# Advanced Practice Registered Nurse Licensing:

## INDIANA'S CURRENT ENVIRONMENT & OTHER STATE APPROACHES

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# EXECUTIVE SUMMARY

## PURPOSE

Advanced Practice Registered Nurses (APRN) are an integral part of Indiana's health care system with nearly 10,000 Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Certified Nurse Midwives (CNM) and Certified Registered Nurse Anesthetists (CRNA) providing enhanced nursing care across the state. Current Indiana law requires that all APRNs be licensed as Registered Nurses (RN) and meet certain educational criteria to provide APRN-level services in their respective APRN role. While one APRN role (CMN) is required to hold a specific license to practice and many APRNs hold a prescriptive authority license, an estimated one fourth (28.8%) of RNs self-identified as APRNs but do not hold any additional licenses. These individuals are providing advanced nursing care under their RN license. The intention of this brief is to examine the current schema of APRN licensing in Indiana and explore alternative licensing strategies based on lessons learned from other states.

## INTRODUCTION

APRNs are licensed RNs with additional training, either through a graduate degree or other advanced certification, that provides the clinical knowledge and experience to provide advanced nursing care such as assessment, diagnosis and treatment of acute and chronic conditions, administration of anesthesia, pain management, labor & delivery, and many more services. Indiana law requires just one (1) of the four (4) recognized APRN roles, to hold an APRN-level occupational license to practice (certified nurse midwives). An APRN-level license is also required to provide prescriptive authority; three (3) of the roles (excluding CRNAs) may choose to hold this license and provide prescribing services. Approximately three quarters of eligible, self-identified APRNs currently hold a prescriptive authority license.

Occupational licensing is currently a top policy issue throughout the nation, with many states reevaluating their regulatory strategies for appropriateness and to reduce unintended economic and workforce consequences. Occupational licensing in the healthcare sector, intended to protect the public from bad actors and enhance the quality of the workforce, remains prevalent. A fifty-state review of APRN licensing regulation reveals that Indiana and Wisconsin are the only two states that do not require an APRN-level occupational license for all practicing APRNs, regardless of prescriptive authority; the remaining 48 states require that all APRNs hold an APRN-level license to practice. On implementation of the APRN-level license, it was found that thirty (30) states offer a single APRN license for multiple APRN roles. Eleven (11) states issue separate licenses for each APRN role. Seven (7) states have a combination of a single license for multiple roles as well individual, role-specific licenses.

## CHALLENGES OF RN-ONLY LICENSED APRNS

The absence of an advanced license for all APRNs in Indiana, regardless of prescriptive authority, poses some challenges for policymakers and the public. Information on licensed healthcare professionals is available to the public through the Indiana Professional Licensing Agency (PLA) website using the search and verify feature. This feature enables public verification of licensure status of Indiana RNs, CNMs and APRNs with prescriptive authority. However, for APRNs that do not hold a CNM or prescriptive authority license, there is currently no publicly accessible verification mechanism beyond the RN license (for Indiana-based nurses). The matter is further complicated by Indiana's participation in the Nurse Licensure Compact (NLC) which allows for RNs with a valid multistate license to practice in Indiana. APRNs from compact participating states can apply for an Indiana APRN prescriptive authority license with their multistate RN license. However, in the absence of an APRN license for all APRN types in Indiana, it is unclear if multistate RN licensees who do not pursue an Indiana CNM or APRN prescriptive authority license, are providing advanced level nursing care in Indiana.

## CONCLUSION

Indiana's approach to occupational regulation for APRNs is relatively unique. A 50-state review of APRN regulation determined that only one other state has a similar approach. The conclusion of the brief outlines four (4) optional approaches to licensure in Indiana and identifies considerations for each approach in terms of intersection with prescriptive authority, consumer perspectives, impact on practicing professionals, and administrative feasibility.

# TABLE OF CONTENTS

**Executive Summary** .......... 2

**Background** .......... 4

What is an APRN? .......... 4

What is Occupational Licensure? .......... 5

Occupational Licensing in the Health Sector .......... 5

**Indiana's Current Approach to APRN Regulation** .......... 6

APRN Licensure in Indiana .......... 6

APRN Prescriptive Authority .......... 6

**RN-only Licensed APRNs – Challenges in Indiana** .......... 8

Inability for the Public to Quickly Verify Credentials for all APRNs .......... 8

Data Tracking .......... 9

Complications Related to Indiana's Participation in the Nurse Licensure Compact .......... 9

**Other State Approaches to APRN Regulation** .......... 9

Exploring APRN Licensure Approaches .......... 11

Indiana's Current APRN Licensing Schema .......... 11

**Conclusion** .......... 15

# BACKGROUND

## WHAT IS AN APRN?

APRNs are RNs with an advanced education, either through a Master's degree, a doctoral degree, or other accredited advanced certification and training that provides the advanced clinical knowledge and experience to provide direct care to patients. APRNs build on the competence of the RN skillset and demonstrate a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and significant role autonomy.[1] An APRN conducts health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which may include the administration and prescription of pharmacologic and nonpharmacologic interventions.[2]

**WHAT IS AN APRN?**
**An Advanced Practice Registered Nurse (APRN) is nursing professional (RN) with specialized education and training. APRNs provide advanced nursing care which includes assessment, diagnosis, treatment and, in many cases, the authority to prescribe medication and controlled substances.**

There are generally four (4) distinct accepted APRN roles nationally, each with their unique education/training and associated scope of practice: nurse practitioners (NP), certified registered nurse anesthetists (CRNA), certified nurse-midwives (CNM), clinical nurse specialists (CNS).

