Central Indiana Organization of Clinical Nurse Specialists

Statutory and Regulatory Credentialing of Clinical Nurse Specialists in Indiana
April, 2015

EXECUTIVE SUMMARY OF WHITE PAPER

- The Clinical Nurse Specialist (CNS) is an Advanced Practice Registered Nurse (APRN).

- The Registered Nurse License is the Foundation for Scope of CNS Practice.

Foundational Principles (mandates) for Regulation of CNS Practice:

1.) Assuring that the CNS is recognized as one of four distinctly different Advanced Practice Registered Nurse (APRN) roles – each has a different scope of practice

2.) Assuring Public Safety

3.) Assuring Public Access to Needed CNS Service

4.) Assuring No Harm to Existing CNSs

CIOCNS recommends that:

1. The CNS title should remain protected by state statute.

   Lack of title protection in a state results in use of the title by those without formal preparation as a CNS;

2. The CNS should be recognized in “Statute” as one of four distinctly different APRN roles with scope of practice explicated in “Regulations”; and

3. The level of regulation for CNS practice should be “registration” achieved by proof to Indiana State Board of Nursing of graduation from a nationally accredited masters or doctoral program that prepares Clinical Nurse Specialists.

Second Licensure:

CIOCNS will ONLY support second license as the level of regulation to authorize a CNS to practice IF the unique scopes of practice of each APRN role are defined separately and if the requirements for licensure are reasonably attainable, appropriate for the CNS role and do not create unnecessary barriers to existing CNSs.

Credentialing of CNSs:

If, in the future, there is evidence that some type of knowledge/skill competency, beyond successful completion of a masters or doctoral program preparing the CNS for practice, is needed, mechanisms for credentialing should include both certification and portfolio.
The portfolio mechanism would allow for all existing and evolving specialties to demonstrate not only knowledge competence but also practical application skills/competence.

**Independent Diagnoses of Pathology/Medical Conditions and Pharmaceutical prescriptive authority:**
Optional additional regulation is recommended for CNSs who desire to extend their practice outside the domain of nursing into the medical domain.
Introduction

Regulation of the health care workforce has long served as a strategic component of consumer protection\(^1\). Given the fluid, dynamic, and sometimes chaotic health care environment in the United States, professional regulation must continue to serve the public good by ensuring protections for safe and effective practice while assuring access to health care providers. Statutory, regulatory, and credentialing requirements are critical elements that affect Clinical Nurse Specialists and other advanced practice nurses in this dynamic health care climate\(^1,3,4-5\). The challenge facing Clinical Nurse Specialists (CNSs) is to meet our obligation to protect the public while removing, or at least not creating, barriers for CNSs and for the public’s access to advanced nursing services. This challenge requires informed and thoughtful debate and balanced solutions while not unduly burdening the regulatory system.

Purpose of White Paper

The purpose of the paper is fourfold: 1) discuss the Registered Nurse license as the foundation for CNS practice; 2) provide background for Clinical Nurse Specialists as APRNs; 3) discuss credentialing issues for CNSs; and 4) articulate the principles that undergird proposed model statutory and regulatory language for CNSs and CNS practice.

1. Registered Nurse License as the Foundation for CNS Practice

Regulatory authority for CNS practice is grounded in a state-issued registered nurse (RN) license. The RN license authorizes the nurse to independently diagnose (nursing diagnoses) and to treat (nursing therapeutics/treatments) health related problems, as well as to implement delegated medical therapeutics. Therefore, registered nurses have an autonomous scope of practice and a delegated medical scope of practice. Registered nursing practice requires licensure because
there is a potential for public harm that requires a high level of accountability. The rationale for licensure is well explicated by the National Council of State Boards (NCSBN) below:

“Licensure is used when regulated activities are complex and requires specialized knowledge, skills, and independent decision-making. The licensure process includes the predetermination of qualifications necessary to perform a unique scope of practice safely and an evaluation of licensure applications to determine that the qualifications are met. Licensure provides a specified scope of practice that may only be performed legally by licensed individuals. It also provides authority to take disciplinary action should the licensee violate provisions of the law or rules. Licensure is applied to a profession when the practice of that profession could cause greater risk of harm to the public without a high level of accountability.”

