

**Report to the NC Board of Nursing
APRN Advisory Committee**

REPORT TO THE NC BOARD OF NURSING
respectfully submitted by
The APRN Advisory Committee

September 16, 2011

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Report to the NC Board of Nursing

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ISSUE

Regulation of advanced practice registered nurses (APRNs) varies across the United States. This variability creates barriers to access to care for consumers and restrictions in workforce deployment of and mobility for APRNs.

BACKGROUND

In July of 2008, the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education* was published (NCSBN, 2008a). This new framework for APRN regulation includes a set of standards that improve access to safe, quality APRN care, protect the public, and improve APRN mobility. In August of the same year, the National Council of State Boards of Nursing (NCSBN) Delegate Assembly approved the *APRN Model Act, Rules and Regulations* (NCSBN, 2008b) which codified the standards in the Consensus Model for use by states in their efforts to implement the new standards for the regulation of APRNs. Since that time, many states with identified barriers to APRN practice have been working toward implementation of these standards.

The NC Board of Nursing established the APRN Advisory Committee in 2010 with the purpose and charge as indicated below.

Purpose of Committee

To assist and support the Board in issues related to APRN practice and regulation.

Committee Charge for 2010-2012

Study NC APRN Licensure, Accreditation, Certification, and Education models; identify differences with the national consensus model for APRN regulation and make recommendations to the Board.

Composition of Committee

Gale Adcock, RN, MSN, FNP-BC, FAANP
SAS Institute Inc.
Practice Representative

Katherine Pereira, RN, MSN, FNP-BC
Duke University
Education Representative

Nancy Shedlick, RN, MSN, CRNA
Raleigh School of Nurse Anesthesia
Education Representative

Diana Hatch
AARP – NC President
Public Member Representative

Dolly Pressley Byrd, RN, MSN, CNM
MAHEC Regional OB-GYN Specialists
Practice Representative

Victoria Soltis-Jarrett, RN, PhD, PMHCNS/NP-BC
UNC Chapel Hill and Private Practice
Practice Representative

James Hicks, RN, MSN, CRNA
Nash Health Care Systems
Practice Representative

Joy Reed, RN, EdD, FAAN
NC Dept of Health and Human Services
Employer Representative

Mary Tonges, RN, PhD, FAAN
UNC Chapel Hill
Employer Representative

Adam Linker
NC Justice Center's Health Access Coalition
Public Member Representative

Pamela Reis, RN, CNM, NNP-BC, PhD
East Carolina University
Education Representative

Susan Williams, RN, DNS
East Carolina University
Education Representative

Bobby Lowery, RN, MN, PhD(c), FNP-BC
East Carolina University
Education Representative

Linda Sangiuliano, RN, CRNA
NC Baptist Hospital
Practice Representative

Nancy Bruton-Maree, RN, MS, CRNA
Board Member Liaison

Eileen Kugler, RN, MSN, MPH, FNP
Board Staff Liaison

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EXECUTIVE SUMMARY

The NC Board of Nursing APRN Advisory Committee has met four times since it was appointed in May 2010. Board staff was assisted in meeting planning and facilitation by consultant Robert Goldberg.

In moving forward with its charge, the committee completed the following activities:

- studied the Consensus Model for APRN Regulation and the NCSBN APRN Model Act, Rules and Regulations;
- identified the major differences between these documents and North Carolina laws and rules regulating APRN practice in the four roles of certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), and nurse practitioner (NP);
- studied APRN regulatory models utilized in other states; reviewed the Institute of Medicine (IOM, 2010) report on the Future of Nursing: Leading Change, Advancing Health; and
- conducted a review of the literature pertaining to APRN practice as it relates to patient safety and quality of care.

Differences between NC APRN Regulation and Consensus Model

The Consensus Model calls for all APRN roles to be regulated by boards of nursing with no regulatory requirement for mandated oversight by another discipline. All APRNs would be required to complete graduate level education programs and be nationally certified in at least one APRN role and population focus in order to be licensed as an APRN. Currently in North Carolina, APRNs are regulated in the following ways:

- CNMs are regulated by the Midwifery Joint Committee which is separate from the Board of Nursing;
- CRNAs are regulated by the Board of Nursing;
- NPs are jointly regulated by the Board of Nursing and the Medical Board through the Joint Subcommittee; and
- CNSs are regulated as RNs by the Board of Nursing. The CNS title is not protected; however, CNSs may seek voluntary recognition from the Board of Nursing if they desire.

APRN Regulation in Other States

The regulation of APRNs varies from state to state as do scope of and privileges to practice. A handout with information regarding APRN regulation in North Carolina's border states is included as an attachment to this report.

Significance of IOM Report to the Work of the Committee

The first of the eight recommendations of the IOM report addresses the removal of unnecessary barriers to nurses practicing to their full scope and relates this recommendation specifically to APRNs stating that "advanced practice registered nurses should be able to practice to the full extent of their education and training" (IOM, 2010). The report also calls upon various professional bodies including Congress, the Centers for Medicare & Medicaid Services, state legislatures, and others to facilitate and advance the role of the APRN in the provision of services to meet the healthcare needs of our citizens.

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Please see attached summaries of the committee’s work organized by meeting date for further details. Full minutes of the committee’s meetings as well as other pertinent documents are available on the Board Member SharePoint site.