Table 1 – APRN Roles in the U.S.

| TYPES OF ADVANCED PRACTICE REGISTERED NURSES[3] | | |
|---|---|---|
| **Who Are They?** | **How Many In The U.S.?** | **What Do They Do?** |
| Nurse Practitioners (NP) | 355,000+ | Take health histories and provide complete physical exams; diagnose and treat acute and chronic illnesses; prescribe and manage medications and other therapies; order and interpret lab tests and imaging studies; provide health teaching and supportive counseling |
| Clinical Nurse Specialists (CNSs) | 70,000+ | Provide advance nursing care in hospitals and other clinical sites; provide acute and chronic care management; develop quality improvement programs; serve as mentors, educators, researchers, and consultants |
| Certified Registered Nurse Anesthetists (CRNAs) | 71,250+ | Administer anesthesia and related care before and after surgical, therapeutic, diagnostic and obstetrical procedures, as well as pain management. Settings include operating rooms, outpatient surgical centers, ophthalmology, podiatric and dental offices. CRNAs deliver more than 65% of all anesthetics to patients in the United States |
| Certified Nurse Midwives (CNM) | 13,515+ | Provide primary care to adolescent and adult women, including gynecological exams, family planning advice, prenatal care, management of low-risk labor and delivery and neonatal care. Practice settings include hospitals, birthing centers, community clinics, and patient homes. |
| Sources: American Association of Nurse Practitioners NP Fact Sheet, August 2022. National Association of Clinical Nurse Specialists NACNS communication December 2018; American Association of Nurse Anesthesiologist Fact Sheet, Accessed August 2022; American College of Nurse Midwives ACNM communication August 2022 | | |

1 Advanced Practice Nurse Reimbursement and Scope of Practice in Indiana – Indiana Center for Nursing
2 Model for Uniform National Advanced Practice Registered Nurse (APRN) Regulation: A Handbook for Legislators
3 Modified from Future of Nursing Campaign for Action – Types of APRNs

These health care professionals practice within the parameters of state licensing policies which determine what APRNs can do and under what level of autonomy. APRN regulatory policies vary substantially from one state to another. They include any policy associated with initial licensure or renewal (commonly referred to as "entry to practice" policies) as well as policies associated with an APRN's practice, such as those associated with an APRN's relationship with a physician or other provider for prescribing. This brief is focused on regulatory policies associated with the approaches taken by states to license and regulate APRNs for entry to practice.

## WHAT IS OCCUPATIONAL LICENSURE?

A growing number of occupations are regulated by government at the local, state, or national levels. Policymakers across the US are currently engaged in a robust discussion on the costs, benefits, and unintended consequences of regulation. The widely accepted primary intent of regulation is to ensure quality of services and to protect the public. "When designed and implemented carefully, occupational regulation can benefit consumers through higher quality services and improved health and safety standards,"[4] but regulatory approaches must be weighed against threats to individual economic opportunity and impacts on the labor market, particularly in instances where a risk to public safety is low.

A 2015 report from the US Council of Economic Advisers and the Department of Labor recommends policymakers consider best practice which include a careful analysis and striking a balance between consumer safety and regulatory burden. First, there must be "present, significant, and substantiated harms" that require intervention. Second, if such harms are identified, legislators must first consider a regulation that is the "least restrictive" and imposes the lowest burdens and costs while protecting consumers from the identified harm.[5]

## OCCUPATIONAL LICENSING IN THE HEALTH SECTOR

Licensing is widely utilized in the healthcare industry to protect the public health and safety. In fact, the health sector has the highest frequency of occupational licensing requirements compared to all other industries. According to the BLS, in 2018, the share of workers with a currently active certification or license was highest among healthcare practitioners and technical occupations (72.6 percent).[6] Not only are the rates of licensure within the health sector high but compared to the overall workforce that holds an occupational license, the healthcare industry makes up the majority of licensed workers across the country.

The public interest in licensing of health care professionals is generally protected through the following state regulatory activities:

1. The establishment of guidelines for the minimum qualifications and competency of those given any license;
2. Protection from those not meeting the minimum competencies and those who are not competent to hold a given license, and;
3. Providing a mechanism and procedures for disciplining those who do not follow established standards.

Healthcare professions, like nursing, that require specialized skills and knowledge are regulated by licensing boards to ensure public safety. In turn, healthcare consumers place trust in providers based on the government's verification of their competency. When regulatory processes are available and it is made clear which individuals meet those qualifications, the burden is removed from consumers to individually verify their practitioners' credentials or qualifications prior to seeking care (unless so desired).

