



Statutory and Regulatory Recognition for Clinical Nurse Specialists in Oregon

SUE B. DAVIDSON, PhD, RN
KATHLEEN BEARDSLEY, MSN, RN, CCRN
ANN H. BUSCH, MS, RN, CWOCN, APN-BC
ANNETTE GARNER, MSN
SANDY HERESA, MS, RN
NANCY D. HODGES, MS, RN
KATHLYNN NORTHRUP SNYDER, MSN
ANNE ROSENFELD, PhD, RN

Clinical nurse specialists (CNSs) in Oregon initiated the process of achieving statutory and regulatory recognition several years ago. Throughout this process, specific phases of activity and events helped CNSs to identify what was required to achieve this goal. The resulting lessons learned are shared in this report. Statutory recognition of CNSs in Oregon occurred in 1999, and the administrative rules for CNS practice were published in 2001.

These administrative rules delineate the CNS scope of practice and other aspects of CNS practice consistent with national standards.

KEY WORDS: clinical nurse specialist, regulation of clinical nurse specialist practice, administrative rule related to clinical nurse specialist practice

INTRODUCTION

Recent articles in *Clinical Nurse Specialist* have described statutory and regulatory barriers to clinical nurse specialist (CNS) practice as well as provided a model practice act.¹ This article describes the experience of CNSs in Oregon who achieved statutory and regulatory recognition of their practice. This story illustrates how health policy is shaped by design and by external events, how CNSs and nurse practitioners (NPs) collaborated on the issue of recognition, and what strategic lessons were learned in the process. Finally, an analysis of whether Oregon's administrative rules have the potential to reduce barriers to CNS practice is presented.

From the Oregon Nurses Association, Portland, Ore; Legacy Emanuel Trauma Service, Portland, Ore; Portland Veterans Affairs Medical Center, Portland, Ore; Sacred Heart Medical Center, Eugene, Ore; Kaiser Permanente-KSNC, Clackamas, Ore; Samaritan Counseling Center, Portland, Ore; Linfield-Good Samaritan School of Nursing, Portland, Ore; and Oregon Health & Sciences University School of Nursing, Portland, Ore.

Corresponding author: Sue B. Davidson, PhD, RN, Nursing Practice Director, Oregon Nurses Association, 9600 SW Oak, Suite 550, Portland, OR 97223 (e-mail: davidson@oregonrn.org).

PRELEGISLATIVE PHASE (1989–1995)

Events and Activities

The approximately 150 CNSs in Oregon had been meeting since 1983 as the Oregon Council of Clinical Nurse Specialists (OCCNS), a special-interest group of Oregon Nurses Association (ONA). NPs and nurse midwives in Oregon had already obtained legislative and regulatory recognition for their practice, prescriptive authority, mandatory reimbursement, and admitting privileges to hospitals. On the other hand, CNSs had aligned themselves with the view that advanced practice should not be regulated within boards of nursing because it would limit expansion of the practice.² With downsizing and reorganizing in many hospitals during the 1990s, many CNSs were shifted from their positions and retitled. These factors led to the realization that one major advantage of regulation would be title protection. On the national level, the locus of recognition for any advanced practice role had moved to boards of nursing. Also, during this period, the Oregon Board of Nursing (OBON) made the decision to drop the requirement for national certification to practice as an NP or a nurse midwife, hence recognition as a CNS in the state of Oregon (when it did occur) meant state certification to practice.³ This certification did not require an examination but did involve board review of transcripts, the educational program of the applicant, and practice hours in the past 5 years.

In 1993, a CNS practicing in rural Oregon requested reimbursement for services that were covered by Medicare. The claim was rejected, and when queried about the reason, the regional director of Medicare said “. . . you do not exist if you are not [recognized as a clinical nurse specialist] in the nurse practice act in your state” (oral communication with Rita Monahan, July 1993). This response mobilized CNSs to request convening a group by OBON to explore how CNSs could become recognized. The OBON’s first response was to ask if CNSs wished to be recognized as NPs. CNSs voted “no” on this question, and an advanced practice task force of 13 NPs and nurse midwives and 2 CNSs was convened. The first order of business was revision of administrative rules for NP practice, and secondly, development of a statement describing CNS practice. The “Interim Position Statement on CNS Practice⁴ was written, revised, and adopted in 1994 through collaboration of the CNS task force representatives with CNSs throughout the state. The revised NP rule and the newly written interim statement on CNS practice were sent to the Assistant Attorney General assigned to the OBON. The conclusion was that OBON did not have statutory authority to regulate CNSs.

