NACNS Statement on the APRN Consensus Model Implementation

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As the only association representing Clinical Nurse Specialists (CNSs) across all specialties, the National Association of Clinical Nurse Specialists calls for careful implementation of the Consensus Model (the Model) in order to preserve patient and health care system access to CNS services, particularly given the significant influence this role has on cost and quality of health care outcomes. Given the challenging economic environment that faces our nation, the states and individuals, it is essential that the Model's implementation be carefully approached. These challenges include, but are not limited to:

- Variability in state title protection of the CNS.
- Inconsistency in state adoption of the grandfathering of the CNS.
- Lack of a regulatory approach to accepting grandfathered CNSs to practice in other states.
- CNSs losing jobs based on misperceptions of the Model.
- Certifiers have not developed population-based CNS examinations for all populations resulting in limited certification examinations for the CNS.
- Accreditors establishing changes with limited time for schools to respond.
- Curriculum challenges.

These challenges must be addressed in order to successfully implement the APRN Consensus Model by 2015. NACNS would prefer to see diligent, sequential implementation of aspects of this model, even if this means a delay of the 2015 implementation date.

Founded in 1995, the National Association of Clinical Nurse Specialists (NACNS) represents the practice, education, regulation, and certification interests of CNSs, one of four of the advanced practice registered nurse (APRN) roles. NACNS is dedicated to advancing CNS practice and education, removing certification and regulatory barriers, and to assuring the public access to quality CNS services. NACNS exists to enhance and promote the unique, high value contribution of the clinical nurse specialist to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing. CNSs are licensed registered nurses who have graduate preparation (Master's or Doctorate) in nursing as a CNS.

CNSs are expert clinicians in a specialized area of nursing practice. The specialty may be identified in terms of: a population (e.g. pediatrics, geriatrics, women's health); a setting (e.g. critical care, emergency room); a disease or medical subspecialty (e.g. diabetes, oncology); a type of care (e.g. psychiatric, rehabilitation); and/or a type of problem (e.g. pain, wounds, stress). CNS practice in a wide variety of healthcare settings. In addition to providing direct patient care, CNSs influence care outcomes by providing expert consultation for nursing staffs and by implementing improvements in health care delivery systems.

Clinical Nurse Specialist practice integrates nursing practice, which focuses on assisting patients in the prevention or resolution of illness, with medical diagnosis and treatment of disease, injury and disability. Research about Clinical Nurse Specialist practice demonstrates outcomes such as:

- Reduced hospital costs and length of stay
- Reduced frequency of emergency room visits
- Improved pain management practices

- Increased patient satisfaction with nursing care
- Reduced medical complications in hospitalized patients (Appendix A)

Background on the Nationally-Proposed Regulatory Model

In an attempt to ameliorate the issues associated with the inconsistency of rules, policies and standards across state lines, the Advanced Practice Registered Nurses (APRN) Advisory Group of the National Council of State Boards of Nursing (NCSBN) in partnership with the APRN Consensus Work Group to form another body to discuss these issues The Joint Dialogue Group developed the "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education" (Consensus Model). It was subsequently endorsed by member organizations of the Joint Dialogue Group and is currently being pursued by a number of the endorsing organizations. One prominent stakeholder in this process is NCSBN who is promoting this new regulatory framework as the "Campaign for APRN Consensus" for their members.

NACNS participated with the advanced practice registered nurse community in the discussions that brought forth the publication of the Consensus Model in July 7, 2008. The NACNS Board of Directors endorsed this version of the Consensus Model. This model is currently supported by over 48 national nursing associations, accrediting and certification bodies.

The NACNS Board of Directors struggled in their decision to endorse the APRN Consensus Model. It was understood that this new regulatory framework would present many challenges for the CNS role; which utilizes population and not specialty for certification. The consensus model would provide a mechanism for recognizing practicing CNSs in states that, to date lacked

regulatory mechanisms for recognizing the CNS role. The NACNS Board determined that the advantages of a national APRN licensure and regulatory model far outweigh the challenges that the CNS community will undergo in the transition. It is important to the NACNS Board that the implementation of the consensus model will not have a negative impact on patient access to Clinical Nurse Specialist services. We will pursue efforts to identify these situations and work to ameliorate the impact of these challenges.