When examining the general considerations that a state takes into account when determining whether licensure is appropriate, it is easy to see why rates of occupational licensure in the health sector are high. Occupational regulation at the level of licensure is generally considered in cases that are compelling for consumer safety and economic reasons.[7] Due to the high physical and mental risk associated with delivery of health care services, licensure is generally considered the most appropriate level of state intervention to deem health care professionals competent to provide such services. The public faces real risks if treated by unqualified individuals, and laypersons may find it difficult (if not impossible) to adequately assess a practitioner's competence at the time of delivery. For similar reasons, consumers might have difficulty distinguishing between professionals who possess certain basic or general competencies and those with more specialized training and experience, as may be appropriate for delivery of specific services. In addition, the oversight required for ongoing licensure (renewal) can help identify seriously impaired or malfeasant practitioners (for example, those who have been sanctioned for repeated malpractice).[8]

4 Occupational Licensing Research Consortium
5 Occupational Licensing: A framework for Policymakers
6 Professional certifications and occupational licenses: evidence from the Current Population Survey (BLS, 2019)
7 The State of Occupational Licensing: Research, State Policies and Trends
8 Competition and Regulation of Advanced Practice Nurses

# INDIANA'S CURRENT APPROACH TO APRN REGULATION

The State of Indiana recognizes four (4) APRN roles, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM) and Certified Registered Nurse Anesthetist (CRNA). The regulatory landscape across the APRN roles in Indiana is a mix of educational, entry-to-practice requirements as well as license/certification minimums (see Table 2).) To illustrate, one of four (4) APRN roles require an APRN-level license and only three (3) of four (4) may attain a prescriptive authority license if certain additional criteria are met.

## APRN LICENSURE IN INDIANA

Indiana does not have a dedicated APRN license (with the exception of CNMs who must attain a limited license to practice nurse midwifery), making it one (1) of just two (2) states that utilize this APRN licensing approach. In Indiana, the remaining three APRN roles are licensed as RNs and most have the option to apply for a Prescriptive Authority license as well as Controlled Substance Registration (CSR). These remaining APRNs who either hold a current RN license or an RN license from a Nurse License Compact (NLC) state and who have successfully completed the advanced education requirements outlined in statute for each APRN role, may "function in an expanded role of nursing at a specialized level through the application of advanced knowledge and skills," without further occupational licensure or oversight.[9] The remaining forty-eight (48) U.S. states license APRNs (with or without prescriptive authority), either as a single APRN license for all state-recognized roles or as a separate licenses per role (See Table 3).

## APRN PRESCRIPTIVE AUTHORITY

Three of the four APRN roles, NP, CNS and CNM, are able to apply for prescriptive authority.[10] Those seeking prescriptive authority must meet additional education requirements and enter into a collaborative practice agreement (CPA) with a licensed practitioner (LP) or are granted privileges at an IDOH or DMHA regulated hospital.[11] The CPA is required to outline the manner in which the APRN and LP will coordinate with each other and requires that the LP review at least five (5) percent of the APRN's charts and medications.[12] These APRNs receive a prescriptive authority designation and are added to the Indiana Professional Licensing Agency's (PLA) publicly accessible database where they can be tracked and verified by employers and consumers.[13]

9 848 IAC Article 4 – Advanced Practice Nursing and Prescriptive Authority for Advanced practice Nursing
10 CRNAs are not permitted to obtain prescriptive authority.
11 IC 25-23-1-19.4(c)
12 848 IAC 5-1-1(7)(f) - Initial authority to prescribe legend drugs
13 Indiana Professional Licensing Agency - Search & Verify Public Database

Table 2 – Current APRN Rules and Regulations in Indiana

<table>
<tr><th></th><th colspan="2">Entry to Practice Only</th><th colspan="2">Entry to Prescriptive Authority</th></tr>
<tr><th>APRN Role</th><th>Qualifying Educational Program</th><th>National Certification Program</th><th>Entry Requirements</th><th>Renewal Requirements</th></tr>
<tr><td>Any Role</td><td colspan="2">Must hold RN license or authority (Nurse Licensure Compact multi-state license)</td><td rowspan="4">• Complete a graduate, postgraduate, or doctoral advanced practice registered nurse program<br>• 2+ Hours Graduate-level Pharmacology within 5 years of application<br>• 30+ contact hours of CE (inc. 8 CE in pharmacology), or Prescriptive experience in another jurisdiction within 5 years<br>• Enter into a collaborative Practice Agreement with a licensed practitioner.<br>• Compliance with national certification or equivalent appropriate for role</td><td rowspan="4">• Maintain a collaborative Practice Agreement with a licensed practitioner unless otherwise specified.<br>• Maintain national certification or equivalence appropriate for role<br><br>Initial Renewal:<br>• 15+ contact hours (at least 4 in pharmacology)<br>• Two Hours in Opioid Abuse & Prescribing (for controlled substance registration)<br><br>Subsequent Renewals:<br>• 30+ contact hours (at least 8 in pharmacology)<br>• Two Hours in Opioid Abuse & Prescribing (for controlled substance registration)</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>Graduate of qualifying, accredited NP graduate program</td><td>Completion of national certification program & certifying exam*</td></tr>
<tr><td>Certified Nurse Midwife (CNM)</td><td>Graduate of nationally accredited school of midwifery</td><td>Completion of National Certifying Examination by the American College of Nurse-Midwives</td></tr>
<tr><td>Clinical Nurse Specialist (CNS)</td><td>Graduate of qualifying accredited graduate program</td><td>N/A</td></tr>
<tr><td>Certified Registered Nurse Anesthetist (CRNA)</td><td>Graduate of Council on Accreditation of Nurse Anesthesia Educational Programs</td><td>Completion of certification exam by the Council on Certification of Nurse Anesthetists, Maintain certification</td><td colspan="2">This role is not permitted to obtain prescriptive authority.</td></tr>
<tr><td colspan="5">Note: There may also be provisions to allow individuals under previous authorities to practice under these roles. A baccalaureate degree in nursing or higher is required in order to prescribe legend drugs; if baccalaureate only, must hold national certification (848 IAC 5-1-1).<br>*Optional pathway: Completion of national certification program for nurse practitioners is an optional and secondary pathway to nurse practitioner in Indiana and is not required.<br>Sources: 848 IAC 4-1-4, IC 25-23-1-13.1, 848 IAC 4-1-5, IC 25-23-1-1.4, IC 25-23-1-19.5, IC 25-23-1-19.7</td></tr>
</table>