2. Background: The Clinical Nurse Specialist as an Advanced Practice Registered Nurse (APRN)

Clinical Nurse Specialist (CNS) is defined by the National Council of State Boards of Nursing as one of the four (4) categories of advanced practice nurse (APRN) roles -- Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Nurse Midwife (NM), and Nurse Anesthetist (CRNA). CNSs have practiced within the scope of practice authorized by an RN license for over 50 years. The differentiation between an RN and an RN as a CNS has been, since the inception of the role, a graduate degree in nursing preparing the nurse with research utilization, theory, and advanced practice expertise in a specialty area of nursing providing both direct and indirect care nursing services focused on improving patient outcomes, including safety, in a cost-effective manner. CNS domains of practice include nursing’s autonomous scope of practice and delegated medical authority. The definition of Clinical Nurse Specialist is:

“Clinical Nurse Specialists (CNSs) are licensed registered professional nurses with graduate preparation (earned master’s or a doctorate) from a program that prepares CNSs....CNSs are clinical experts in the diagnosis and treatment of illness, and the
delivery of evidence-based nursing interventions .... are experts in executing delegated medical regimens associated with the diagnosis and treatment of disease for a specialty population...possess advanced knowledge of the science of nursing with a specialty focus and apply that knowledge to nursing assessments, diagnoses, and interventions, and the design of innovations ...function independently to provide theory and evidence-based care to patients/clients in the their attainment of health goals ... work with other nurses to advance their nursing practices and improve outcomes, and provide clinical expertise to effect system-wide changes to improve programs of care.” (7 p. 12)

Specifically, the CNS

1. integrates (as appropriate) knowledge of disease and medical treatments in a holistic assessment of persons while focusing on the differential diagnosis of illness experiences (symptoms, functional problems, and risk behaviors) or wellness experiences (comfort and functioning at capability level) that have 
etiologies that require nursing interventions\ to prevent, maintain, or alleviate;

2. designs, implements, and evaluates population based programs of care by integrating nursing interventions and [delegated] medical treatments, as appropriate, to enhance patient outcomes cost-effectively;

3. serves as a leader/consultant/mentor/change agent in advancing the practice of nursing to achieve quality, cost-effective patient outcomes within the specialty population and, as appropriate, across populations; and

4. leads multidisciplinary groups in designing and implementing innovative alternative solutions that address system problems and/or patient care issues occurring across the full continuum of care.

What is done by the CNS in advancing the practice of nursing by bridging the gap between what is known (theory and research) and what is done by nursing and other health care personnel affects a wide range of patients. If evidence based protocols for nursing care are not implemented or implemented appropriately patients can be harmed.
Clinical Nurse Specialist practice is consistently targeted toward achieving quality, cost-effective outcomes within three (3) spheres of influence -- patients, nurses and nursing personnel, and organizations/systems. The patient sphere encompasses the direct care activities of CNSs. The essence of a CNS is clinical expertise with a defined specialty population. Clinical expertise is evident in shaping the delivery of interdependent care -- medicine and nursing working in concert to provide patient care, such as when a physician prescribes the type, rate, and duration of intravenous fluids and the nurse determines both the placement of the intravenous therapy line and the equipment. Currently, complex pharmacological and surgical therapies, supported by increasingly sophisticated technologies, are increasing demands in the area of interdependent practice, nonetheless, CNS responsibilities for interdependent practice remains within the scope of nursing. All of the CNS competencies with the patient care sphere fall within nursing’s autonomous domain and the delegated medical authority domain authorized by initial RN licensure.

In addition to direct patient care, CNSs advance the practice of nursing by influencing the practice of other nurses. And, CNSs influence the health care delivery systems and organizations though activities that change the system and therefore influence nursing care and patient outcomes. Therefore, CNS practice includes three spheres of influence -- patients, nurses and nursing personnel, and systems/organizations. The competencies for practice in all three spheres are consistent with nursing’s autonomous scope of practice and delegated medical authority described in the initial RN license.

The NCSBN argues that licensure is the preferred method of regulation for advanced nursing practice because of the nature of the practice that requires advanced knowledge, clinical proficiency, independent decision-making and autonomy and that the risk of harm from unsafe and incompetent providers at this level of complex care is high\textsuperscript{5}. Licensure does protect the public from unsafe practitioners by determining and testing for a basic level of safety. However, the practice of each advanced practice role -- CNS, NP, CNM, CRNA -- is distinctly different. Only CNS practice is within the scope of practice defined by the RN license. NP, CNM, and CRNA practice have each, in unique ways, extended into the medical domain of practice. Since extension into
medical practice is not authorized by the initial registered nurse (RN) license, it is logical, for public safety reasons that a new or second license be required for NPs, CNMs, and CRNAs whose APRN practice includes the medical domain. On the other hand, a second license is not appropriate where CNS practice, although advanced, is within the scope originally authorized by RN license.

