



Operationalizing Advanced Practice Registered Nurse Legislation

Perspectives From a Clinical Nurse Specialist Task Force

JULIE PONTO, MS, RN, CNS, AOCN

JULIE SABO, MN, RN, CCRN, CS

MAURA A. FITZGERALD, MS, RN, C

DAWN E. WILSON, MS, RN, CNS

Many state boards of nursing are currently examining advanced nursing practice and determining a process to recognize and regulate it appropriately. In 1999, Minnesota state law was altered to define and provide title protection for advanced practice registered nurses. After passage of the new law, the Minnesota Board of Nursing convened 4 task forces, representing each of 4 advanced practice nursing groups, to develop recommendations regarding issues of certification, criteria for determining acceptable certifying organizations, procedures in the event of examination failure, and a process for communicating this information to the nursing community. This article provides an overview of the legislation and describes the process used to obtain and operationalize the new law. The process undertaken in the clinical nurse specialist task force is also described, including the key issues that emerged and lessons that were learned.

KEY WORDS: advanced practice registered nurse, legislation, CNS, specialty practice, certification

On May 17, 1999, the governor of the state of Minnesota signed into law a bill that amended Minnesota statutes (commonly referred to as the Nurse Practice Act) to include defining and regulating advanced practice registered nursing.¹ The passage of this law was the culmination of 3 years of efforts by the Minnesota Board of Nursing (MN BON), Minnesota Nurses Association (MNA), and advanced practice registered nurses (APRNs) in the state. This article describes the legislation as it relates to clinical nurse specialist (CNS) practice and discusses the mechanism developed by the MN BON to operationalize the new law, focusing on the issues confronting CNS practice.

From Mayo Clinic Women's Cancer Program, Rochester (Ms Ponto); John Nasseff Heart Hospital of United Hospital, St. Paul (Ms Sabo); Children's Hospitals & Clinics, Minneapolis/St. Paul, and the University of Minnesota School of Nursing, Minneapolis (Ms Fitzgerald); and the Minneapolis Veteran's Administration Medical Center (Ms Wilson), Minn.

Corresponding author: Julie Ponto, MS, RN, CNS, AOCN, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (e-mail: ponto.julie@mayo.edu).

OVERVIEW OF THE LEGISLATION

As a result of the new legislation, an APRN in the state of Minnesota is required by law to be licensed as a registered nurse (RN) by the MN BON and certified by a national nurse certification organization, acceptable to the BON, to practice as a CNS, nurse midwife, nurse practitioner, or nurse anesthetist. According to Minnesota statute, APRN practice:

includes functioning as a direct care provider, case manager, consultant, educator, and researcher. The practice also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers, including but not limited to physicians, chiropractors, podiatrists, and dentists, provided that the APRN and other providers are practicing within their scopes of practice as defined in state law. The APRN must practice within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient.”²

In the state of Minnesota, CNS practice is defined as

“the provision of patient care in a particular specialty or subspecialty of advanced practice registered nursing within the context of collaborative management. The practice includes (1) diagnosing illness and disease; (2) providing non-pharmacological treatment, including psychotherapy; (3) promoting wellness; and (4) preventing illness and disease. The certified CNS is certified for advanced practice registered nursing in a specific field of clinical nurse specialist practice.”³

Collaborative management and consultation were also defined in statutes. Collaborative management was defined as a “mutually agreed upon plan” between the APRN and a physician that “designates the scope of collaboration necessary to manage the care of patients.”⁴ This plan does not need to be in writing. Consultation was defined as the process of seeking advice or the opinion of a physician or another member of the healthcare team by the APRN who “maintains primary management responsibility for a patient’s care.”⁵

A need was identified to establish a common element among the 4 categories of APRNs that would define advanced practice nursing. Certification was proposed to be that unifying element. However, CNSs proposed the use of a master’s degree as the common element rather than certification, because a master’s degree had historically been used to define the standard for CNS practice. CNSs also argued that the certification processes for the other APRN categories were entry-level processes, undertaken before assuming the APRN role, whereas most CNS certification processes at that time were at the mastery level, undertaken after months or years of CNS practice. If certification became a required element for APRN practice, newly graduated CNSs would not be able to function in the role without an entry-level process or a waiver allowing practice until they could sit for a certification examination. Using a master’s degree was determined to be unacceptable to the nurse midwife group, because their national organization did not recognize a master’s degree as being necessary for advanced nursing practice. Eventually, the CNS group compromised and agreed that certification

would be the primary defining characteristic for advanced practice registered nursing and that a stipulation be included allowing CNSs to practice for a defined period of time until appropriate certification could be obtained. Additionally, the CNS group became aware of an entry-level CNS process being developed by the American Association of Critical Care Nurses (AACN) and a movement toward entry-level CNS certification through the American Nurses Credentialing Center (ANCC) that would render moot the issue of post-master’s practice requirements to take a certification examination.