# RN-ONLY LICENSED APRNS – CHALLENGES IN INDIANA

## INABILITY FOR THE PUBLIC TO QUICKLY VERIFY CREDENTIALS FOR ALL APRNS

Indiana's Professional Licensing Agency (PLA) houses an online, up-to-date, searchable database of all professional license holders in the state, commonly referred to as the Search & Verify or Provider Profiles. A quick search allows Hoosiers and employers alike to identify and verify the credentials of any of state-regulated practitioner.[14] Under Indiana's current regulatory schema, RNs are licensed and can be easily identified through the PLA website, as can CNMs, and APRNs who have been granted prescriptive authority in the state. However, APRNs who only hold an RN license, and who, based on self-reporting during the 2021 RN license renewal period, make up approximately 24% (2,213) of the current APRN workforce, may practice at an advanced level of nursing including, identifying abnormal conditions, diagnosing health problems, developing and implementing nursing treatment plans and evaluating patient outcomes[15] without any additional state designation or license that is verifiable by the public (see Table 3). Furthermore, the ability for the State to take any adverse action such as revocation, suspension, probation, and monitoring of the licensee is limited to the RN license alone.

Table 3 – Indiana APRNs by License Type

| Self-Reported APRN Role (on RN license) | Total APRNs by Self-Reported Role (on RN License) | Hold Prescriptive Authority | Do Not Hold Prescriptive Authority | Estimated % of APRNs That do not Hold Prescriptive Authority |
|---|---|---|---|---|
| Nurse Practitioner (NP) | 8,525 | 6,818 | 1,707 | 20.0% (1707) |
| Clinical Nurse Specialist (CNS) | 546 | 73 | 473 | 86.6% (473) |
| Certified Nurse Midwife (CNM) | 156 | 123 | 33 | 21.1% (33) |
| Certified Registered Nurse Anesthetist (CRNA) | 637 | 9 | 628 | 98.6% (628) |
| **TOTALS** | | | | |
| All APRN Roles | 9,864 | 7,023 | 2,841 | 28.8% (2841) |
| NP, CNS, CNM only* | 9,227 | 7,014 | 2,213 | 24.0% (2213) |

* Excluding CRNAs as they are not eligible to apply for prescriptive authority in Indiana

About the Data: Nurses are licensed and regulated by the Indiana State Board of Nursing at the Indiana Professional Licensing Agency (PLA). Indiana's registered nurses (RNs) provide information on their demographic, education, and practice characteristics through a series of supplemental questions that were embedded within the online license renewal process. For additional detail related to Indiana nursing workforce data, explore the Data Report, Information Fields, or reach out to the Bowen Center at bowenctr@iu.edu for assistance.

14 Note: Many hospital employers undergo an additional credentialing process with APRNs (and other practitioner-level staff) associated with third party certifications for health care facilities, such as the Joint Commission on Accreditation of Healthcare Organizations.
15 848 IAC Article 4

## DATA TRACKING

An indirect but valuable benefit of licensing is data collection. By collecting APRN credentials and supplemental information such as practice location, continuing education and appropriate certification, the State is able to maintain an accurate picture of the workforce for tracking, analysis and policymaking. As it stands now in Indiana, for those APRNs that do not hold prescriptive authority, officials must rely on RNs that self-report as APRNs in order to collect complete and accurate data on the healthcare workforce.