Undeterred, CNSs looked for another way to form a support base, this time with staff nurses. They sought recognition of CNS practice through a resolution of the Oregon Nurses Association Board of Directors and House of Delegates, although this resolution carried no statutory or regulatory authority. To achieve this, the scope of CNS practice that had been written for the OBON was presented to the ONA Board of Directors who, in the course of learning about CNS practice, edited and revised the statement into a form that they believed would be understood by staff nurses.

A resolution was presented at the yearly convention to members of the House of Delegates, and the vote in support of CNS practice was unanimously passed in April 1996. As another stopgap measure, CNSs new to the state who inquired about recognition at OBON were referred by the OBON to ONA/OCCNS, and staff at ONA was requested to answer questions and refer callers to OCCNS.

Lessons Learned in the Prelegislative Phase

1. Revisions of the interim position statement by NPs emphasized independence and autonomy and other core values inherent in the administrative rule for NP practice. Such values had not been articulated by CNSs before, perhaps because of the joint and collaborative nature of CNS practice in acute care settings.
2. CNSs learned from their NP colleagues what was entailed with revision of a scope of practice. This was helpful for CNSs to write their own scope of practice later. As NPs had haggled over the right words for their rule, CNSs learned to haggle over the right words for their rule. For example, words such as *nursing specialty* did not have the same meaning when applied to CNS practice.
3. CNSs learned that clarifying the likely outcome of a task force at the outset was better than discovering that the intended outcome was not possible. Such clarification might have enabled CNSs to seek statutory recognition in the 1995 legislative session, rather than in 1997.
4. Building bases of support with nurse constituents and others had to be a continuous process.

LEGISLATIVE PHASE (1996–1999)

Events and Activities

At this point, CNSs realized that they would have to obtain statutory recognition through the legislature. A conference call with the NP leadership was held in fall 1996 before the 1997 legislative session to discuss two options for proceeding: 1) to revise a section of the practice act into an advanced practice division and move the separate scopes of practice for NP, nurse midwives, and CNSs underneath it or 2) for CNSs to seek recognition at the legislature on their own. The first option was rejected, and CNSs were supported on the second one. CNSs then turned to ONA for support. The results of a state survey of CNSs that defined barriers and benefits of statutory/regulatory recognition of CNSs was presented to the ONA Cabinet on Health Policy (Oregon Council of Clinical Nurse Specialists, unpublished data, 1996). The Cabinet and the Board of Directors voted to make recognition of CNSs a legislative priority and assigned resources to the effort. As a result, HB 2525 was introduced in February 1997. It included a detailed description of preparation and scope of CNS practice. The idea that CNSs made major contributors to the health of Oregonians, reduced hospitalization costs, customized care for patients and families, and enhanced the practice of nurses was the strategy used. Informational packets were distributed to every House and Senate legislator. (See Appendix 1 for a listing of packet contents). The bill was referred to a House committee, was given a second hearing but died in committee.

Lessons Learned in the 1997 Legislative Phase

1. Three major contextual issues influenced the fate of HB 2525, demonstrating that it is necessary to know, if possible, the legislative environment before introducing a bill. Before HB 2525 was heard, the OBON adopted rules to create a new category of NP, the acute care nurse practitioner (ACNP). Although the Oregon Medical Association (OMA) did not support this, it did not provide public testimony in opposition. It was the CNSs belief that what OMA did do was intensify its efforts to prevent passage of HB 2525 and to prevent passage of another bill seeking statutory recognition of nurse anesthetists. Although CNSs and ONA knew that nurse anesthetists were going to seek statutory recognition, it was not known that the ACNPs would be coming before the OBON. Secondly, Oregon legislators did not have coherent policies on healthcare workforce and, whether by intention or default, took the position that “. . . less is better.” Because bills were also being heard regarding a mental health technician and expansion of the scope of Emergency Medical Technician (EMT) practice at the same time as HB 2525, CNSs concluded that legislators were on “overload” with expansion of roles and scopes and chose to avoid dealing with the issue rather than working through it. Finally, a bill to create a “health professions superboard” was circulated and actively opposed by ONA, CNSs, NPs, and many others. This created a difficult environment for HB 2525. The lesson learned was that it is desirable to know the legislative environment as much as possible before introducing a bill.