The new legislation provides title protection for all 4 categories of APRNs. The certified CNS is to use the initials “RN, CNS” for identification and documentation purposes. Educational degrees and specialty fields may be added. No other abbreviations for identifying a CNS are acceptable, and only those CNSs who meet all the criteria of the law may use this designation.

Before the passage of the APRN legislation, psychiatric CNSs were the only CNS group with prescriptive authority. With passage of the APRN legislation, all CNSs who meet the requirements of the law are able to prescribe. However, the law states that non-psychiatric CNSs must complete no less than 30 hours of formal study in pharmacology and the coursework must include supervised practice and competence evaluation, neither of which are usually components of CNS pharmacology courses. The MN Board of Nursing had never granted prescriptive authority through an additional licensing process and the BON reaffirmed that position. Instead, each APRN is to determine if s/he meets the requirements necessary to prescribe “safely and competently”, and must maintain a written agreement of prescriptive authority between the APRN and a physician at the primary practice site. Nurses who desire registration with the Federal Drug Enforcement Agency will still need to verify their credentials with the BON. In addition, the BON will initiate disciplinary action against an APRN who prescribes inappropriately.

A number of issues surfaced during the process of negotiating the language in the law, and several compromises were made to promote passage of the APRN legislation. One important compromise was the use of the word “independent”. An early draft of the law contained definitions for each of the 4 advanced practice nurse categories, which included the term “independent” as a descriptor for practice. This was later removed because the nursing groups determined that including this language would increase opposition of physician organizations to the proposed legislation.

By January 1999, the draft introduced to the Minnesota Senate had been amended to describe an APRN as someone who “practices within a health care system that provides for consultation, collaborative management, and referral as indicated by the health status of the patient.” The May 1999 draft sent to the Minnesota House of Representatives stated “the practice of advanced practice registered nursing also includes accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers, including but not limited to physicians, chiropractors, podiatrists, and dentists, provided that the APRN and the other provider are practicing

within their scopes of practice as defined in state law.” All 4 APRN groups believed that this additional language further defined and clarified the practice parameters of APRNs as well as their collegial relationships. Collaboration and compromise with the physician organization resulted in the May 1999 draft also adding the term “written agreement” between the APRN and a physician for prescribing purposes. This was specific to certified nurse practitioners (NPs), certified CNSs, and certified registered nurse anesthetists (CRNAs).

A transition time between the effective date of the provisions and the operationalization of the provisions was believed to be necessary. A 5-year period with a 3-year extension was proposed in the January 1999 draft sent to the Minnesota Senate. This transition time could apply to an APRN who had graduated from a formal graduate program and was practicing as an APRN but was not certified, most likely because of an absence of an appropriate specialty certification examination. Ultimately, a compromise was achieved with the physician organization and the transition time was decreased to 3 years with no additional extension. The effect of this change was most keenly felt by the CNS group, because many did not yet have a certification process appropriate to their specialty (eg, pediatric CNSs). Additionally, an RN who had completed an APRN course of study and was awaiting the period of time required to sit for some certification examinations could practice as an APRN for a period of no longer than 6 months and could not prescribe drugs during this time. Although the nursing groups, especially the CNSs, were concerned about the shortened transition period, there was greater concern that not accepting the reduced time frame would hamper passage of the legislation. The 3-year period was agreed upon.

The new legislation regulating advanced practice registered nursing was signed in to law on May 17, 1999, by Governor Jesse Ventura. The provisions of the law became effective July 1, 1999. The new law authorized qualified RNs to practice as APRNs and prescribe drugs and therapeutic devices without the necessity of obtaining a separate license or other document from the Board. A complete copy of the law is available on the board’s Web site at <http://www.nursingboard.state.mn.us/license/license.html>.