## COMPLICATIONS RELATED TO INDIANA'S PARTICIPATION IN THE NURSE LICENSURE COMPACT

Indiana joined 35 other states when it enacted the Nurse Licensure Compact (NLC) in 2020. The NLC allows nurses that hold a multi-state license granted by a compact state to practice in the State of Indiana. This policy change adds an important tool to facilitate nurse workforce recruitment and retention efforts though enhanced portability of healthcare credentials across state lines. APRNs from compact states can apply for prescriptive authority in Indiana using their member state-administered multi-state RN license and meeting other criteria required for prescriptive authority (meaning APRNs with Compact RN licenses do not need to hold an Indiana RN license in order to apply for APRN prescriptive authority). It is estimated that as of January 18, 2023, 760 APRNs in Indiana have obtained or are seeking prescriptive authority through this mechanism.[16]

Additionally, due to the current state of Indiana's APRN licensing status (APRNs may practice at an advanced level under their APRN role's protected practice scope without a license, unless prescriptive authority is desired), there may be no clear mechanism for APRNs from compact states to practice as APRNs in Indiana if prescriptive authority is not pursued. In some cases, APRNs from Compact states may be practicing "under the radar" in Indiana without any state mechanism in place to recognize, monitor and track that these individuals meet the state requirements to provide APRN-level services. Therefore, while Indiana does not participate in an APRN Compact, the addition of compact RNs to the Indiana workforce, coupled with the lack of a general APRN license, may paradoxically allow out-of-state APRNs to practice in the state, essentially acting as an APRN compact.

# OTHER STATE APPROACHES TO APRN REGULATION

Outside of the VA health system, there are no federal rules or guidelines regarding APRN licensure; this authority is given to each state to decide how health professionals, including APRNs, should be regulated.[17] In the case of APRNs, several approaches to regulation can be found throughout the nation. Most states require APRNs to obtain some type of APRN-level license prior to providing advanced nursing services.

The APRN license approach for most states falls into one of two categories: 1) a universal license with role designations (such as in South Carolina), or 2) individually licensing each APRN role (such as in Georgia). A few states have a mixed approach where some APRN roles are covered under a single APRN license and others are licensed separately. For example, New Jersey has both a single APRN license for most APRN roles (NP, CNS, CRNA) and a separate license for CNMs.[18] In fact, only one state (Wisconsin) implements an approach similar to Indiana whereby individuals can provide advanced practice nursing services (aside from prescriptive authority) under the authority of their registered nurse license alone (and meeting criteria as outlined within state code).

16 Estimated based on the number of individuals who hold a designation of "APRN – RN Compact" as was identified through a review of the PLA's Search & Verify function on January 4, 2023.
17 In late 2016, the Department of Veteran Affairs (VA) authorized three (3) APRN roles (NP, CNS & CNM), who are licensed and nationally certified, for practice authority only within the VA health system, regardless of State policies. Source: Advanced Practice Registered Nurses – Federal Register
18 For reference, the National Council of State Boards of Nursing (NCSBN) has developed an APRN consensus model which includes considerations for state legislatures and regulatory boards to implement when establishing the appropriate licensure, accreditation, certification, and education of APRNs. The consensus model includes references to APRN licensing based on standardized educational and certification standards. More information about NCSBN's consensus model can be found at: https://www.ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

Table 4: State Approaches to APRN Licensure

| APRN Licensure Approach | Number of States |
| --- | --- |
| State issues single APRN license for multiple roles | 30 |
| State issues separate APRN licenses for each APRN role* | 11 |
| State issues license only to APRNs seeking prescriptive authority and CNMs | 2[§] |
| State issues a combination of single license that covers multiple roles and individual role-specific license (ex. Nevada issues both a single APRN license and a CRNA license) | 7 |
| * Not all states recognize four (4) APRN roles<br>[§] Indiana and Wisconsin | |

The following common themes are presented in other state approaches:

- **Streamlined application process that also acknowledges the uniqueness of each APRN Role.** Most states were found to offer a single license that incorporates multiple roles. As a part of implementation of this single license, states generally offered a streamlined approach such that all APRN roles would access a single application process with clear expectations for licensing requirements. This streamlined application is likely accompanied by well-defined processes for licensing board review which balances a single, streamlined application process and a unique review process for each individual APRN role.
  - For example, South Carolina implements a single APRN license. Their application process is streamlined for all APRN roles. Illinois also implements a single APRN license and application process, but with differing requirements across roles that are clearly messaged within the application guidance.

- **Clear, publicly accessible information for each professional providing APRN-level services. States with other approaches generally have accessible provider profiles,** similar to the Indiana Professional Licensing Agency's Search & Verify database, that allows individuals to quickly identify professionals' credentials license status. In the case of states with a single APRN license (and specific roles), it generally appears as "APRN – Nurse Practitioner" (or other role). In the case of states with a separate license for each role, the license look-up is generally by role. (Currently only Indiana CNMs and APRNs with prescriptive authority are accessible via the Search & Verify feature. Other APRNs would be identified by their Indiana RN license only or unable to be identified if they hold a Compact RN license only.)
  - For example, although Ohio implements a single APRN license approach with designations for multiple roles, Ohio APRNs are searchable via the License Look-up feature by their specific APRN role designation.

