CLINICAL EXPERTISE
NURSING PRACTICE
SYSTEMS INNOVATION
NACNS
National Association of Clinical Nurse Specialists

September 16, 2016

Standard Occupational Classification Policy Committee
U.S. Bureau of Labor Statistics, Suite 2135
2 Massachusetts Avenue, N.E.
Washington, DC 20212

RE: Standard Occupational Classification (SOC) Policy Committee's Recommendations for the 2018 SOC (81 FR 48306)

Dear Members of the Standard Occupational Classification Policy Committee:

The National Association of Clinical Nurse Specialists (NACNS) is responding to the Standard Occupational Classification Policy Committee's (SOCPC) recommendations to the Office of Management and Budget for revising in 2018 the 2010 SOC broad occupational units and detailed occupations. Specifically, the NACNS is commenting on Docket number 1-0210, the SOCPC's recommendation and rationale to not accept the request for a new detailed occupation "Clinical Nurse Specialists" (CNS).

Since July 2014 when the NACNS filed comments regarding the SOCPC's initial solicitation (79 FR 29619) for revising the SOC, the NACNS – the voice of more than 72,000 CNSs – has collected data and is submitting it today to demonstrate that the work performed by CNSs meets all the criteria for this profession to be assigned a stand-alone occupational code, as required under SOC Classification Principle 2. NACNS also submits that the evidence, contained in and attached to this letter, demonstrates that the CNS work is sufficiently distinct to reliably collect data as required by Classification Principle 9.

SOC Classification Principle 2 – Occupations are classified based on work performed and, in some cases, on the skills, education, and/or training needed to perform the work at a competent level.

The CNS has been a part of the healthcare industrial complex in the United States for over sixty years[1]. Through the decades, CNSs have been widely accepted in the healthcare system as a standardized, licensed, and fully regulated healthcare occupation.[2] The CNS occupation is one that significantly impacts the nation's economy by providing expert specialty-focused, safe, low-cost, and effective evidence-based healthcare services[3]. CNSs are an unambiguously separate occupation dissimilar from registered nurses (RN)

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration (2010). *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses*. Accessible at http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/rnsamplesurvey/rnsurveyfinal.pdf

[2] National Council of State Boards of Nursing (2008). *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*. Accessible at https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf

[3] National Association of Clinical Nurse Specialists (2013). *Impact of the Clinical Nurse Specialist Role on the Costs and Quality of Health Care*. Accessible at http://www.nacns.org/docs/CNSOutcomes131204.pdf

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(SOC 29-1141). This substantive contrast from the RN is based on the expert, specialty-focused work performed, specialty-focused skills, and the minimum of a master's level education needed to perform the CNS work at a competent level. Evidence to support CNSs as an individual profession include such detailed traits as specialized skill performed as a clinical expert including prescriptive authority and autonomous patient management; specified education to prepare the CNS as an independent healthcare provider; and separate licensure and certification for the CNS body of knowledge. See the table below illustrating key clinical nurse specialists' traits as compared to those of RNs.

LICENSED CLINICAL NURSE SPECIALISTS COMPARED TO REGISTERED NURSES		
Traits needed to perform the work at a competent level	**CNS**	**RN**
WORK ACTIVITIES:		
▪ Direct patient care	X	X
▪ Formulate medical and nursing diagnoses	X	Only nursing diagnosis
▪ Prescribe pharmacological (including scheduled drugs) and non-pharmacological therapies	X	
▪ Prescribe durable medical equipment	X	
▪ Prescribe diagnostic and laboratory tests	X	
▪ Admit and discharge patients	X	
▪ Interpret values/results of laboratory and diagnostic tests with consideration of age, ethnicity, and health status	X	
▪ Perform advanced clinical procedures (e.g., complex wound management, bone marrow aspiration, chest tube insertion)	X	
▪ Provide consultation services in complex patient/client and family issues, in performance improvement/quality initiatives, and in system evaluation/program development	X	
▪ Write, contribute to and approve policy and standards to incorporate evidence-based practice (EBP) into clinical setting (e.g., clinical decision-making, policies and procedures/ protocols, standards, guidelines)	X	Contributes to implementation; EBP based on policy
▪ Write, contribute to and approve population specific interdisciplinary standards of practice and guidelines for care (e.g., pathways, care maps, benchmarks)	X	
▪ Design, implement, evaluate and approve population specific programs/innovative models of practice across the continuum of care	X	
EDUCATION: Nursing degree from an accredited educational institution required for entry into practice	X	X
▪ Diploma, 2-yr community college, or 4-yr undergraduate degree		X
▪ Graduate master's or doctoral degree	X	
LICENSURE: Licensed practitioners expected to practice within standards established under a state nurse practice act and recognized by a state board of nursing	X	X
▪ Independent licensed healthcare provider	X	
COMPETENCY ASSESSMENT: Certified by a recognized national certifying body that has established standards for entry-level competence assessment	X	
▪ In a population-foci with specialty education	X	
▪ At the level of advanced practice registered nurse	X	