LEGISLATIVE INTERIM/LEGISLATIVE SESSION PHASES (1997–2000)

Events and Activities

In the 2-year interval between 1997 and 1999, a CNS joined the Oregon Nurses—Political Action Committee (ON-PAC). This group interviews candidates and incumbents before each election, seeking to identify those who may become or support issues important to Oregon nurses. Because of the CNS member in this group, a question was included in the interview guide that asked whether the candidate supported statutory recognition of CNSs from the OBON. Although most candidates had never heard of a CNS before, this initial introduction to the name formed the basis for follow-up by CNSs after the legislative session began. Another CNS was appointed to a joint legislative interim committee dealing with pain, thus increasing the presence and contribution of CNSs in the public policy arena. As before, the CNS group consulted with the NP group regarding its plans. This time, the approach to legislators was altered to take advantage of the passage of the Balanced Budget Act of 1997. Hence, the CNS campaign shifted from focusing on CNS practice to focusing on justice. Because CNSs are recognized at the federal level and are eligible for reimbursement, it is just and fair that Oregon CNSs are not penalized by lack of recognition from the OBON. Rather than contacting all legislators on both sides of the aisle, legislators were contacted who were

party and caucus leaders and who served on the committees that would hear the bill in the House and the Senate. HB 3000 went into bill process early in December 1999, came out in print in January 2000, and was assigned to a House committee by mid-February 2000. The bill passed unanimously out of committees and in the House and Senate by May 2000 and was signed into law in July 2000.

Lessons Learned in the Legislative Interim/Legislative Phase

1. These events were occurring at a time when the National Council of State Boards of Nursing (NCSBN)⁵ were disseminating new model practice act language for advanced practice nurses. The NCSBN approach focused on regulation of the similarities between various advanced practice nurses rather than the unique contributions and scope of each. The decision made in Oregon by CNSs and NPs deviated from the model of regulation being supported at that time. In the long run, this provided CNSs with latitude in writing the administrative rules for CNS practice.
2. The 1997 legislative effort of CNSs focused on explanation of CNS practice. However, this description inevitably led to questions about how CNS practice differed from NP practice, whether prescriptive authority was involved, and many related inquiries. This response had been anticipated, but not to the degree and extent that it occurred. This enabled OMA to capitalize on confusion and to offer clarifying amendments which, for the most part, were unacceptable to the CNSs. The strategy for 1999 differed markedly from 1997 because it focused less on the practice and more on the barrier that this lack of CNS recognition was causing. This placed legislators in the role of fixing something rather than resolving something.

REGULATORY PHASE (1999–2001)

Events and Activities

The summer before the OBON was required to initiate rule making, OCCNS conducted another survey to assess opinions of CNSs about aspects of administrative rule that included elements of the scope of CNS practice, requirements for initial and continuing state certification, waivers, grandfathering, and standards for preparation (Oregon Council of Clinical Nurse Specialists, unpublished data, 2000). The OBON selected members for the CNS Rule Making Task Force from the core group who had worked on the legislation, other CNSs practicing in the state, a CNS student, a CNS in an administrative role, and a CNS faculty person. The first meetings of the CNS Rule Making Task Force were spent learning the process of rule making and the Board's thinking on the structure and content of the CNS rule. The Board hoped that the CNS rule would be very similar if not the same as the structure and content of the administrative rules for NPs, nurse midwives, and nurse anesthetists. An initial draft of the rule was developed using this design. It became clear, however, that conceptions of CNS practice differed from the NP, nurse midwife, and nurse anesthetist, and a new approach that

focused on the specific competences or practice behaviors in the 3 domains of practice of CNSs emerged.⁶ Other aspects of the administrative rule were folded into this new approach.