- **All APRNs have a state designation.** In the instance of states that have APRN licensure, APRNs have both their national credentials (such as certifications from relevant associations) as well as a state-provided licensure credential.
- **States are able to monitor and track the APRN workforce.** In an era of health workforce shortages, the ability to easily identify where gaps in services may exist, is crucial to targeting policy initiatives. Initial licensure and license renewal periods are convenient times for a state to collect and update information on practitioners.
  - For example, the Oregon State Board of Nursing reports on the counts of APRNs by role and is able to monitor these counts longitudinally.

## EXPLORING APRN LICENSURE APPROACHES

If Indiana were to explore licensing strategies for APRNs, there are various implementation options that could be considered, each with their own considerations. A summary of implementation options, informed by research on other state strategies, is presented below with a description for each approach in the subsequent text:

1. **Continue as is**
2. **Single APRN License for all APRN roles**
3. **Single APRN License for CNS, CRNA, and NP roles, with separate License for CNMs**
4. **Separate APRN Licenses for Each APRN Role**

## INDIANA'S CURRENT APRN LICENSING SCHEMA

### Approach #1: Continue as is – License for CNMs; No license for other APRN roles (beyond RN license); Optional prescriptive authority

The first option is for Indiana to continue as is through issuing a separate license for CNMs, but not requiring a license (beyond RN) for other APRNs to provide APRN-level services (other than prescribing). Qualified APRNs continue to access prescriptive authority through a separate application and process if desired. Wisconsin is an example of another state that has implemented a similar approach.

### How does this option intersect with prescriptive authority?

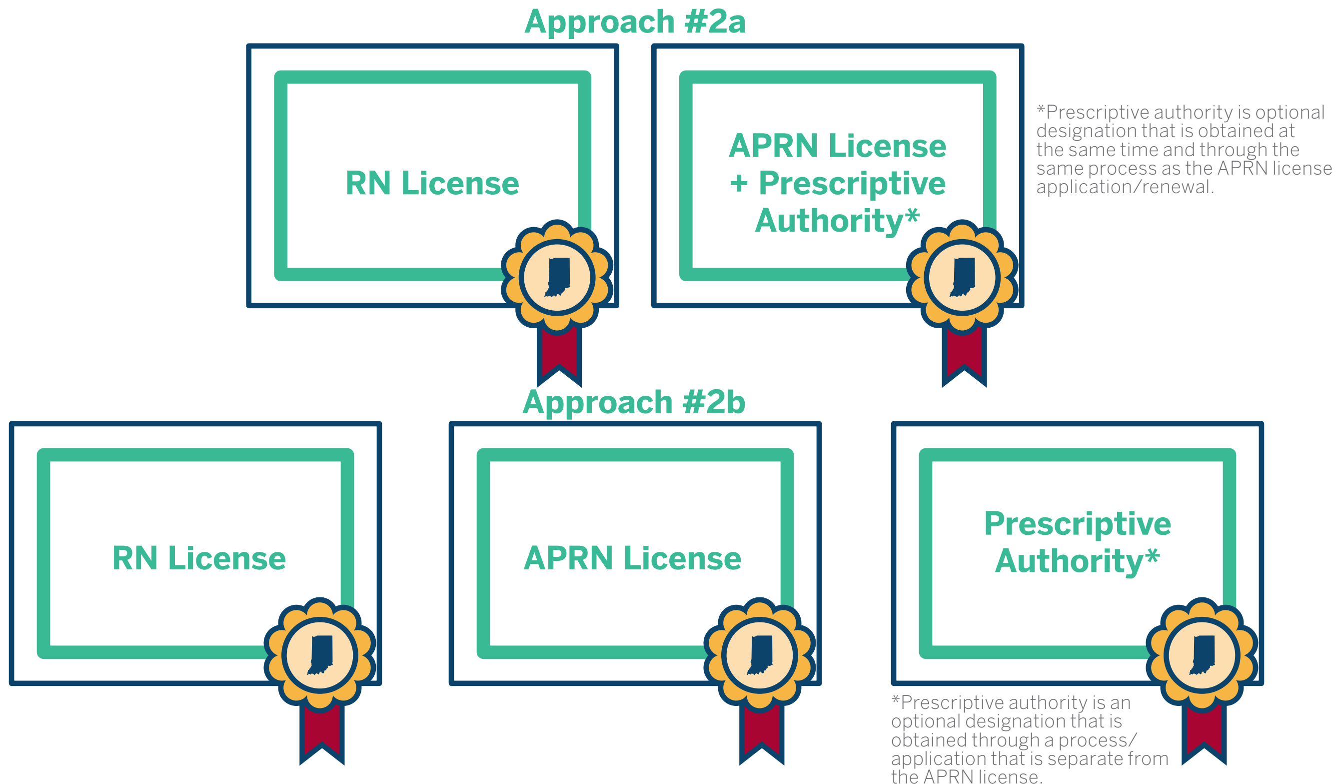
- Prescriptive authority is optional for qualifying roles and professionals. Prescriptive authority is obtained through a separate application and review process that is on the same timeline as RN license renewal.