Under state-specific rules and regulations, CNSs have the authorization, ability, and education to attend to myriad patient, workforce, and systems issues that are the daily environment of healthcare settings[4]. Yet to exemplify the important differences between CNSs and RNs, note simply the two work activities "formulate medical and nursing diagnoses" and "prescribe pharmaceuticals". CNSs can perform both, whereas RNs are not sanctioned to perform either.

This divergence in scope of practice is founded on the education and training required as part of qualifying as an advanced practice registered nurse (APRN) and as a CNS. The difference was articulated in the 2008 national policy paper, the ***Consensus Model for APRN Regulation: Legislation, Accreditation, Certification and Education***.[2] This paper, released July 2008 and signed by 48 organizations, is the landmark document articulating the unique criteria required for each of the four categories of APRNs. It differentiates their independent practice for state licensure beyond that of the RN and other nurses who achieve advanced degrees yet practice within the scope of practice of the registered nurse.

Currently, CNSs have the state-level authority to prescribe pharmacotherapeutics in 39 states. Forty-three states allow the CNS to practice a range of autonomous practice. Specifically, CNSs can practice to the full extent of their education and training in 28 states and prescribe without supervision in 19.[5] An additional 13 states allow CNSs to practice with the collaboration of a physician bringing the total to 43 states.

Exploring further the example of prescriptive authority, consider the CNSs who are enrolled as healthcare providers in the Centers for Medicare and Medicaid Services' (CMS) Medicare Part B services. Data from their 2008 claims[6] indicate that the single Current Procedural Terminology code responsible for the largest share (17%) of CNS total approved Medicare Part B charges was 90862, medication management. Total CNS approved charges in that year for code 90862 amounted to $7.5 million.

Congress recognized and defined the unique, valuable role of CNSs when it passed the ***Balanced Budget Act of 1997*** (P.L. 105–33), allowing CNSs to directly bill their services through the CMS under Part B participation in Medicare, Title 18.[7] Similarly, CNSs were recognized as eligible for Medicare's Primary Care Incentive Program in the ***Patient Protection and Affordable Care Act*** (P.L. 111-148). In addition, this summer the Department of Veterans Affairs (VA) proposed amending its medical regulations to permit full practice authority for VA CNSs, as well as all APRNs, when they are acting within the scope of their VA employment.

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[4] For studies of CNS work activities, see the various American Nurses Credentialing Center's CNS Role Delineation Studies. According to ANCC – the world's largest and most prestigious nurse credentialing organization, and a subsidiary of the American Nurses Association – role delineation or job analysis studies typically are carried out at the national level with the goal of describing current practice within a particular role or specialty. Accessible at http://www.nursecredentialing.org/certification.aspx

[5] National Association of Clinical Nurse Specialists (2015). *CNS Scope of Practice and Prescriptive Authority*. Accessible at http://www.nacns.org/html/prescr-authority.php

[6] Data can be accessed via the Centers for Medicare & Medicaid Services' public data set, the *Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File*. The Physician and Other Supplier PUF has information on Medicare Part B services and procedures provided to Medicare beneficiaries by health care professionals. That information includes utilization, payment, and submitted charges organized by National Provider Identifier, Healthcare Common Procedure Coding System (HCPCS) code, and place of service.