The first hearing of the new rules took place in November 2000; the second hearing was conducted in February 2001, at which time the rule was adopted. (Appendix 2 contains the full text of the new CNS Administrative Rule.)

Lessons Learned in the Regulatory Phase (2000–2001)

1. All relevant board rules should be reviewed before meetings with Board task forces to avoid the appearance of intentional wrongdoing. In our case, to prepare for the CNS Rule Making Task Force meetings, members of the group who had worked on the legislation met before the meetings with the OBON to find common ground and consensus. This was a problem for the OBON who, via letter from the OBON Attorney, insisted that the group cease and desist because of violation of the open meetings law of the state. Meeting to plan ahead has been a typical behavior of CNSs in the state for many years. The CNS Rule Making Task Force members were unaware of the open meetings law, and were thus caught unaware by this response of the OBON staff.
2. Boards of Nursing (BON) have varying conceptions, models, and procedures for conducting their work. During the time that CNSs and the OBON worked together, those conceptions emerged, requiring CNSs on the task force to explain and justify elements of the scope of this advanced practice role and sometimes to delay dealing with a particular issue until a later time. For example, the concept that a CNS works in 3 domains is not familiar, especially when one of the domains is an organization or system. The experience of Oregon's CNSs suggests that BON throughout the nation may have a similar lack of knowledge if they have not clearly described the scope of CNS practice in rules or if they have blended the description of CNS practice with that of other advanced practice nurses.
3. The hearings of the draft administrative rule were attended by members of the task force and elected members of the Board of Nursing in the presence of board staff and a public audience. The questions asked about CNS practice provided a new venue for explaining what CNSs were about, their value, and their practice.

ADMINISTRATIVE RULES FOR CLINICAL NURSE SPECIALIST PRACTICE IN OREGON REDUCE BARRIERS TO CNS PRACTICE

The Oregon administrative rules for CNS practice reduce many regulatory barriers. First, the rules give legal authority to provide and be reimbursed for CNS services because they delineate the qualifications, scope, and standards for CNS practice and describe disciplinary actions and protect the title. Second, the recognition of CNS practice is provided as certification by the state. Third, the Oregon rule for CNS practice avoids the barrier of tying a supervisory agreement to a physician. Fourth, the Oregon rules enable

the CNS to order durable medical equipment (DME). Statutory authority to prescribe medications will be sought in the next legislative session for those CNSs whose practice requires this privilege, thus reducing this potential barrier in the near future.

The Oregon rules need to be strengthened in the issuance of state certification based only on review of transcripts, educational program of an applicant, and verification of practice hours. This approach lacks relevance to practice as in the case of a CNS who has been out of his/her program for more than 20 years, and it also lacks external verification of knowledge for initial practice as a CNS through, for example, national certification. The Oregon rule also needs strengthening in its requirements for evidence of continuing competency at renewal of certification because of reliance on continuing education and required practice hours only.

Collaboration between CNSs in Oregon and leaders such as Dr Brenda Lyon, Chair of the Legislative/Regulatory Committee of the National Association of Clinical Nurse Specialists, occurred when these administrative rules were being written. Thus, congruence between the national model language and administrative rule in a state jurisdiction occurred.

SUMMARY

During a period of time and through a collaborative effort with a state nursing association, the CNSs practicing in Oregon have obtained legislative and regulatory actions to reduce barriers for CNSs practicing in Oregon and for CNSs who come to Oregon to practice. This achievement has reduced barriers and increased the access of Oregonians to CNS practice.

ACKNOWLEDGMENTS

Martin Taylor, Susan King, and Brian DeLashmutt provided brilliant strategizing and unstinting support to the efforts of CNSs in this endeavor in 1997 and 1999. Oregon Nurses Association Board of Directors provided resources and staff. Kathy Pfister Minogue and Jane Harrison Hohner, Chairs of Nurse Practitioners of Oregon, provided support and guidance for our legislative contacts. The members of ON-PAC graciously enabled us to participate in their interview process and eventually became our advocates in all the candidate interviews. In addition to members of the CNS Rule Making Task Force, those who talked with and wrote to legislators and gave written or verbal testimony included Laura Borders, Diane Cockburn, Linda Dietrich, Marilee Donovan, Carol Duncan, Theresa Harvath, Peggy McComb, Mary Jo Mead, Meg Munger, Barbara Strunk, Helen Turner, Jeannine White, and Jean Falls Wright. Finally, without the knowledge, patience, and committed presence of Tracy Klein, Louise Shores, Mary Amdall Thompson, and Joan Bouchard of the Oregon Board of Nursing, this final product could not have happened.

