NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

FAQs: CNS Recognition as Advanced Practice Registered Nurses (APRNs) Under the Consensus Model

This document is intended to provide some answers to frequently asked questions (FAQs) that many Clinical Nurse Specialists (CNSs) have as they face the full implementation of the APRN Consensus Model[1] in their state. NACNS supports the Consensus Model as prepared and adopted by the Joint Dialogue group and endorsed by numerous nursing organizations. There are, however, issues unique to CNS practice that states will encounter as they begin the work of implementing this regulatory model with CNSs (a group of APRNs who may or may not have been recognized previously in the state). As with the implementation of any conceptual model, the APRN Consensus Model will have many areas that will need to be addressed as it is fully implemented. For example, there are a number of education and certification issues that have been conceptually discussed and adopted in the model but have not yet been implemented in the education and certification communities. (See article by Hudspeth) These issues will become evident as the model is implemented. Listed below are a number of options for CNSs to consider bringing forward to their state boards of nursing as the model is examined, explored and enacted through legislative action in each state.

The questions addressed are:

- What is Grandfathering and why is it necessary?
- Why is the issue of certification under the Consensus Model a concern for CNSs?
- Why is licensure important in adoption of the Consensus Model?
- How does the Consensus Model address “direct” and “indirect care?”
- What are the Accreditation and Education issues for CNSs under the Consensus Model?
- What about obtaining prescriptive authority in my state?
- Do I need to be Doctoral prepared by 2015?
- What are the Education issues for CNSs under the Consensus Model?

What is Grandfathering and why is it necessary?

The model defines **grandfathering as a provision in a new law exempting those already in or a part of the existing system that is being newly regulated.** In other words, when states adopt new eligibility requirements for APRNs, those who are already practicing will be permitted to continue practicing within the state without needing to fulfill the additional requirements. [1] The APRN Consensus Model

[1] Consensus Model for APRN Regulation, page 15

recognizes that some of the requirements in the model may not be consistent with current state licensing regulations for APRNs. To address this situation the Consensus Model [2] recommends grandfathering those already practicing in the state thereby removing the requirement to meet the new regulations in order to practice. Currently Oregon and Pennsylvania have adopted a form of grandfathering that recognizes CNSs currently practicing in the states.

NACNS recommends that legislation to implement the Consensus Model include a grandfathering clause for CNSs who are already practicing in the state regardless of current recognition status. It is critical that CNSs are involved and actively engaged in the legislative process, as some state boards of nursing are not including the grandfathering clause. To not include the clause means that CNSs will no longer be able to practice, thereby creating a restraint of trade for CNSs in current practice.

Why is the issue of certification under the Consensus Model a concern for CNSs?

The gap between the implementation of the concepts included in the Consensus Model, practice, and re-formatting education programs and certifying exams affects the CNS more than other APRN roles. One of the identified themes in the APRN Consensus Model is that all APRNs will have national certification in role and population as defined by the model. This is consistent with a model of validation for entry to practice adopted by all other APRN roles. CNSs however identified certification as a mark of excellence to be achieved after a period of clinical practice rather than an assessment of competence for entry to practice. This presents a complex situation for many CNSs. Currently there are no national certification examinations for CNSs that include the concepts of role and population as defined by the model. There are a number of CNS examinations available, but these certifications are based on specialty. Specialty examinations are not accepted as national certification under the Consensus Model. There must be a redesign of the current examinations to meet the model

Historically, the CNS entered into practice following their education as a nurse prepared with a masters degree. Additionally, the role of advanced practice Clinical Nurse Specialist was built on the concept of specialty expertise. The Consensus Model adopts a new approach to APRN education that standardizes expectations and focuses on role and population with specialty being an added attainable skill but not a core requirement for regulation/licensure. This separation of regulation/licensure from the professional expectations of specialty practice for CNSs is a difficult concept to grasp since the professional role has been built on specialty from the outset. The removal of specialty from the regulation/licensure of CNSs will add a greater level of flexibility to the role, however it needs to be clearly defined that specialty continues to be an expectation for CNSs.

The NACNS is working with national certifying organizations to ensure that new graduate CNSs will have a national certifying exam that meets the requirements of the Consensus Model available by 2015, the date of expected full implementation of the model

Why is licensure important in adoption of the Consensus Model?

Currently there are 13 states that do not recognize and/or license CNSs. Many of the CNSs in these states are presently working on writing rules/regulations or working with their legislators to introduce bills to address this issue. Licensure is not only important for the recognition of CNSs under the APRN Consensus Model, but provides title protection and allows the state to set the credentials required for a CNS to be licensed as an APRN. Without title protection, institutions are able to use the job title “clinical

nurse specialist" for a nurse that may or may not have graduated from a clinical nurse specialist program. There are currently 39 states that recognize CNSs and consider "Clinical Nurse Specialist" to be a protected title.

How does the Consensus Model address "direct" and "indirect care?"

