible for ENP certification once eligibility criteria is met. Certification for ENPs in the specialty, regardless of population focus, is in the best interests of ensuring patient safety.

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