FORMATION OF FOUR TASK FORCES FOCUSED ON CERTIFICATION ISSUES

Once the legislation was passed, the MN BON recognized the need to develop uniform criteria for organizations that offered certification examinations. These criteria would be applied to all existing certification organizations. Four task forces were subsequently formed to develop these criteria, one task force for each advanced practice specialty role. The objectives of each task force were to (1) define criteria to apply to organizations that certify APRNs, (2) determine consequences of and options in the case of an individual failing a certification examination, (3) determine a plan for communicating information about the legislation and approved certifying organizations to nurses, and (4) draft a proposal regarding an alternative certification process for situations in which no certification organization was available.

The MN BON requested that individuals interested in being appointed to these 4 task forces submit their names for consideration. Task force members would be appointed based on the need to create a diverse group of individuals who had a clear understanding of the issues and legislative language. The CNS task force consisted of one cardiovascular CNS who was certified in critical care nursing but not certified as a CNS, one oncology CNS who was certified in advanced oncology nursing but not certified as a CNS, one cardiovascular CNS who was certified as a CNS, and two psychiatric CNSs who were both certified as CNSs. After the first meeting an additional CNS was added. This CNS was certified as a pediatric nurse but not as a pediatric CNS because no such examination existed at the time. She was added to the task force to represent those individuals who did not have a certification process available.

The assistant director of the BON assisted as a representative to the CNS task force, served as the task force secretary and facilitated the first meeting. She often was called upon for interpretation of specific language in the nurse practice act and to communicate with the executive director of the BON regarding issues discovered by the CNS members. One CNS was selected to serve as chairperson. The CNS task force was to make recommendations to the BON, and the full MN BON would vote upon the final decision.

The CNS task force met for the first time in September 1999. Initially, the group met once a month for 3 hours. All meetings were open to the public and often were attended by one or more interested CNSs, particularly from a local CNS networking group (This networking group eventually became a Minnesota affiliate of the National Association of Clinical Nurse Specialists [NACNS].) These individuals offered valuable input, which was often considered during the final decision-making process of the CNS task force. An individual who served as secretary to the CNS networking group attended the task force meetings and facilitated communication among CNSs in the state.

KEY ISSUES FOR THE CLINICAL NURSE SPECIALIST TASK FORCE

The task force faced a number of key issues, some of which were apparent at the start of the process and others emerged as discussions continued. Many of the concerns affected group members personally or would have affect their colleagues. The group worked hard to keep the discussion professional and focused. The key issues and concerns were related to developing an acceptable process for obtaining and granting transition period extensions for noncertified CNSs, criteria for certifying organizations, recommendations for certification examination failure, and recommendations for a method to be used if no certification process was available.

The legislation provided a 3-year transition period extension for those APRNs who did not currently have acceptable certification. This was most applicable to the CNSs because other APRN groups already required certification soon after completion of their educational program. Unfortunately, many CNSs did not have any certifi-

cation process available (eg, pediatric, perinatal, perioperative) or at the time were required to complete a number of hours of postgraduate practice before they could sit for the examination (eg, ANCC examinations). Although the original legislation was being created, there was an expectation that a relatively generic CNS certification process would be available or that a greater number of examinations would become available through ANCC and that these would be suitable for the majority of CNSs. As it turned out, this was an unrealistic expectation.

During the initial months after passage of the legislation, CNSs without certification were to apply to the MN BON to receive the 3-year extension. The application for extension needed to include documentation verifying that the individual graduated from a master's nursing program with a CNS focus. The MN BON planned to require the CNS to submit a statement from the school indicating completion of a program designed to prepare him or her as a CNS. Unfortunately, for CNSs who graduated 10 to 15 years earlier, many schools did not believe that they could do this. At that time, there were few specific CNS programs and many graduates had designed their own programs. For example, the largest institution conferring nursing graduate degrees in the state had not had a specific CNS program for a number of years. In addition, for a period of time, the maternal-child health graduate nursing program was organized within the school of public health, resulting in a master's degree in public health. The task force discussed these issues extensively. The MN BON representative made it clear that the intent was not to make it difficult for people to practice or restrict anyone currently practicing in an advanced practice role. The final option that was accepted to address this problem was that those CNSs who were not able to obtain a statement from their graduate program could instead submit their transcript with their own statement providing evidence that their coursework prepared them as a CNS.