References

1. Lyon BL, Minarik PA. Statutory and regulatory issues for clinical nurse specialist (CNS) practice. *Clin Nurse Spec*. 2001;15(3):108-114.

2. LaBar C. *The Regulation of Advanced Nursing Practice as Provided for in Nursing Practice Acts and Administrative Rules*. Kansas City, Mo: American Nurses Association; 1983.
3. Oregon State Board of Nursing. Proposed Amendments to OAR 851-50-001, 002, 010, 138, 139, and 851-45-025 (1993).
4. Oregon Council of Clinical Nurse Specialists and Oregon Nurses Association. *Interim Position Statement re: CNS Practice in Oregon*. Portland, Ore: Oregon Council of Clinical Nurse Specialists and Oregon Nurses Association; 1994.
5. National Council of State Boards of Nursing. *Model Nursing Administrative Rules*. Chicago: National Council of State Boards of Nursing; 1994.
6. National Association of Clinical Nurse Specialists. *Statement on Clinical Nurse Specialist Practice and Education*. Glenview, Ill: National Association of Clinical Nurse Specialists; 1998.

APPENDIX 1

Information in Oregon Legislator Packets

- Brochure describing what the bill will do
- A copy of the bill
- Talking points related to the bill
- Description of rural CNSs' practice, outcomes of practice
- Description of urban CNSs' practice, outcomes of practice
- Information about the various nursing specialties of Oregon CNSs
- Comparison of generic registered nurse role with CNS and NP advanced practice roles.

APPENDIX 2

Division 54—Clinical Nurse Specialists

PURPOSES AND DEFINITIONS

851-054-0010

- (1) Purposes of these rules
 - (a) To implement the provisions of ORS 678.370 to 678.372 governing the certification of Clinical Nurse Specialists (CNSs) by the Oregon State Board of Nursing.
 - (b) To define the scope of practice of the CNS.
 - (c) To establish standards for safe practice for the CNS.
 - (d) To serve as a guide for the board to evaluate CNS practice.
- (2) Definitions used in these rules
 - (a) *Assessment* means a process of collecting information regarding a client's health status using tools, techniques, and methodologies based on nursing theory and research. The skills employed during the assessment process include collecting, analyzing, and evaluating data to diagnose symptoms, functional problems, risk behaviors, and health status and to develop interventions and plans of care.
 - (b) *Client* means the recipient of CNS services for whom the CNS has established a provider relationship. A provider relationship is established through assessment and planning for the recipient.

- (c) *Clinical Nurse Specialist* is a registered nurse who has been approved and certified by the board to provide healthcare in an expanded specialty role.
- (d) *Collaboration* is a process involving the CNS and one or more members of the healthcare team working together to achieve common goals, each responsible for their particular area of expertise.
- (e) *Consultation* means interaction between the CNS and the consultee for the purpose of transmitting or obtaining information or advice.
- (f) *Continuing Education hours* are contact hours of education. One contact hour is equal to 50 minutes of instruction. Ten contact hours are equal to one Continuing Education Unit (CEU).
- (g) *Medical equipment* means medical supplies or durable or disposable equipment ordered by the CNS that are related to or required for self-care, or the plan of care.
- (h) *National Certification* means a certificate of recognition in a specialty area issued by a national nursing organization.
- (i) *Order* means written or verbal directives by the CNS to other members of the healthcare team.
- (j) *Organization* means a system or network that provides patient care.
- (k) *Population* means the collection of individuals in a community or a group of individuals defined by age, health status, lifestyle, disease, and/or geographic location.
- (l) *State Certification* means certification to practice advanced nursing as authorized by the Oregon State Board of Nursing.