The aging of our nation and the long discussed impending nursing shortage, one of many health professional shortages, has begun a movement to utilize all health care providers to the full extent of their education and training. The Institute of Medicine (IOM) published a Robert Wood Johnson Foundation report in 2010, "The Future of Nursing: Leading Change, Advancing Health" calls for a "transformation" in how nurses are utilized in all sectors of health care. There are four overarching key messages articulated in this report:

- Nurses at every level of nursing should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through improved education systems that promote seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy-making require improved data collection and information infrastructure.

This IOM report is the most read IOM publication in 2010 and 2011. It has been circulated widely and is the subject of discussion among clinicians, policy makers, regulators, funders and

association leaders. The Model was developed prior to the release of this IOM report. As a result, the Model did not have the benefit of review and critique from the perspective of the IOM report. One pressing concern for the NACNS Board is that the Model, through its implementation, should not limit the practice of CNSs, but rather allow them to practice to the full extent of their education and training.

Variability in Title Protection

One clear benefit of the Model is the opportunity for states to uniformly recognize the CNS role. Currently, there are 39 states that recognize the CNS as an APRN through state law and regulation. There are five states currently pursuing this clarification. The other states vary in their approach to the role; many title a more general category of APRNs and include the CNS in this category. The implementation process of the Model will hold additional challenges for the CNS role as there may be unintended consequences seen in some states due to their history of recognition of the CNS. It is essential that the states, NSCBN and NACNS work in partnership to ameliorate these consequences and work to anticipate and avoid issues as needed.

Grandfathering – Key Element in Regulatory Model

To prevent the Consensus Model from restricting services provided by practicing CNSs, the APRN Consensus Model recognizes that some of the APRN requirements in the model may not be the same requirements used by the state to license those APRNs who are currently recognized by the state and practicing. To address this situation the Consensus Model, under "Implementation Strategies for the APRN Regulatory model,"Appendix B recommend grandfathering those already practicing in the state from any new requirements. The Consensus

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 who are already currently practicing; those APRNs will be permitted to continue practicing within the state(s) of their current licensure without needing to attain the additional requirements. ii (Consensus Model for APRN Regulation, page 15 see appendix for language)

In recognition of the unique challenges faced by the CNS role, the Consensus Model calls for State Boards to grandfather this specific APRN role. NACNS supports grandfathering of these CNSs within their current state of licensure and at their currently recognized scope of practice. This level of practice should be allowed without the burden of additional APRN requirements. Of course, if a previously licensed, recognized CNS wishes to work within the allowed enhanced scope of practice, it would be expected that they would need to obtain the required education requirements.

This would include:

- A nationally recognized population based examination or some other system of certification;
- Adoption of CNS curriculum that contains three core graduate-level courses: advanced physiology/pathophysiology, physical/health assessment and pharmacology.
- Modification of CNS graduate programs that emphasize specialty within role and population;

The Model should be implemented as long as the CNSs who are not able to meet the Model requirements can receive grandfathering in order to allow them to practice as they did when they

received their state CNS licensure (or related state recognition). This practitioner would be responsible to continue their practice and maintain any appropriate licensure requirements for them to remain grandfathered. NACNS supports states that may wish to consider allowing grandfathered CNS' to opt-out of prescriptive authority as part of their practice.

NACNS understands that NCSBN will be working through the regulatory details of how a grandfathered CNS will be able to move from their home state (where they are grandfathered) to another state that has adopted the APRN Consensus Model. This critical discussion will have a profound impact on the economic potential of the CNS and the ability of the CNS to meet the health care needs of the nation. NACNS looks forward to working with NCSBN as they work through the issues related to this important question. We are hopeful that CNSs who are practicing successfully as an APRN in one state will be able to access a process to allow them to be licensed at the same scope of practice in another state. NACNS supports the fact that these providers
would not be eligible for expanded practice such as prescriptive authority unless they have met the criteria established in their new state.

Economic Impact

Even before the Consensus Model is implemented, some CNSs are experiencing a negative economic impact from this model. NACNS has received reports from CNS's currently practicing in the role, that some employers, in anticipation of the adoption of the Consensus Model regulatory framework in their states, are eliminating CNSs that have not obtained certification for APRN practice: despite the fact that such certification examinations may be unavailable. This

action is not consistent with the Model and is evidence of the wide confusion about the steps required for seamless implementation of this change. It is important to note, that employers are taking this action without articulating evidence that there are any patient safety issues with these CNSs. We can only conclude that these actions are being taken in order to comply with the proposed regulatory model that may or may not be implemented in their state. This underscores the importance of well-planned and well-communicated change in reaching compliance with this Model.