[7] For more details on the required qualifications, coverage criteria, billing, and payment for Medicare services furnished by CNSs, see the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2015). *Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants*, ICN: 901623. Accessible on the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html

Other Distinguishing Features of CNS Work

The CNS is one of the four advanced practice registered nurses. The other three APRN occupations are "Nurse Anesthetists" (29-1151), "Nurse Midwives" (29-1161), and "Nurse Practitioners" (29-1171). Similar to all APRNs, CNSs initially attain an entry level RN education and sit for state level nursing boards for their RN professional license. As with other APRNs, CNSs attain a graduate education-level nursing degree that prepares them for a specialized practice healthcare role as an APRN. As called for in the APRN Consensus Model, CNSs as well as other APRNs are licensed to perform "advanced nursing practice" with a separate APRN license across the nation. This further and legally distinguishes the CNS from the RN role in the provision of healthcare services at the state level.

General population foci for the CNS and Nurse Practitioner (NP) include family/individual across the life span, adult/gerontology, neonatal, pediatrics, women's health/gender-related and psychiatric-mental health. There are no requirements for NPs, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists to specialize beyond any of these general population foci.

CNSs also must specialize beyond and within populations to provide acute and chronic care services (e.g., diabetes, cardiovascular disease, pulmonary disease, mental health). CNSs are responsible for a specialty population of patients. Sometimes confused with CNSs, NPs are primarily generalists whose focus of care is on individuals and families. Generally, the majority of NPs serve in roles that allow them to provide direct care for the majority of their clinical time in the primary care setting.

CNSs and NPs both are responsible and accountable for health promotion; prevention of illness and risk behaviors; diagnosis and treatment of health/illness states, and disease management for individuals and families. However, there are additional aspects of CNS professional practice that are not required of the NP role: 1) specializing in a population, 2) specializing in the care of groups and communities, and 3) providing acute and chronic care through the spectrum of wellness to illness. These aspects include, but are not limited to, health maintenance and prevention, management of patients with chronic conditions and care transition needs, management of patients with physiologically unstable conditions, rehabilitation, palliative, and end-of-life care. CNS roles are frequently enacted in collaboration with other healthcare providers, such as NPs, physicians, Certified Registered Nurse Anesthetists, dietitians, respiratory therapists, etc., and when implemented as designed, CNS roles do not notably overlap these other providers' roles. The role differentiation has been captured in the entry-level core competencies for the CNS.[8]

CNSs are distinct from RNs because they are specialists, not generalists. Generalist preparation cannot adequately address specialty competencies, where specialization is an unequivocal attribute of CNS practice. For CNSs, specialization is a concentrated area of expert clinical practice with focused knowledge and competencies. Unlike 29-1140 Registered Nurses, CNSs are master's- or doctoral-prepared RNs, and are required to perform the unique role of expert consultant in order to organize care delivered to high-cost, high-demand patients in the tertiary care system and/or consult on system improvements to enhance the care of populations of patients. They may also utilize their advanced nursing skills to provide direct and ongoing care to patients in outpatient settings as primary complex providers, specifically focusing on a population of patients. Typically, these patients are those experiencing complex chronic or multiple chronic conditions and require both primary and specialist nursing care. Some examples of such patients are, but not limited to, diabetics, technology dependent newborns and children, high-risk obstetric patients and post-myocardial infarction and heart failure patients.

[8] National Association of Clinical Nurse Specialists (2010). *Clinical Nurse Specialist Core Competencies*. Accessible at http://www.nacns.org/html/competencies.php

Finally, no state board of nursing grants APRN license or accreditation to 29-1140 Registered Nurses. Since the mid-1950s, CNSs always have been employed in roles manifestly separate from the RN and have performed work that is different from that of the RN. Increasingly, with the growth of complicated healthcare needs in the nation and the looming physician shortages, more of the CNSs' science-based expertise, skills, and services will be in demand to provide the specialized advanced care they are educated and trained to provide.

Mischaracterizing "Clinical Nurse Specialists" as a title within the 29-1141 Registered Nurses 2010 SOC inadvertently creates confusion. Misconstruing "Clinical Nurse Specialists" as an RN title is inconsistent with federal agencies, with nursing practice in the states, and with the larger healthcare community, all of which distinguish CNSs as a singular occupation. CNS services are unique, forming the core of the profession; thus, it is appropriate to distinguish CNSs and to recognize their specific professional identity.