USE OF THE CLINICAL NURSE SPECIALIST TITLE

851-054-0015

As of 10-01-2001 an individual shall meet the requirements and receive state certification as a Clinical Nurse Specialist to use the title Clinical Nurse Specialist or CNS. Pursuant to ORS 678.370, no person shall hold themselves out to the public as a Clinical Nurse Specialist or CNS without recognition and certification from the Oregon State Board of Nursing.

CLINICAL NURSE SPECIALIST SCOPE OF PRACTICE

851-054-0020

The Clinical Nurse Specialist (CNS) independently provides advanced theory and research-based care to clients and facilitates attainment of health goals. Within the practice of advanced nursing, the CNS provides innovation in nursing practice, based upon clinical expertise, evidence-based decision making, and leadership skills. The CNS practices within 3 spheres of influence. These 3 spheres of influence are: individual clients and populations; nurses and other multidisciplinary team members; and organizations. Practice may target one or more spheres of influence.

- (1) The CNS may practice with individual clients and populations of clients.
 - (a) Individual client care includes but is not limited to
 - (A) Assessing the client using tools, techniques, and methodologies based on theory and research
 - (B) Diagnosing symptoms, functional problems, risk behaviors, and health status of the client

Source: Oregon State Board of Nursing (www.osbn.state.or.us, Advanced Practice Nursing)

- (C) Developing a mutually derived therapeutic plan of care with the client
 - (D) Designing, implementing, and evaluating nursing interventions by using data, research, and theoretical knowledge
 - (E) Selecting, recommending, and ordering medical equipment, laboratory and screening or diagnostic tests for the client
 - (F) Establishing standing orders related to nursing interventions and specific plans of care
 - (G) Encouraging disease prevention, health promotion, and health maintenance
 - (H) Providing referrals for the client to other health-care services or providers as indicated
- (b) Population care includes, but is not limited to
- (A) Planning, implementing, and evaluating data collection
 - (B) Selecting, ordering, and recommending screening and diagnostic tests for individuals within a population
 - (C) Interpreting and analyzing population data to formulate diagnoses in the areas of needs, functional problems, risks, and health issues
 - (D) Reviewing and revising diagnoses based on subsequent data collection
 - (E) Innovating, implementing, guiding, evaluating, and revising population-focused plans and programs
 - (F) Encouraging disease prevention, health promotion, and health maintenance
 - (G) Establishing criteria for referral within a population
 - (H) Establishing algorithms, standing orders, or practice guidelines related to specific populations
 - (I) Informing the population about its health and promoting other community systems that influence health
 - (J) Assessing need for and participating in activities to change health and social policies that affect the health of the community
- (2) The CNS may practice with nurses and other members of the multidisciplinary care team to advance the practice of nursing and improve client care. This practice includes, but is not limited to
- (a) Consulting and collaborating to identify and manage healthcare issues
 - (b) Providing leadership in the utilization of research in practice
 - (c) Coaching nursing staff in clinical practice development
 - (d) Identifying knowledge deficits or target groups providing healthcare
 - (e) Developing, providing, and evaluating educational and other programs that enhance the practice of nursing personnel and/or other members of the healthcare team
- (3) The CNS may practice with organizations to provide clinical expertise and guidance. This practice includes, but is not limited to
- (a) Using system-wide change strategies based on an assessment of the needs and strengths of the organization
 - (b) Initiating collaborative relationship among teams to facilitate interdisciplinary practice
 - (c) Collaboratively developing and evaluating research-based and client-driven systems and processes
 - (d) Creating, advising, and influencing system-level policy that affects programs of care
 - (e) Evaluating and recommending equipment and products being used in patient care for efficacy, efficiency, cost-effectiveness, and client/consumer satisfaction
- (4) The CNS may provide expertise that includes, but is not limited to
- (a) Summarizing, interpreting, and applying research results
 - (b) Teaching, coaching, and mentoring healthcare members in the evaluation and use of research
 - (c) Planning, directing, and evaluating multidisciplinary programs of care for clients
 - (d) Evaluating client outcomes and cost effectiveness of care to identify needs for practice improvement
 - (e) Conducting and participating in research and research protocols
 - (f) Designing and establishing standing orders related to nursing interventions