### Policy analysis considerations:

- **Consumer Perspective:** Under this approach, consumers can easily verify licensure for APRNs that are CNMs or those that have obtained prescriptive authority. No process exists for consumers to verify credentials for APRNs in other roles without prescriptive authority (consumers may verify RN licensure).
- **Impact on Professionals:** CNMs must currently maintain three designations to provide all APRN-level services (RN, CNM, and APRN Prescriptive Authority licenses). Other APRN roles who choose to obtain prescriptive authority maintain an RN license (or authority through compact) as well.
- **Administrative Feasibility:** This approach would be highly feasible as it is currently being implemented.

### Approach #2: Single APRN License for all APRN roles

This is the most common approach implemented in other states. This approach would result in a single APRN license for all APRN roles, including replacing the CNM license for CNMs. Because of this, implementation of this option would require careful design and consideration. Examples of states that have implemented this option include Missouri, Montana, and Texas.




### How does this option intersect with prescriptive authority?

There are two general approaches to prescriptive authority for states which have optional prescriptive authority for APRNs. Some states have implemented prescriptive authority as an optional designation within the APRN license application (such as Texas). In these states, APRNs' qualifications for prescriptive authority are reviewed at the same time as general APRN licensure requirements. Other states have implemented a separate prescriptive authority designation with a separate application and review process (such as in Montana). In these instances, the review for prescriptive authority is limited to a review of just the qualifying credentials for prescriptive authority, such as pharmacology courses or relevant continuing education. The prescriptive authority designation could be implemented as an additional cost to APRNs, or as an add-on designation for APRNs at no cost.

### Policy analysis considerations:

- **Consumer Perspective:** Under this approach, consumers can easily verify licensure for all APRNs in the state, regardless of prescriptive authority. Despite having a single and streamlined license, the unique APRN role designation can be made publicly available to consumers for review.
- **Impact on Professionals:** All APRNs would be required to maintain an APRN license in order to provide any APRN-level service. This may result in an additional license cost for APRNs who are currently practicing under their RN license authority alone currently. There would be little impact to CNMs in Indiana, as they would transition to holding an "APRN-CNM" license through the same application process as other APRN roles. APRNs would have a state license and designation to display in an office-based setting or share in addition to their national certifications or credentials.
- **Administrative Feasibility:** This approach would require modification to the current licensing approach for APRNs in Indiana. The CNM license would either need to be retired or the statutory authority and processes would need to be modified to incorporate all APRN roles. A decision would need to be made as to how prescriptive authority would be implemented; both approaches have administrative implications (incorporating within the single APRN application would require modification of current processes but would result in a more streamlined approach for APRNs; maintaining a separate prescriptive authority designation would be a low administrative burden to the state but would require additional effort from professionals during application and renewal).

### Approach #3: Single APRN License for CNS, CRNA, and NP roles, with separate license for CNMs

This option is a blend of two approaches, as it creates a streamlined license for some APRN roles (CNS, CRNA, NP) and maintains a separate license for others (CNM). This option may be the most accessible approach, as it acknowledges the work that has already been done for CNM licensure and would likely not require a complete overhaul of those established processes. Examples of states that have implemented this option include Colorado, Connecticut, and Rhode Island.

### How does this option intersect with prescriptive authority?

- Similar to the previous option, prescriptive authority could be done within the license to practice (APRN or APRN-CNM) or it could be provided as a separate add-on designation.

### Policy analysis considerations:

- Consumer Perspective: Under this approach, consumers can easily verify licensure for all APRNs in the state, regardless of prescriptive authority. Despite having a single and streamline license for most roles, the unique APRN role designation can be made publicly available to consumers for review for all roles (including the separate CNM license).
- **Impact on Professionals:** All APRNs would be required to maintain an APRN license in order to provide any APRN-level service. This may result in an additional license cost for APRNs who are currently practicing under their RN license authority alone. There would be little-to-no impact on CNMs in Indiana, as they maintain a separate license and designation compared to other APRN roles. All APRNs would have a state license and designation to display in an office-based setting or share in addition to their national certifications or credentials.
- **Administrative Feasibility:** This approach would likely require the establishment of a new APRN license type and associated processes which include CNS, CRNA, and NP roles. The CNM license would likely remain relatively unchanged. A decision would need to be made as to how prescriptive authority would be implemented; both approaches have administrative implications (incorporating within the single APRN application would require modification of current processes but would result in a more streamlined approach for APRNs; maintaining a separate prescriptive authority designation would be a low administrative burden to the state but would require additional effort from professionals during application and renewal).

### Approach #4: Separate APRN Licenses for Each APRN Role

This option creates new licenses for each individual APRN role. Instead of a streamlined application, this option would require separate code, applications, and processes for each APRN role.  Examples of states that have implemented this option include Michigan, North Carolina, and Pennsylvania.

#### Approach #4a

*Prescriptive authority is optional designation that is obtained at the same time and through the same process as the APRN license application/renewal.

#### Approach #4b

*Prescriptive authority is an optional designation that is obtained through a process/application that is separate from the APRN role license application/ renewal.

**How does this option intersect with prescriptive authority?**

- Similar to the previous options, prescriptive authority could be done within each APRN role's unique license to practice or it could be provided as a separate add-on designation for any qualifying APRN.