Not recognizing the CNSs occupation as distinct from the current general RNs' SOC classifications for the 2018 revision unintentionally makes the SOC classification invalid for both RNs and CNSs. Obscuring the quality of the healthcare workforce data diminishes the efficacy of that database, contrary to the aims of a standardized occupational classification to boost data utility while accurately reflecting the workforce structure across the United States.

SOC Classification Principle 9 – The U.S. Bureau of Labor Statistics and the U.S. Census Bureau are charged with collecting and reporting data on total U.S. employment across the full spectrum of SOC major groups. Thus, for a detailed occupation to be included in the SOC, either the Bureau of Labor Statistics or the Census Bureau must be able to collect and report data on that occupation.

The healthcare sector is one of the largest contributors to the U.S. economy. According to the Bureau of Labor Statistics, nursing professionals are the largest workforce in the healthcare industry.[9] Accurately tracking the supply of all healthcare professions is critical to planning for sufficient numbers of nursing professionals, as well as for ensuring a safe, diverse, accessible, and effective healthcare system

The CNS has been a distinct functional component of the healthcare system. Through the years, several organizations have been able to track the growth and status of the profession in terms of various metrics, e.g., numbers of practitioners, specialty, income, geographic distribution, practice settings, certifications, work activities, plus other demographic and clinical practice variables.

One example is the Health Resources and Services Administration 2004 ***National Sample Survey of Registered Nurses*** (NSSRN), which separated not only APRNs from RNs, but also CNSs from NPs, nurse anesthetists, and nurse midwives. CNSs in the survey included those RNs who had identified as CNS, which for 93.3% of respondents was a minimum of a clinical master's degree in nursing. The report estimated that 72,521 RNSs (2.5% of all RNs) were prepared to practice as CNSs in 2004, including the 14,689 RNs who were prepared as both NPs and CNSs. To track the growth, between 2000 and 2004, the number of CNSs increased by 5.1% (an additional 3,504 CNSs).[10]

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[9] U.S. Department of Labor, Bureau of Labor Statistics (July 13, 2015). Registered nurses have highest employment in healthcare occupations; anesthesiologists earn the most. *The Economics Daily*. Accessible at http://www.bls.gov/opub/ted/2015/registered-nurses-have-highest-employment-in-healthcare-occupations-anesthesiologists-earn-the-most.htm

[10] U.S. Department of Health and Human Services, Health Resources and Services Administration Bureau of Health Professions (2006). *The Registered Nurse Population; Findings from the March 2004 National Sample Survey of Registered Nurse*. Accessible at http://bhw.hrsa.gov/healthworkforce/supplydemand/nursing/rnsamplesurvey/rnsurvey2004.pdf

For 2008, the NSSRN survey was redesigned structurally to only allow RNs with a minimum of a master's degree and preparation as a CNS to identify as CNSs. Therefore, in 2008 it was no longer possible for an RN to self-identify as a CNS. At that point, the 2008 data (98.2% prepared with a master's degree and 7.2% prepared with a doctoral degree) was the most reliable CNS data in the history of the NSSRN. This structural change in the survey was not made for the other three APRN categories, which allowed RNs to continue to self-identify as NPs, CRNAs and CNMs.

Because HRSA conducted its last NSSRN in 2008, to ensure that these CNS data still are captured, the National Association of Clinical Nurse Specialists and several other national nursing organizations continue to gather this critical information. NACNS conducted the first-ever national online survey of CNSs from June 1 to December 31, 2014.[11] This survey resulted in a profile of, among other things, what work CNSs do, how CNSs use their time in a typical workday, the specialties where the CNS role is most often used, and the type of healthcare settings that hire the CNS. For example, the survey found that about two-thirds (66%) of the CNSs worked in hospital settings, where two in five (44%) have responsibility across the entire hospital system and nearly 40% have responsibility for more than one department. The other workplace settings of CNSs are either their own independent practices, or physician practices, or institutions of higher learning where they are educators. The 2016 CNS Census survey is currently in the data collection phase and will close on December 31, 2016. This survey will be repeated every two years.