STANDARDS FOR CLINICAL NURSE SPECIALIST SCOPE OF PRACTICE

851-054-0021

The Clinical Nurse Specialist (CNS), shall meet the standards for Registered Nurse practice, and shall also meet the practice standards for advanced practice, including but not limited to

- (1) Recognize and practice within the limits of knowledge and experience of the individual CNS and consult with or refer clients to other healthcare providers when indicated.
- (2) Develop and practice within jointly derived statements of agreement, or jointly derived practice protocols, preprinted orders, or algorithms to facilitate interdependent practice when CNS practice overlaps with the scope of medical practice
- (3) Provide and document nursing services within the scope of practice and specialty for which the individual CNS is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic course work, workshops or seminars, or other supervised planned learning, provided both theory and clinical experience are included.

ELIGIBILITY FOR INITIAL CERTIFICATION

851-054-0040

- (1) An applicant for certification as a Clinical Nurse Specialist (CNS) shall
 - (a) Hold or obtain a current unencumbered registered nurse license in Oregon
 - (b) Hold a graduate degree in nursing, or a post-master's certificate in nursing demonstrating evidence of CNS theory and clinical concentration. The program shall meet the following educational standards
 - (A) The program shall be at least one academic year in length

- (B) There shall be faculty and/or clinical instructors who are academically and experientially qualified in nursing, and who maintain expertise within the CNS scope of practice
- (C) NLNAC or CCNE accreditation
- (D) Applicants who graduate or obtain a post-masters certificate on or after January 1, 2006, shall have completed 500 hours of clinical practice within the program; or prior to state certification
 - (ii) Complete a formal academic program offering any remaining hours of clinical practice; or
 - (iii) Complete a board-approved clinical continuing education course offering supervised clinical practice for any remaining hours.
- (c) Meet the practice requirement through verification of
 - (A) Graduation from a CNS educational program within the past five years; or
 - (B) Practice within the CNS scope of practice for at least 960 hours within the five years preceding the application. Verification of practice hours is subject to random audit.
- (2) If an applicant does not meet the practice requirement in 851-054-0040 (1)(c) the applicant shall
 - (a) Submit for board approval, a detailed plan for precepted practice that includes: competencies that support the CNS scope of practice; names and qualifications of CNS preceptor(s); and a description of the nature of the proposed, unpaid, voluntary, precepted clinical experience.
 - (A) If the applicant has practiced at least 960 hours within the past six (6) years prior to the date of application, the practice plan shall provide for 250 hours of preceptorship. Documented practice hours within the CNS scope for the past two (2) years may be recognized and may reduce the required hours, except that in no case shall the precepted practice be less than 120 hours.
 - (B) If the applicant has practiced at least 960 hours within the CNS scope for ten (10) years prior to the date of application, the practice plan shall provide 400 hours.
 - (C) If the applicant has not practiced at least 960 hours within the CNS scope for the ten (10) years prior to the date of application, the practice plan shall provide for 500 hours.
 - (b) Obtain a limited certification for precepted practice. The limited certification shall be issued only upon receipt of a completed CNS application, application for limited certification, board approval of the plan for supervised practice, and payment of all applicable fees. The limited certification is valid only for precepted practice that has been approved in advance by the board and will be valid for one (1) year from the date of issue. One extension of the limited certificate may be granted upon approval and payment of fee, provided there is a current valid application for certification on file and no disciplinary action has been taken against the applicant. This extension will be valid for one year from the date of approval.
 - (c) Successfully complete the precepted hours of practice supervised by the CNS preceptor. Successful completion shall be verified by a final evaluation submitted by the supervising CNS to the board to verify that the applicant is competent to practice in the CNS scope at a safe and acceptable level, and that the number of required hours of precepted practice were completed.
 - (d) Submit evidence of continuing education to total 20 contact hours for each year out of practice. Continuing education taken concurrent with the reentry plan may be applied toward the total continuing education requirement, provided all hours are complete by the end of the preceptorship.
- (3) The applicant shall submit all fees required by the board with the application. The fees are not refundable. An application that remains incomplete after one year shall be considered void.
- (4) Prior to 10-01-2005, an applicant for Clinical Nurse Specialist (CNS) certification who meets all requirements for initial certification, except the masters in nursing or post-master's certificate in nursing (as specified in 851-054-0040(1)(b)) may be eligible for certification. In addition to other initial certification requirements, the applicant shall:
 - (a) Document practice in the CNS scope, as defined in 851-054-0020, a minimum of 400 hours within the two years prior to the effective date of these rules; and
 - (b) Prior to 10-01-2001, hold a baccalaureate degree in nursing, and hold a masters degree in a related field from an institution accredited by the nationally recognized, regional accrediting agency, with a clinical specialty focus supporting the CNS scope of practice; and
 - (c) Meet the general practice requirement of 960 hours within the past 5 years.