A second issue that surfaced concerning the extension was that a number of individuals currently practicing in the state as CNSs had completed their graduate education in another APRN role, most often as an NP. This was more often the case in subspecialties, such as pediatric cardiology, in which recruitment was more difficult than it was in more common areas such as adult critical care. Discussion within the task force mirrored the national debate on whether these roles are interchangeable or will eventually merge. Many APRNs had strong opinions surrounding this concern, and it was difficult to negotiate a middle ground. The issue was simultaneously being addressed at the local CNS networking group. The dialogue within the task force and with the CNS networking group included the problem of recruiting and retaining advanced practice nurses, experiences people had with NPs working as CNSs, and the debate on whether to keep the roles separate or to merge them.

As the national debate continues, so does the debate in Minnesota. However, the MN BON made the decision regarding the extensions to practice. The MN BON decided that it was not necessary to issue extensions to NPs, because these individuals were already certified as APRNs. The legislative language attributes research, consultation, clinical practice, and coordination to all APRNs,

and the differentiation between the CNS and NP role as written in the law was limited. From the MN BON's perspective, these APRNs were not practicing inappropriately but were using the wrong title. The MN BON believed this was primarily an issue for individual institutions to address regarding how they title various roles and whom they choose to hire into those roles.

The remainder of the task force time was spent on determining criteria for accepting certification organizations that certify advanced practice nurses. These criteria would then be recommended to the MN BON for final acceptance. The CNS task force believed this would be a fairly straightforward process that would consist of consolidating existing criteria from certifying organizations. Unfortunately, as with several aspects of this process, this assumption proved wrong. The group reviewed criteria as defined by the National Commission for Certifying Agencies (NCCA) and the American Board of Nursing Specialties (ABNS). These agencies accredit organizations that administer certification examinations based on established standards. Criteria that the task force considered essential and agreed on included the administration of a secure examination, an examination based on a job analysis, the existence of a blue print for the examination, and not requiring membership in the allied organization.

However, more difficult discussion occurred as the CNS task force tried to define what would specify that this was an examination for a CNS. The task force believed that the requirements to sit for a CNS examination should include the stipulation that the nursing educational program covered content relevant to a specialty area and that degrees from other fields, such as a master's of nursing education or nursing administration, were not acceptable. For that reason, it was recommended that the certifying organization "has educational requirements [for its examination] which are beyond the initial preparations for professional nursing and include content and clinical practice in the *specified area of specialty practice* [authors' italics] within the educational program that is at the advanced practice level."

After agreeing to this language and believing it clearly reflected the opinion of the task force, it was discovered that it essentially eliminated one of the specialty examinations. At that time, the certification process of the AACN did not require a master's degree with a CNS focus. This was disturbing to the task force because it would eliminate the only organization that certified critical care CNSs and eliminate one of the few examinations that had both a neonatal and a pediatric component. However, the task force affirmed its original work and decision, realizing that the AACN organization would not fit with the current requirements. Instead, members of the task force communicated with the AACN, requesting that it reconsider its criteria. Ultimately, the AACN did revise its requirements for certification, and the organization is now accepted by the MN BON.

Another issue concerning organizational criteria erupted at the same time when task force became aware that the Oncology Nursing Certification Corporation (ONCC) did not certify an individual as a CNS. Rather, the examination is offered to both NPs and CNSs. Although the certification is in advanced oncology nursing knowl-

edge, it does not certify in an APRN role. The Minnesota legislation specifically requires that certification would be in a role, such as CNS. Therefore, ONCC did not meet the requirements of the legislation. This was an unforeseen development and resulted in yet another certifying organization becoming unacceptable to the MN BON.

One area in which the task force was always in agreement was that the certifying organizations should require a master's degree in nursing to be eligible to sit for the examination. CNSs had asked the MN BON and the MNA to make this required for the APRN legislation, but the efforts were not successful primarily because a master's degree was not a requirement for nurse midwives. The task force then worked hard to develop wording that would indicate that CNS certification would require a master's degree. Because all existing certifying organizations did have a master's-degree requirement, the concern was directed toward potential new certifying organizations. The CNS task force included in its criteria that a master's degree in nursing would be required if the certifying organization was established and/or begins certification at the advanced-practice level July 1, 1999, and thereafter. This stipulation would meet the concerns of the CNS group but not restrict nurse midwives.

Discussion and decisions regarding the consequences of examination failure and a process for CNSs who did not have an examination to take were still remaining. Although determining the consequences of certification examination failure was challenging, it seemed clear that certification examination failure would result in failure to be certified and subsequently the individual should not be able to practice as an APRN. This is similar to failure to pass the registered nurse examination, resulting in removal of the temporary permit to practice. The reality of this recommendation hit home with many of the task force members who were either waiting for examination results or were facing an examination in the future. The group encouraged the MN BON to continue to work with other states to convince certifying organizations that the examination content needed to be at the level of entry into practice rather than at the expert level as it had been in the past.