**Policy analysis considerations:**

- **Consumer Perspective:** Under this approach, consumers can easily verify licensure for all APRNs in the state, regardless of prescriptive authority.
- **Impact on Professionals:** All APRNs would be required to maintain the appropriate license in order to provide the related APRN-level service. This may result in an additional license cost for APRNs who are currently practicing under their RN license authority alone currently. There would be little-to-no impact to CNMs in Indiana, as they maintain a separate license and designation compared to other APRN roles. All APRNs would have a role-specific state license and designation to display in an office-based setting or share in addition to their national certifications or credentials.
- **Administrative Feasibility:** This approach would likely require the establishment of three new APRN license types and associated processes (for CNS, CRNA, and NP roles). The CNM license and processes would likely remain relatively unchanged. A decision would need to be made as to how prescriptive authority would be implemented; both approaches have administrative implications (incorporating within the single APRN application would require modification of current processes but would result in a more streamlined approach for APRNs; maintaining a separate prescriptive authority designation would be a low administrative burden to the state but would require additional effort from professionals during application and renewal).

## ADDITIONAL CONSIDERATIONS FOR ANY APPROACH

### Reciprocity/Portability

Reciprocity and portability of licensure have been top policy priorities for states, including Indiana, in response to health workforce shortages. States are balancing autonomy with policy options that are competitive against (or in many cases, in alignment with) strategies that have been implemented in other states. This approach ensures professionals have credentials across state lines which would first require standardization. Much like the mission of the Nurse Compact, the NCSBN recommends state recognition and licensing of each of the four APRN roles, along with minimum educational requirements and national certification.[19] Many states have reviewed and adopted these considerations when developing their schema for APRN regulation. Aligning with strategies implemented in other states would allow professionals from other states to receive authority to practice in Indiana (either through licensure by endorsement/reciprocity or other means such as a licensure compact).

### Implications for Indiana Statute and Associated Messaging

While Indiana's approach to APRN regulation is an anomaly compared to most other states, Indiana's APRN community is likely familiar with the idiosyncrasies of current processes. Any change to Indiana's current approach would require modifications to state statute and may require promulgation of new rules. To mitigate any confusion among licensees and the public, Indiana could consider exploring opportunities for clear messaging on any new schema that would be explored. For example, the Texas Board of Nursing has outlined on the homepage the specific educational requirements by role, accepted examinations by role, a definitions page, and has created a supplemental educational video to serve as a reference for APRN applicants during the application process.

### Cost of License Application

The initial application for credentials and credential renewals are subject to a fee. The state renewal cycle is every two (2) years in odd-numbered years while the DEA renewal is 1 year after the initial approval and then every three years after that. The fee range experienced by APRNs in Indiana today varies significantly. An APRN who is a CNS, CRNA, or NP who is not pursuing prescriptive authority is subject only to the $50 fee every two years that is associated with RN license renewal. A CNM would be required to maintain both the RN and the CNM license, at an additional $50 fee every two years. Those APRNs who desire prescriptive authority have an additional $50 fee each biennium associated with APRN Prescriptive Authority renewal. Of note, APRNs who seek prescriptive authority for controlled substances face an additional fee associated with a Controlled Substances Registration. Changes in APRN licensing approach would likely alter the fees posed to APRNs and subsequently the revenue generated from APRN regulation. A recent review was conducted on state licensing fees for health professions and Indiana was found to consistently have lower fees compared to contiguous states and the national average, including for APRNs.[20]

Table 5- Indiana License Renewal Schedule and Fees

| Initial Application and License Renewal Fees | Renewal Cycle | Fee |
|---|---|---|
| Certified Nurse Midwife Limited License | 2 yrs. | $50 |
| APRN Prescriptive Authority | 2 yrs. | $50 |
| Controlled Substance Registration | 2 yrs. | $60 |
| Indiana RN License | 2 yrs. | $50 |
| DEA Registration | 3 yrs. | $888 |

19 Occupational Licensing in Health Care: Sorting the Wheat from the Chaff
20 Annual License Renewal Fees for Select Health Occupations by State. Bowen Center for Health Workforce Research & Policy. 2020. Available at: https://scholarworks.iupui.edu/bitstream/handle/1805/22103/Health%20Professions%20License%20Renewal%20Fees%20by%20State%202020-Compiled3.pdf?sequence=1&isAllowed=y

# CONCLUSION

Indiana's current licensing structure for APRNs is unique compared to common approaches implemented in other states. While Indiana APRNs that choose to pursue prescriptive authority or practice as an CNM hold additional state licenses, APRNS in other roles that do not pursue prescriptive authority currently provide advanced nursing services under their RN license. A 50-state review found that Indiana is one of only two states that does not have a licensing approach for all APRNs. Recent policy developments, such as the Nurse Licensure Compact, and those that may be emerging, such as the APRN Compact and other APRN practice policies, present an opportunity for Indiana to examine APRN regulation more broadly.

**The question to consider: Would an Indiana APRN license be helpful to protect public health and safety and support modernization of regulation, or are the current regulatory strategies sufficient?**

# ACKNOWLEDGEMENTS

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