



Advanced Practice Registered Nurse Compact

A Call to Action With a Primer on the Regulation of CNS Practice

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After 15 years of practicing as a clinical nurse specialist, what would you think if tomorrow you found out that you could no longer practice as a clinical nurse specialist? If you're in specialty areas, such as rehabilitation, orthopedics, oncology, wound/ostomy, women's health, perioperative, diabetes, pulmonary, cardiovascular, and neuroscience, this could happen to you in the near future!

It is imperative that clinical nurse specialists (CNSs) become increasingly knowledgeable about the regulation of CNS practice and how to have input into policy decisions that can drastically affect the ability to practice as a CNS. The purpose of this article is threefold: first, to present the most pressing regulatory issue for CNSs, including background information; second, to review some basics about regulating nursing practice, and; third, to call CNSs to action.

THE ISSUE

As currently written, the *National Council of State Board's of Nursing (NCSBN) proposed Advanced Practice Registered Nurse (APRN) Compact language will require all* CNSs in your state to obtain CNS certification in their respective specialty areas if your state of residence adopts the Compact as written (see NACNS Response to NCSBN APRN Compact language¹). This certification requirement creates an insurmountable barrier for the majority of CNSs, because there are no CNS certification examinations available for the majority of CNS specialty areas.

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Issue Background

During the past few years, some state legislative and regulatory actions have forced many CNSs out of practice by requiring certification as a CNS in a designated specialty area when no such examination is available. Often, these actions took practicing CNSs by surprise! Don't be surprised. Know that the regulations proposed by NCSBN's APRN Task Force will make certification a requirement for ALL CNSs in states who participate in the multistate compact. As previously discussed in this journal, the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements (APRN Compact), despite opposition from most national nursing organizations, was approved by the NCSBN's delegate assembly last year. NACNS, along with many other nursing organizations, opposed the language requiring certification in the specialty area, unless an option for waiver was included. Waiver options create alternatives for CNSs to demonstrate competence when no specialty examination is available for the CNS. Since passage of the APRN Compact, the NCSBN's Advanced Practice Task Force has been writing proposed rules that a state must adopt to participate in the APRN Compact. **These rules will be presented to the NCSBN's Delegate Assembly at its national meeting in August!** Only those states that have adopted and successfully passed the RN/LPN Compact through their respective legislative bodies are eligible to participate in the APRN Compact. However, currently only 20 states have adopted the RN/LPN Compact, and the number continues to increase.

The overarching purpose of the Compact is admirable—that is, to establish common requirements for practice and mutual recognition that would allow a nurse who is licensed to practice in his or her state of residence to practice across state lines. However, proposed rules/regulations will create insurmountable barriers for the majority of CNSs. As previously discussed in other articles,^{2,3} one of the root problems of the Compact is that it approaches all 4 APRN groups as

if their practices were the same. The term *advanced practice nurse* includes CNSs, nurse practitioners (NPs), nurse anesthetists, and nurse midwives. Although there are some common core of competencies across the groups, such as advocacy, ethical practice, critical thinking, and commitment to professional development, the practice of each group requires different knowledge and skills, because the practice of each group is distinctly different.

The hazard created by ignoring the differences between the various advanced practice nurse (APN) groups, particularly the differences between CNSs and NPs, is that regulatory requirements establish barriers for CNS practice and recognition. Specifically, because the NCSBN's APRN Task Force views the advanced practice of nursing as diagnosing and treating disease with prescriptive authority, the APRN Task Force believes it is appropriate to require all CNSs, like NPs, to obtain a second license to practice. That is, you must obtain a second license, because the diagnosis and treatment of disease with prescriptive authority is outside the domains of practice authorized by the RN license (autonomous nursing practice and delegated authority in implementing medical regimens). Because a second license is required, there must be a demonstration of minimal competence to practice within the new previously unauthorized scope of practice. Currently, certification examinations are used as a "proxy" for licensure examinations.

The primary assumption driving the APRN Task Force's proposal that all CNSs, like NPs, nurse anesthetists, and nurse midwives, should be forced to obtain a second license is their belief that all CNSs desire to independently diagnose and treat disease and, therefore, need and want prescriptive authority. However, the majority of CNSs in this country are not *independently* diagnosing and treating disease. Anecdotal data from NACNS board members, based on interactions with CNSs from throughout the country, suggest that the majority of CNSs do not want to diagnose and treat disease nor do they desire corresponding prescriptive authority. Rather, they are practicing within the domains authorized by the RN license—nursing's autonomous scope of practice and delegated medical authority. Requiring these CNSs to obtain a second license is overregulation. When that second license is granted on the basis of a certification examination, it will have the unintended consequence of creating barriers that prohibit CNS practice in any specialty or subspecialty that does not have a CNS certification examination. In the end, the public will be denied the expertise of the CNSs evidence-based nursing care. Certainly, if a CNS desires to diagnose medical problems and treat those problems using prescriptive authority, the requirement for a second license makes sense, because the scope of practice has extended beyond that authorized by the RN license.