It seems that many nursing leaders and associations are anticipating the implementation of the Model. But, since not all states have adopted the model, and certification examinations for the CNS under the new Model are not available, confusion and misinformation are rampant. With the optimistic implementation date of 2015
looming, there is a growing anxiety to get details of the plan in place; yet, when it comes to the CNS role, many of these details need to be carefully discussed, analyzed and decided.

One excellent example is the need for communication with the CNS education programs. Educational systems move deliberately and changes must be managed through registrars and at times with state entities. When a student is enrolled under a certain curriculum, they have approximately 6 years to finish a specific curriculum. We have a growing situation where states have not adopted the Model, but the certifying organizations are implementing changes to their exams that go into effect in 2013. NACNS would be happy to partner with NSCBN and certifying organizations to develop an algorithm for mapping school CNS curriculum and certification to the Model.

States are not Implementing the Full Model – Resulting in Apparent Loss of Consistency

At the beginning of 2012, 19 states have indicated plans for beginning work to implement this model have not implemented the full model. Due to many circumstances, these states have elected to select portions of the Model that work for them. This is contrary to the intent of passing the full Model as drafted. The more states that pass this model in a piecemeal manner may result in problematic variations
between states. It is unclear at this point if these new variations will have an unforeseen impact on APRN roles including the CNS role.

NACNS acknowledges the importance of moving to a more unified regulatory model, and therefore participated in the national dialogue that resulted in this Model. There is true value in regulation to protect the safety of the consumer. But, until the components of the regulatory model are built for the CNS, restrictions on scope of practice, titling, and/or licensure of the CNS can be burdensome when there is no evidence of demonstrable patient harms. These restrictions may have a significant impact on the employment and livelihood of CNSs. This economic impact, without demonstrable patient harms related to this establish role, raises questions similar to those raised by the FTC in their comments to the FL legislature concerning their 2006 law and subsequent regulation.

Because of these many unknowns, it is important that NCSBN and the APRN Community develop a systematic plan for implementation of the Model with regard to the CNS role. NACNS

would like to work with the stakeholders to identify issues and develop the plan to rectify these issues.

Curriculum Changes

A challenge for schools and universities that offer CNS masters and/or doctoral programs is the timely implementation of the changes called for in the Model. These institutions need time to develop and assess the new requirements that are articulated in the Model. There is a major re-alignment related to CNS education included in the Model. CNS education will shift from an emphasis on role and specialty to a model that includes population and role. CNS programs will need to develop curriculums that balance the requirements for education on population, role and specialty education which is unique to the CNS within the mandated 500 clinical hours.

Certification Exams

A core examination was developed by ANCC and NACNS. This examination was offered twice and was well received by the CNS community. This examination provided an option for the CNS to certify based on components of the CNS role. Due to a number of factors, this examination is no longer available and will not be available in the near future. Therefore, a certification process that fulfills the Model's requirements for population-based certification across all identified population groups should be developed. NACNS is currently meeting with experts to determine a recommendation for this situation.

It is important to keep in mind that certification exams are proprietary and the degree to which they are psychometrically sound and legally defensible is not public knowledge. Certification

exams are a business product, and they can only be developed and made available if they are profitable. There is no benefit for a company to offer a product that will not generate at least a modest amount of profit. While understandable, it results in a unique relationship between regulators, certifiers and clinicians. Because of the need for certifiers to ensure they do not create exams that are unprofitable, there are gaps in certifying exams that are available to the CNS. Specifically, this is in the area of family across the lifespan and gender specific. Until a certification examination or process is made available for all CNS populations, NACNS recommends the following:

- In absence of a general CNS population certification examination, specialty examinations, if available, should be considered a proxy for the population specific CNS certification examination until such time that a valid and reliable test and/or certification process is established. A basic examination is not considered a substitute if an advanced practice specialty examination is available.
- Key clinical practice areas that do not have an available population certification examination for the CNS such as family across the lifespan and gender specific population should rely on an extended grandfathering process.

The Model does not recognize alternative certification mechanisms such as portfolio as a proxy for population exams. It is important that a mechanism for certification is selected for population's – family across the lifespan and gender specific – that will allow these CNSs to certify and continue to provide needed services to women and families. NACNS would like to see the adoption of alternative certification models, such as portfolio, for those individuals that find themselves unable to qualify for the available certifying exams.