Finally, there was the issue of what to do with those CNSs who did not have a certification process specific to their specialty. Good news was received during the tenure of the task force that the ANCC was in the process of developing an examination for the pediatric CNS. However, a number of specialties still have no examination. The group recommended to the MN BON that a stipulation be added that provides for a review process in lieu of certification. The task force suggested potential criteria to be used when determining eligibility for the review process, which the MN BON has taken under advisement (Figure 1).

The greatest challenge of the review process may be whether an appropriate certification is available. The determination of whether certification is available depends on how narrow or wide the CNS defines his or her practice. CNSs have traditionally linked their role to their specialty, and there may never be certification in subspecialty areas such as adult or pediatric cardiology. Does the CNS take a more general examination or undergo the review process? Due to time constraints on the tenure of the task

1. Minnesota licensure and current registration as a registered nurse.
2. Graduate degree or post-graduate preparation that is beyond the initial preparation for professional nursing; includes content in the specified area of clinical specialty practice and clinical practice within the educational program that is at the advanced practice level.
3. Evidence of clinical practice hours (number to be determined) within the educational program and as a post-graduate clinical nurse specialist (CNS).
4. Evidence that there is no certification for which the individual is eligible.
5. The individual would have to meet requirements to maintain certification that is similar to those issued by certifying bodies (ie, attendance at educational events, research, publishing).
6. If certification became available the individual would be required to become certified before expiration of the authority to practice.

Figure 1. Recommended criteria for review process eligibility in lieu of certification through a certifying organization.

force, further discussion would be continued once the recommendations were accepted by the MN BON.

PROPOSED CRITERIA FOR CERTIFYING ORGANIZATIONS

The CNS advisory task force approved a set of draft criteria for organizations that certify advanced practice RNs. The chairs of the other 3 APRN task forces approved these same criteria. The criteria are now applied to organizations that certify APRNs, and if the organization meets all criteria, the MN BON will accept the credential of the organization as an indication of APRN certification.

The approved criteria require that the certifying organization that certifies and/or recertifies individuals in advanced practice nursing:

- is affiliated with a national professional nursing organization that describes scope and standards statements specific to the practice as a CNS, nurse midwife, NP, or registered nurse anesthetist in the clinical specialty for which the individuals will be certified or recertified;
- is independent from the national professional nursing organization in decision making for all matters pertaining to certification and/or recertification;
- does not require the individual applying for certification and/or recertification to be a member of the national professional nursing organization;
- has education requirements that are beyond the initial preparation for professional nursing, and includes content in the specified area of clinical specialty practice and clinical practice within the educational program that is at the advanced-practice level;
- requires a graduate degree in nursing if the organization is established and/or begins certification at the advanced-practice level July 1, 1999, and thereafter;

- requires the educational program be approved or accredited by nationally or regionally recognized organization;
- administers a secure examination that is based on job analysis studies conducted using standard methodologies acceptable to the testing community and is current, reliable, and legally defensible, with a passing standard established to measure, at a minimum, entry-level competence and meets the American with Disabilities Act requirements;
- has a blue print (test plan) for the examination that reflects the practice of the type of advanced-practice registered nurse to be certified;
- issues a certificate as evidence that the requirements for certification or recertification have been met;
- maintains a registry of those certified and recertified that is accessible to the public and has policies and procedures that delineate what information about certified individuals may be made public and under what circumstances;
- requires periodic recertification or is affiliated with an organization that provides for recertification; and
- has formal policies and procedures for imposing sanction or revoking a certificate.

COMMUNICATING TO THE NURSING COMMUNITY

In 1997, a group of CNSs from the local metropolitan area began meeting to network and discuss the potential regulation of APRN practice. During the course of 2-years, this group became more unified, grew to include members from outside the metropolitan area, and in 1999 became an affiliate of the NACNS. A communication method by e-mail was developed to inform CNSs around the state of the discussions occurring about CNS practice and the legislative efforts. This communication included individuals within the metropolitan area and smaller communities throughout Minnesota where CNSs had fewer colleagues immediately available. This communication process allowed CNSs throughout the state to keep in contact despite their geographic separation.