The APRN Task Force suggests that a way around the lack of CNS certification examinations in subspecialty areas is to have CNSs take a generalist examination, such as the American Nurses Credentialing Center (ANCC) CNS Medical-Surgical certification examination. This alternative begs the question of the purpose of certification as a proxy for a licensure examination—that is, to demonstrate knowledge competencies in the CNS's specialty. It's a stretch to assume that passing the ANCC's CNS Medical-Surgical examination is a testament to the knowledge

competence of an oncology CNS, orthopedic CNS, rehabilitation CNS, diabetes CNS, perioperative CNS, women's health CNS, and many other specialty CNSs. Nevertheless, if the current APRN Compact language and rules proposed by the NCSBN APRN Task Force are adopted, it will require CNSs to take an examination that does not correspond to the knowledge competencies required in a subspecialty area. The legal defensibility of such an examination to demonstrate minimal competence in a CNS's designated subspecialty is highly questionable.

Both NACNS and the ANCC are working on developing a legally defensible portfolio option and a CNS "core" role certification examination. Both of these alternative methods to demonstrate competence may prove to be fruitful when there is no CNS certification examination available in a subspecialty area. However, there is considerable work to be done on both of these options.

A PRIMER ON CLINICAL NURSE SPECIALIST REGULATION

Nursing practice is regulated via government oversight in each state. Nursing is a regulated discipline because it is one of the health professions that could cause harm to the public if practiced by a person who does not have the competencies to deliver services competently. Regulatory credentialing (designation/recognition, registration, certification, and licensure) serves the public by identifying those individuals who have demonstrated minimum "safe" competencies to provide the services within a defined scope of practice. The most restrictive form of regulation is licensure. However, designation/recognition and registration can provide for title protection and scope of practice protection. The regulation level recommended by NACNS for CNSs practicing within the scope of practice authorized by the RN license is designation/recognition or registration. Each state has a Nurse Practice Act that delineates out the requirements for legal recognition to practice and via statute and/or rules specifies scopes of practice.

State boards of nursing are authorized agencies with the legal authority to regulate nursing. State boards of nursing comprise nurses (RNs, licensed practical nurses [LPNs]/licensed visiting nurses [LVNs], APNs) and consumers. The exact composition of each state board of nursing varies according to statute, and, in most states, the appointments are political—that is, members are appointed by the governor. However, in a few states, the members are elected by nurses who are licensed in the state. State boards are typically funded by the license, and the renewal fees are paid by nurses.

Nurse Practice Acts are laws that regulate nursing practice. Practice acts commonly (1) define the authority of the board of nursing, its composition, and its powers; (2) define nursing and the boundaries of the scope of nursing practice; (3) identify types of licenses and titles; (4) protect titles; (5) state requirements for licensure (in the case of APNs, the establishment of these requirements is largely delegated via statute to the respective state board of nursing); and (6) and identify the grounds for disciplinary action.⁴

A state board of nursing is authorized via state statute to develop administrative rules and regulations that are necessary to implement and clarify the respective state's Nursing Practice Act. Rules and regulations must be con-

sistent with statute—that is, not go beyond the statute and, once enacted, have the force of law. When a state board of nursing desires to establish new rules/regulations or modify existing ones, the board must hold public hearings and/or have public comment periods to allow stakeholders to have input into the rule-making process.

Each state board of nursing is a member of the NCSBN. The NCSBN is an organization through which state boards act and counsel together on public safety matters related to or are affected by the regulation of nursing practice. The mission of the NCSBN is to “...lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting public health and welfare.”⁵ The vision of the NCSBN is to ... “advance optimal health outcomes by leading in health care regulation worldwide.”⁵

The NCSBN develops the NCLEX-RN examination, analyzes policy and promotes uniformity in the regulation of nursing practice, disseminates data pertinent to the licensure of nurses and regulation of nursing practice, conducts research pertinent to these activities, and serves as a forum for exchange of information between members.⁵

A CALL TO ACTION

Take these action steps NOW!

1. Call your state board of nursing and
 - a. Find out the members of your state board of nursing;
 - b. Ask if your state board has an advanced practice committee or task force and request the names of members;
 - c. Find out when your state board and the advanced practice committee meet AND request notification of meeting times and the agenda (NOTE: state agencies must publicize meeting times and agendas).

2. Call your state nurses association and find out if there is an advanced practice group that is providing oversight of state board actions regarding advanced practice nursing.
3. Write to your state board of nursing to express your concerns about the APRN Compact—specifically, language that creates insurmountable certification barriers to CNS practice. *Urge your state board to delay acting upon APRN compact language until unnecessary barriers to CNS practice can be resolved.*
4. Meet with other CNSs in your hospital, city, state, or NACNS Affiliate Group and pass along this “Call to Action.”
5. Copy your written or e-mail communications to your state board to NACNS national office.

The National Association of Clinical Nurse Specialists is working hard to represent CNSs at the national level. Help us help you!

References

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