The provision of "indirect care" (working through, and in support of, the staff as they provide "direct care") is addressed in the APRN Consensus Model. Some have questioned whether CNSs can be recognized as APRNs if they provide indirect care. Under the definition of APRN in the Consensus Model an APRN "…is an individual who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care…"[2]

What are the Accreditation and Education issues for CNSs under the Consensus Model?

Accreditation and Education issues for CNS education programs have been a subject of extensive discussion with both the National League for Nursing – Accreditation Commission (NLN-AC) and the Collegiate Center for Nursing Education (CCNE) – the two nursing education accrediting bodies. As the nursing organizations negotiated and discussed the APRN Consensus Model all APRN groups (CNSs, Nurse Practitioners, Certified Registered Nurse Anesthetists and Certified Nurse Midwives) adopted the concept of core competencies for entry into advanced practice.

Core competencies for CNSs were created through a consensus process for both the Masters level of preparation and the doctoral level of preparation. Specific educational criteria for CNS programs have also been established through a consensus process and are being disseminated to the various programs that provide CNS education. The Writers Group of the NACNS National Task Force created recommendations for CNS curricula. [3] These recommendations served as the basis for the validation panel that further refined the 2011 Criteria for the Evaluation of CNS education programs. The final criteria provide guidelines for evaluation of CNS programs at the Masters, Practice Doctorate and Post Masters certificate levels.

What about obtaining prescriptive authority in my state?

The APRN Consensus Model defines that all APRNs must be educationally prepared to prescribe. This does not mean that you must obtain prescriptive authority. The Consensus Model identifies that prescriptive authority is optional for CNSs. Many states now provide prescriptive authority to CNSs and have made it optional.

How can I prescribe durable medical equipment?

Many CNSs need authority to prescribe durable medical equipment (DME). However, it is not necessary in every state to have prescriptive authority to order DME. It is possible to work with the state board of nursing to include DME in rule rather than requiring CNSs to seek prescriptive authority. Check with your state to see what the specific requirements are if you need to order DME but choose not to seek prescriptive authority.

Do I need to be Doctoral prepared by 2015?

The APRN Consensus Model does not address the need for doctoral preparation at all. It does describe the educational needs for preparation of APRNs but does not specify whether that is at the Masters or

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[2] Ibid. p.5

Doctoral level. The move to completion of a doctoral level of preparation is a personal choice not required by the APRN Consensus Model.

What are the Education issues for CNSs under the Consensus Model?

Per the APRN Consensus Model, the core foundation for all APRN programs is what is commonly called "the 3 P's": Pharmacology, Pathophysiology, and Physical/Health Assessment. Many CNS educational programs over the years did not include the three P's as core elements of the curriculum. With the full implementation of the model this will need to change. Many schools of nursing that offer CNS educational programs have already incorporated the required courses into the curriculum. Those that have not will need to move to the model prior to their next accreditation cycle as the NLN-AC and CCNE have both agreed to refuse accreditation to programs that do not meet the minimum requirements. Additional changes that will be required are considerable as programs wrestle with the incorporation of population versus specialty and then further define how the specialty content will be infused in the program. These discussions are also under way in many educational programs as they consider how best to meet the needs of both the regulatory and professional expectations for CNS practice.

Important Definitions

It is important to have consistent definitions of what a CNS is and does when discussion changes with the legislature or a regulatory body, such as the state board of nursing. One of the elements that your state boards of nursing will be very familiar with is the APRN Consensus Model for Regulation that addresses elements of Licensure, Accreditation, Certification, and Education (LACE) of the APRN in all its forms. The CNS is one of those roles and it is in your best interest to learn and know the definition of what a CNS is according to the APRN Consensus Model (2008). The definition of a CNS is as follows:

> The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, and system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities (p. 13).

While this definition gives a broad description of what CNSs can do, all APRNs, including the CNS, have a scope of practice that is delimited by regulatory guidelines legislated and detailed by individual State Boards of Nursing (SBON) Nurse Practice Acts. A review of these Acts quickly reveals that nationally, the CNS is faced with inconsistent interpretation of their scope of practice, varied regulatory requirements, lack of population specific certification examinations, and a diversity of educational backgrounds for professional entry. It will be your job to teach the legislators about the impact of these inconsistencies and how they can help you in your task of seeking legislative action to improve patient care and access to your services as a CNS.

References

1. APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee. (2008). Consensus model for APRN regulation: Licensure, accreditation, certification & education. Retrieved July 12, 2011 from https://www.ncsbn.org/7_23_08_Consensue_APRN_Final.pdf

2. Hudspeth, R. (2011). Changes for the valuable Clinical Nurse Specialist, *Nurs Admin Q,35*(3), 282-284

3. Recommendations for CNS Curricula based on nationally validated Master's and Practice Doctorate CNS Competencies. (2009). Prepared by the writer's group of the NACNS National Task Force on the Guidelines for Clinical Nurse Specialist education.

4 Criteria for the Evaluation of Clinical Nurse Specialist Master's, Practice Doctorate, and Post-Master's certificate programs. (2011). Prepared by the Validation Panel of the National Association of Clinical Nurse Specialists, May 2, 2011 (draft).