While we have concerns with the impact of the implementation of the Consensus Model on the CNS role, NACNS does support the adoption of this model. We urge **schools of nursing** to work diligently to comply with the NACNS Education Standards and adjust their programs to meet the demands of the Model.

We ask **states** to consider the impact the adoption of the Model will have on the CNS and their patients within the state. We are hopeful that if a state adopts the model, that it is adopted with a grandfathering clause that allows the profession time and opportunity to discuss and develop strategies to comply with the provisions of the Model that create barriers CNSs. In addition, as the state embarks on data collection efforts to describe the nurse workforce, we encourage data collection on the CNS role and practice in your state.

Certification bodies are encouraged to engage in discussions on how to achieve certification or similar recognition of individuals that will practice with family across the lifespan and women's health/gender specific populations. In addition, certification bodies should communicate effectively about the program changes that will be required for students to comply with the eligibility for their exams.

Accreditors are encouraged to provide schools the time needed to adapt to the required changes. In addition, we ask them to look at the education criteria from CNS as a guide for how programs should be accredited. Given the time it takes to make such significant curricular changes, Accrediters should consider a school's efforts to move in that direction even if it is not completely finished and allow them to remain accredited and give them time to complete it.

Appendix A

DeJong, S. & Veltman, R.H. (2004), The effectiveness of CNS-led community based COPD screening and intervention program. Clinical Nurse Specialist, 18(2) 72-79. This study investigated the effectiveness of a CNS- led community based chronic obstructive pulmonary disease screening and intervention program. The results indicated that of the subjects contacted after the screening, 47% indicated that they stopped smoking, were in the process of quitting, or were seriously considering quitting.

Murray, T. & Goodyear-Bruch, C. (2007).Ventilator-associated Pneumonia Improvement Program. AACN Advanced Critical Care, 18 (2), 190-192. Murray and Goodyear-Bruch found that a ventilator-associated pneumonia (VAP) prevention program developed by CNSs resulted in a reduction in incidence of VAP in the critical care units of a hospital system, with two units having no cases of VAP over a two year period.

Naylor, M., Brooten, D., Campbell, R., Maislin, G., McCauley, K., & Schwartz, J. (2004). Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. Journal of the American Geriatrics Society. 52(5), 675-684.

This research team conducted a randomized, controlled trial and found that APRN directed discharge planning and a home follow-up protocol resulted in: fewer readmissions, lower mean total costs, and short-term improvements in quality of life and patient satisfaction.17

Ryan, M. (2009) Improving self-management and reducing readmissions in heart failure patients. Clinical Nurse Specialist, 23(4) 216-221. Hospital readmissions are expensive and have a significant impact on a patient's quality of life. This study investigated the effectiveness of an evidence-based group discharge education program for patients with heart failure and their families. The results showed that a team of CNSs, a nurse manager, and nursing staff helped reduce hospital readmissions.

Vollman, K. (2006) Ventilator-Associated Pneumonia and Pressure Ulcer Prevention as Targets for Quality Improvement in the ICU. Critical Care Nursing Clinics of North America, 18(4), 453-467. Critically ill patients often experience complications including ventilator-associated pneumonia and pressure ulcers. This CNS team found that a CNS-directed program reduced pressure ulcer prevalence among vulnerable intensive care patients from 50 to 8%. This is a huge decrease in pressure ulcer prevalence in this at-risk population.

Appendix B

APRN Consensus Model – Grandfathering Language

Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education July 7, 2008 pages 14 and 15

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses;
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;

8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact; Except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse- midwives and midwives jointly.
9. have at least one APRN representative position on the board and utilize an APRN advisory committee that includes representatives of all four APRN roles; and,
10. institute a grandfathering* clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

* Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure. However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- current, active practice in the advanced role and population focus area,
- current active, national certification or recertification, as applicable, in the advanced role and population focus area,
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and
- compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure). Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) all new graduates applying for APRN licensure must meet the

requirements outlined in this regulatory model 8 Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs. 9 The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

I) States that have indicated interest: Georgia, Hawaii, Iowa, Kansas, Minnesota, Nebraska, Oklahoma, Tennessee and Vermont, Montana, New Hampshire, West Virginia, and Wisconsin. Florida and Virginia have bills already introduced or about to be. States that anticipate introducing bills or rules changes: Missouri, Kentucky, Washington, Idaho, Minnesota, Arkansas, Delaware, Idaho, Massachusetts. Personal email communication with M. Cahill, NCSBN and P. Mittelstadt, NACNS, January 12, 2012.