In previous comments regarding the SOC, NACNS has cited CNS data sets gathered by various institutions including national credentialing entities (American Nurses Credentialing Center)[4] and the CMS[6]. In addition, the Occupational Information Network (O*NET) continually has collected occupational data on CNSs (29.1141.04) since 2010.[12] Another example is the occupational data from the VA, the largest single employer of RNs and of APRNs in the United States. Using the General Schedule rather than SOCs, the VA collects and maintains occupational data on all the nursing professions, including CNSs, and supplies that information to the Office of Personnel Management. The VA explicitly recruits for CNS-only job openings, even as it hires them for slots identified as GS-0610 Nurse.[13]

These examples of regularly collected and reliable CNS data validate this occupation's distinct work existence and, likewise validate that the CNSs' professional identity is distinct enough that occupational data can be gathered and analyzed. With the number of CNS professionals in the healthcare workforce and the critical impact of their work on healthcare and the economy, it is important that the 2018 SOC acknowledge CNSs as an independent SOC. It is critical that the data on this occupation be disseminated as essential economic information to support public and private decision-making.

Embedding the CNS workforce data within the RN workforce data does not allow CNS contributions (e.g., unique work performed and healthcare outcomes resulting from the advanced education and specialty training of the CNS) to be differentiated from RN data or to be compared to any other APRN data. An example is that the unique CNSs' billing for diagnostic services and prescribing will skew the general registered nursing category, causing confusion and misunderstanding about the work executed by the discrete professions. Similarly, because the CNS is authorized to perform these advanced nursing practice tasks, it is important to collect the CNS data separate from the RN data, as it does for the other advanced practice registered nurses, and so that the four APRN occupation data can be compared.

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[11] National Association of Clinical Nurse Specialists (2015). First National Census of Clinical Nurse Specialists Provides Insights into Education Levels, Employment, Practice Specialties and More. Accessible at http://www.nacns.org/html/cns-census.php

[12] Occupational Information Network (O*NET). Summary Report for 29-1141.04 - Clinical Nurse Specialists. Accessible at http://www.onetonline.org/link/summary/29-1141.04

[13] See CNS job openings at the U.S. Department of Veterans Affairs at http://www.vacareers.va.gov/careers/nurses/

Additionally, when capturing CNSs only as RNs, the RN workforce data are not psychometrically valid. Any work drawing on the RN SOC database – whether by federal, state, regional, local, research, or private entity – would not be well founded because the RN data are not reliable. A data set using the 2010 SOC categories has no way to differentiate over 72,000 CNSs in the United States from RNs. This lack of explanatory power is shortsighted at a time when the increasing healthcare needs of the nation require both improved quality of and reduced costs that are afforded by the specialized, advanced level competencies of the CNS. In healthcare research, it potentially misappropriates certain healthcare outcomes to RNs, when there is a CNS "effect" buried in the statistical data. As a result, employers make erroneous decisions about workforce composition when they mistakenly apply certain outcomes to what they believe is their all RN-only staff, when in fact the outcomes are the effect of the specialized CNS advanced nursing practice.

There is a compelling need to have CNSs recognized in their own right. Given the long time increment associated with the next SOC revision, it would, at minimum, be unfortunate if designation of CNS as a separate and distinct occupation were further delayed beyond this current review cycle to that of the 2028 revision. Based upon our review, NACNS requests that due consideration is given to making the following changes to the 2018 SOC:

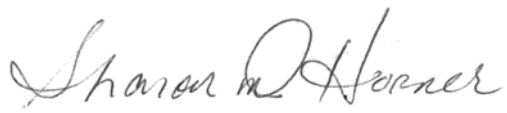
1. Under the Broad Occupation group 29-1140 Registered Nurses, delete the title "Clinical Nurse Specialists"

2. Under Minor Group 29-1000 Health Diagnosing and Treating Practitioners, add a new Broad Occupation 29-11X0 "Clinical Nurse Specialists"

3. Under a new Broad Occupation 29-11X0 "Clinical Nurse Specialists" add a new Detailed Occupation 29-11XX "Clinical Nurse Specialist"

Thank you for the opportunity to provide these comments. If you have questions or require additional information, please feel free to contact Melinda Mercer Ray, MSN, RN, NACNS Executive Director, at 703-929-8995 or via email at mray@nacns.org.

Sincerely yours,



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