It is particularly important to emphasize that the essence of CNS practice **expertise is imbedded in a specialty**. In addition to core knowledge areas for all CNSs, specialty competencies are necessary to build on the core. Consistent with other advanced practice roles the NACNS recommends that programs preparing CNSs include at least 500 hours of supervised clinical experience. Specialty practice areas can be identified in terms of the following:

- population (e.g. pediatrics, geriatrics, women’s health)
- setting (e.g. critical care, emergency room, home care)
- disease/pathology (e.g. diabetes, oncology, orthopedics)
- type of care (e.g. perioperative, rehabilitation, medical/surgical, genetics, hospice)
- type of problem (e.g. pain, wound, stress). \(^2,7\)

**Specialty areas for CNS practice have evolved and continue to evolve over time in response to societal needs.** The competencies required in a specialty area are not identified in an *a priori* fashion but rather are defined *after* CNSs have worked to formulate programs of care to meet new societal needs, and there is a consensus about the knowledge and skill competencies required. As Peplau noted in an early description of CNSs:

> When the attention of the public focuses on areas of public need which hitherto have received scant attention from the available professions, new areas of specialization tend to be formulated. These new fields usually have a greater shortage of professional personnel who have both the interest and some know-how specific to the phenomena relating to these problems.... From this standpoint new specialties tend to be developed in response to public need and interest... With specialization the focus tends to become narrowed upon a piece
of the field, which allows greater development in depth of such a piece, or the focus is a recombination of a piece of one field with a piece of another field -- so that relations among specific phenomena can be studied and formulated (e.g. biophysics). 10, p. 269

In some situations, CNSs desire optional practice responsibilities that do extend into the medical domain, such as prescriptive authority. Since these optional responsibilities are outside the scope of the initial RN license, additional regulatory mechanisms are needed to cover only those responsibilities that extend into the medical domain.

The degree to which each APRN role extends into the medical domain is unique for each role. It is for each APRN professional organization to determine the respective scopes of practice and therefore the extent to which their practice extends into the medical domain, e.g. diagnosing and treating disease and prescriptive authority. Correspondingly each APRN group should recommend appropriate statutory and regulatory mechanisms that would authorize expansion of the scope of practice beyond practice activities authorized by the Registered Nurse scope of practice.

3. Credentialing of CNSs and Protection of the Public

The explicit goal of professional regulation is to establish standards that protect the public from incompetent health care providers. The legal authority to provide health services is tied to state statutes or practice acts that establish professional practice authority in scopes of practice. The development of multiple advanced practice nursing roles has led to a proliferation of legislative and regulatory activity related to professional practice authority. The legal authority to practice can be granted in a number of ways. Varying from least to most restrictive, the four levels of regulation include designation/recognition, registration, certification, and licensure. The basic approaches are licensure, certification (by a state authority), and registration 5.

It is particularly important to note here that, while attractive on the surface in its simplicity, the attempts to treat all APRN roles the same has resulted in tremendous confusion in the discipline and in the policy arena. It is axiomatic that requiring masters
prepared CNS to obtain pharmaceutical prescriptive authority to practice even though he/she does not wish to enter into that domain of practice is problematic.

The purpose of nursing education is to prepare individuals with the knowledge and skill competencies to practice nursing safely and effectively. To responsibly meet societal needs, graduate education programs for CNSs must prepare them adequately both in role and specialty competencies. Role competencies encompass direct care competencies in the provision of “advanced” nursing care informed by theory and research with an emphasis on indirect care competencies in the nurse and organizational spheres. Specialty competencies put particular emphasis on direct care within a specialty context while also addressing competencies in the interdisciplinary arena that inform interdisciplinary decision making in patient care and the development of programs of care.

Certification. A legal requirement that a CNS be certified as a CNS in a designated specialty area to practice as a CNS in the advanced practice of nursing creates a capricious and substantial barrier for many CNSs. First, there is no evidence that national certification of any type beyond initial RN licensure for CNSs improves patient outcomes and/or protects the public. Second, not all CNS specialties have appropriate certification examinations available. Third, if the underlying principle of certification is protection of the public (despite lack of evidence) then the knowledge required to practice in a particular specialty such as oncology, diabetes, rehabilitation, and orthopedics should be CNS specialty knowledge in a designated area not in a more generalized population. Because an oncology or critical care CNS could pass the non-specialty specific such as Adult Health to Frail Elderly examination does not mean that the public can be assured that the CNS has an adequate level of advanced nursing knowledge competence in oncology or critical care. 5, 6

Because of the rapid proliferation of knowledge and specialties, it is unreasonable to think that appropriate certification exams for every specialty area will be available to CNSs to demonstrate knowledge competency. The proliferation of specialties and subspecialties occurs because of the evolution of societal needs.

If, in the future, there is evidence that some type of knowledge/skill competency, beyond successful completion of a masters or doctoral program preparing the CNS for
practice, is need another mechanism such as portfolio review\textsuperscript{*} should be utilized. The portfolio mechanism would allow for all existing and evolving specialties as well as demonstrate not only knowledge competence but also practical application skills/competence.