RENEWAL OF CLINICAL NURSE SPECIALIST CERTIFICATION

851-054-0050

Renewal of the Clinical Nurse Specialist (CNS) certification shall be on the same schedule as renewal of the registered nurse license. The requirements for renewal are:

- (1) Current unencumbered license as a registered nurse in Oregon; and
- (2) Practice as a CNS for no less than 960 hours within the five (5) years prior to renewal or have completed a preceptorship established in OAR 851-054-0040(2); and
- (3) Forty (40) contact hours of continuing education accumulated during the current certification period;
- (4) The CNS shall affirm and document completion of the continuing education and practice hours on the application renewal form. Verification of all hours and credits is subject to random audits by the Board. Falsification of continuing education or practice hours is grounds for disciplinary action.
- (5) The CNS shall maintain accurate records of any claimed CE hours and practice hours for no less than 5 years from the date of submission to the Board.
- (6) An applicant for renewal who has graduated from the CNS program less than two (2) years prior to the first renewal will not be required to document the full 40 contact hours of continuing education. Continuing

education will be prorated on a monthly basis based on the length of time between graduation and the date of the first renewal.

- (7) The applicant shall submit the required fees with the application. Fees are not refundable. An application shall be void if not completed during the current biennial renewal cycle.
- (8) An applicant for renewal up to 30 days past the expiration date shall meet all the requirements for renewal and pay a delinquent fee.
- (9) Any individual whose CNS certification is delinquent may not practice as a CNS until certification is complete, subject to civil penalty.

REACTIVATION OF CLINICAL NURSE SPECIALIST CERTIFICATION

851-054-0055

Any applicant for renewal who applies more than thirty (30) days past the expiration date of their CNS certificate shall be considered delinquent, and required to demonstrate eligibility for renewal.

- (1) Requirements for eligibility include:
 - (a) Current unencumbered licensure as a registered nurse;
 - (b) Verification of continuing education hours equal to twenty (20) contact hours per year since the last renewal;
 - (c) Evidence of practice as a CNS in an expanded nursing role equal to 960 hours in the past 5 years. If the applicant does not meet this practice requirement, he or she must apply for re-entry and submit

a supervised practice plan as established in OAR 851-054-0040(2).

DISCIPLINARY ACTION ON CLINICAL NURSE SPECIALIST CERTIFICATION

851-054-0100

- (1) The Board may deny, suspend or revoke the authority of a Clinical Nurse Specialist (CNS) to practice under a limited or full certificate for causes identified in ORS 678.111(1) and OAR 851-054-0015 and 0016.
- (2) Revocation, suspension, or any other encumbrance of a registered nurse license, or any special authority to practice as a CNS, in another state, territory of the United States, or any foreign jurisdiction may be grounds for denial of Clinical Nurse Specialist certification in Oregon.
- (3) In addition to standards identified in OAR 851-054-0015, it shall be conduct derogatory to nursing standards for the CNS to:
 - (a) Charge the client or any third-party payer in a grossly negligent manner;
 - (b) Use ordering authority without sufficiently documented evidence of advanced nursing assessment and establishment of a client/provider relationship;
 - (c) Prescribe or dispense medications requiring specific authority under state or federal law;
 - (d) Practice as a CNS in a specialty area or scope of practice not supported by the licensee's clinical and didactic training.