The CNS task force determined that communication to the CNS community was vital to obtain input on all aspects of APRN practice this legislation could potentially affect. At the conclusion of each meeting the discussion and decisions were summarized. One member was then designated to provide the written summary to the NACNS affiliate secretary, who would then e-mail to the CNS community around the state.

The NACNS affiliate met formally once a month during this time. Members of the task force attended these meetings and presented the task force summaries. The legislation was controversial for many CNSs, and much discussion was generated at these meetings. Often, new attendees were present and required orientation to the legislative language and its effect on CNS practice.

In addition to the CNS communication methods, the MN BON provided information in its newsletter sent to each RN licensed in the state. This information was specific to the legislation itself, its effect, and the formation of the task forces. Summaries of the task force meetings were typically not provided in this newsletter.

FUTURE DIRECTIONS

Unresolved issues and procedures still exist on which both the MN BON and the advanced practice nursing groups are working. One issue is how to reconcile the availability of an advanced practice certification examination when the certifying organization does not meet the criteria outlined by the task force and the MN BON. The MN BON and the certifying organizations continue to search for an acceptable solution to this problem.

The MN BON has also been challenged with developing a process of registering and tracking APRNs in the state. Such a process requires new methods of record-keeping and database management and a new service of the MN BON. This process has been time-consuming and resource intensive.

Reopening the MN statutes addressing nursing practice to attend to the issue of the expiring 3-year extension has been broached. Many individuals, including CNSs, are leery of this option due to potential debate over the entire APRN legislation that may ensue.

LESSONS LEARNED

The process of developing APRN legislation and the resulting procedures was informative and eye opening for all involved. Many individuals involved in the process commented on the many lessons that were learned.

There were issues that united all APRNs and issues that separated the groups. APRNs in general were brought together through this process. Each group represented in the APRN title came to a better understanding of the similarities and differences in roles and came to appreciate the contributions and strengths of each other.

In addition, CNSs as an advanced-practice group became more organized during this process despite the diversity of specialties, practice settings, and CNS practice patterns. The need to represent combined interests as one of the 4 categories of APRNs caused the group to come together, learn about each other, and come to consensus about what was important to the entire group of CNSs. In this process, CNSs learned to listen, compromise, and support each other as CNSs and as APRNs.

CNSs were also better able to articulate the CNS role and scope of practice to the other APRN groups. The CNSs became more visible as a group during this process, and it appeared that a better understanding of the CNS role was achieved. In turn, CNSs gained a greater appreciation of the other APRN roles.

The APRNs in the state also learned much about the legislative process. When CNSs understand and use the political and legislative aspects of the process, their effectiveness within it is enhanced. Involving nurses and nurse advocates familiar with the legislative process can be invaluable and may assist in producing the most effective and beneficial outcome.

The language used in statutes and rules must be clear and well defined. For example, in Minnesota, the CNS and other advanced practice nursing roles are described in statute by role components (eg, clinician, consultant, educator, and researcher) versus spheres of influence (eg, direct care versus indirect care). Approaching the legislation by

focusing on what is similar to the advanced practice roles may have made the process easier, but it may also have blurred the distinctions between various advanced practice nurses. This issue—uniqueness versus similarities—is one that APRNs in Minnesota continue to consider and debate.

The importance of having influential relationships and using those connections was also realized. Although many physician groups were initially opposed to the legislation, chiropractors were very supportive and had significant influence with the legislature. In addition, rural legislators expressed support for APRNs, especially NPs and CRNAs.

Nurses from all practice settings who were involved in this process learned that clear communication, including listening, clarifying, restating, asking questions, avoiding assumptions, negotiating, and compromising, were crucial communication skills in this process. It became vital to put

aside perceptions and biases, define common ground, and encourage the articulation of the essential components of advanced nursing practice. In addition, maintaining a sense of composure during tense times went a long way in the success of the effort and shaping the future of advanced nursing practice in Minnesota.

The process has only begun, and at the end of the tenure of the CNS task force, the group had all acquired a healthy respect for the process and an appreciation for the opportunity to be involved.

References

1. Minn Stat 148, §148.171-148.285 (1999).
2. Minn Stat 148, §148.171 Subd 13 (1999).
3. Minn Stat 148, §148.171 Subd 5 (1999).
4. Minn Stat 148, §148.171 Subd 6 (1999).
5. Minn Stat 148, §148.171 Subd 7 (1999).