**Education.** To responsibly meet societal needs, graduate education programs for CNSs must prepare them adequately both in role and specialty competencies. Role competencies encompasses direct care competencies in the provision of “advanced” nursing care informed by theory and research with an emphasis on indirect care competencies in the nurse and organizational spheres. Specialty competencies put particular emphasis on direct care within a specialty context while also addressing competencies in the interdisciplinary arena that inform interdisciplinary decision making in patient care and the development of programs of care.

It is particularly problematic when external curricular requirements either through regulation or accreditation requires CNS graduate programs to meet the same "content" and experiential requirements for any one or more of the APRN roles that are focused on the delivery of services within the medical domain emphasizing the biomedical model. Such requirements include “advanced assessment, advanced pathophysiology, and advanced pharmacology” courses that are focused on foundational knowledge for the diagnosis and treatment of disease\textsuperscript{2, 6}.

4. **Foundational Principles (mandates) for Regulation of CNS Practice**
   a.) **Public Safety**
   1.) *Regulation of CNSs must assure that CNSs are appropriately educated in the CNS role; and*
   2.) *Regulation of CNSs and CNS practice must assure that patients receive care from CNSs that are competent in a designated established or evolving specialty area through educational preparation in the specialty area in a masters or doctoral program that prepares CNSs; and*
   3.) *Regulation of CNSs who need prescriptive authority to effectively deliver services in their nursing specialty must meet the same requirements as other*
b.) **Public Access to Needed CNS Services**

1.) *Regulation of CNSs must assure that unnecessary barriers to recognition of CNSs and granting of the authority to practice are not created; and*

2.) *Regulation of CNS practice must assure that CNSs can practice to the full scope of practice including prescribing DME, referral to other health care supportive services and authorizing special services such as home care.*

c.) **No Harm to Existing CNSs**

1.) *Grandfathering language pertinent to ANY new requirements for legal recognition of CNSs must maintain authorization for CNSs who have previously met requirements for title protection and practice.*

The mandate to protect the public must be balanced with the mandate to not create unnecessary barriers to the public’s access to CNS services. The public has a right to access the full range of qualified CNSs services to benefit from advanced practice nursing competencies and should be able to rely on public third party reimbursement of needed services from qualified CNSs. The “public” is defined here as a consumer of CNS services and therefore includes both individual/family/community clients as well as employers in health care. To enable the public to benefit from CNS services, CNSs must be available and authorized to provide services to the full extent of their knowledge and competencies. That is, CNSs must be legally authorized to practice and the CNS scope of practice should be inclusive of the full range of CNS services. The full scope of CNS practice encompasses both direct and indirect care services as well as device prescription and referrals to other services. The provision of direct care is an essential part of the CNS scope of practice. Equally important is the inclusion of indirect care services focused on the cost-effective improvement of patient outcomes by working through nursing personnel and changes at the system level (Lyon, et.al, 1998).
The points presented above are cogent arguments for why some level of state regulation of CNSs and CNS practice that includes title protection and scope of practice is required. However, it is argued here that requiring CNSs to obtain a second license verses designation/recognition is “over regulation” creating unnecessarily burdensome requirements and barriers to CNS practice. In particular, the requirement for certification as a CNS in the respective specialty area is unachievable when no valid and reliable specialty exam exists and therefore a portfolio option is essential.

Specifically, CIOCNS recommends that:

1. **The CNS title should remain protected by state statute.**
   Lack of title protection in a state results in use of the title by those without formal preparation as CNSs;

2. **The CNS scope of practice should be explicated in regulations at not in statute;**

3. **The level of regulation for CNS practice should be registration achieved by Proof of graduation to Indiana State Board of Nursing from a nationally accredited state board-approved masters or doctoral program that prepares clinical nurse specialists**;

4. **Optional additional regulation is recommended for CNSs who desire to extend their practice outside the domain of nursing into the medical domain.**
   The most important differentiating feature of CNS practice that extends into the medical domain is the inclusion of the independent diagnoses of disease/medical conditions and pharmaceutical prescriptive authority. Because these activities are not authorized in the RN scope of practice, CNSs should meet the same recognition/licensure requirements as any other advanced practice nurse whose practice similarly extends into the medical domain. Where CNS practice extends into the medical domain and includes the independent diagnosis and treatment of disease, optional regulations should specifically speak to practice in the medical
domain and should not be extended to be requirements for CNS practice in nursing's autonomous domain of practice authorized by the RN license.

* If the CNS declares a specialty area and educational preparation was not specialty focused in the same area then proof of certification or an approved portfolio in the specialty is required.
REFERENCES