EVIDENCE SUPPORTING IMPLEMENTATION OF MODEL ACT/RULES

A literature review related to the four APRN roles revealed that APRNs provide safe, cost effective care with outcomes equal to, or better than, those of physicians or other colleagues in similar practice settings. Please see the attached literature review tables for more detailed information on the literature review submitted by the four role groups.

- CNS Literature Review p. 6
- CNM Literature Review p. 20
- CRNA Literature Review p. 21
- NP Literature Review p. 22
- Comprehensive APRN Review Articles p. 23

RECOMMENDATION

The APRN Advisory Committee recommends that the NC Board of Nursing pursue implementation of the NCSBN APRN Model Act, Rules and Regulations.

Additional Considerations

The four role groups (CNS, CNM, CRNA, NP) and the employers and public members as one group were asked what they wished to retain and what they wished to gain as the implementation process moves forward. As the Board proceeds with implementation, the APRN Advisory Committee requests that the Board members consider the following information:

CNS	Retain	Gain
	Sole regulation by the Board of Nursing	Title protection, grandfathering provision, prescriptive authority
CNM	Retain	Gain
	Midwifery Joint Committee	Elimination of physician supervision
CRNA	Retain	Gain
	Sole regulation by the Board of Nursing	Prescriptive authority
NP	Retain	Gain
	Prescriptive authority	Elimination of physician supervision
Employers/ Public Members	Retain	Gain
	Interdisciplinary care	Sole regulation of all advanced practice registered nurses by Board of Nursing

ATTACHMENTS

- References
- Literature Review Tables
- Excerpts from Consensus Model
- Major Differences Documents
- APRN Regulation in Border States--Snapshot
- Meeting Summaries
- CNS Documents

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REFERENCES

Institute of Medicine (IOM). (2010). *The future of nursing: leading change, advancing health*. Washington, DC: The National Academies Press.

NCSBN. (2008a). (APRN Consensus Work Group and NCSBN APRN Advisory Committee). *Consensus model for APRN regulation: licensure, accreditation, certification & education*.

NCSBN. (2008b). *APRN Model Act and Rules*. https://www.ncsbn.org/Article_XVIII_1.31.11.pdf. Accessed May 23, 2011.

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Literature Review Tables

Literature Review Submitted by CNS Group			
Author, Journal, Date	Title	Study Setting and Population	Key Findings
Allen, M., Chubb, S., (2011) <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	I'm Hungry, Mommy: Evidence-Based Initiatives to Improve Breast-feeding Outcomes of Newborns	Inpatient New mothers	The CNS within the client, staff, and community spheres of influence and application of an EBP model resulted in improvement of breast-feeding outcomes and improved breast-feeding outcomes for vulnerable infants. By using an evidence-based practice (EBP) model, breast-feeding outcomes improved through staff education, enhancing inpatient and outpatient services, community collaboration, and parent education.
Courteny, L (2011) . <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Blazing a New Role for the Clinical Nurse Specialist. With Implementation of Electronic Health Record	Inpatient staff	A CNS strategically placed in the organization can lead in the adoption of new technology, workflow, and electronic documentation and can bridge the technical aspects of an electronic system with the clinical needs of the electronic health record user. The CNS can: -assist in educating staff on workflow change and documentation in the electronic record. -work with information technologists on enhancements as well as changes to existing applications for regulatory compliance. -serve as consultant to inpatient units who is beginning his/her journey to electronic record. -develop standardized checklist for units for port draw rooms and infusion areas and -educate staff on medical necessity documentation in electronic records
Fisher, K., Sink, L., Brown J. (2011) <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice.</i>	Bottoms Up! An Innovative Approach to Code Blue	Inpatient Patients needing resuscitation	CNS collaborated with interdisciplinary team to develop interdisciplinary team training in resuscitation. Qualitative data revealed 83% of staff acknowledged an improvement of familiarity of ACLS protocol, increased comfort level of code procedures, and improved teamwork. A quantitative analysis found that enrollment in ACLS class increased by 35%. A chart review demonstrated an improvement of documentation.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Ford, P.E.A. Rolfe, Kirkpatrick, H. <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice:</i> July/August (2011) - Volume 25 - Issue 4 - pp 198-206	A Journey to Patient-Centered Care in Ontario, Canada: Implementation of a Best-Practice Guideline	Inpatient staff	CNS and other advanced practice nurses demonstrated clinical competencies in initiating changes that resulted in increased use of evidence-based practice. There was evidence of sustainability and spread of these best-practice guidelines to other corporate initiatives through research, patient safety workshops, nursing staff orientation, and other educational activities focusing on professionalism, quality of work life, and falls prevention.
Fuhrman, S. (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Optimizing Stroke Patient Care Across a Hospital System	Inpatient Stroke patients	Clinical practice guidelines have been published to promote best practice and patient outcomes. CNS part of team that improved system-wide care by implementing successful stroke care across system to improve the patient outcomes. Length of stay dropped, compliance with stroke core measures continuously improved, hospitals exceeded the national average for compliance for all primary stroke centers. Practice changes based on current research were able to be implemented in a matter of months rather than several years.
Johnson, M., Amber, R., Cahill, D. Nolan, S., Azuma, N., Davidson, (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Clinical Nurse Specialist. Multidisciplinary Rounds as a Strategy to Translate Evidence-Based Practice to the Bedside	Inpatient ICU patients	The CNS is in a position to expedite the translation of EBP to the bedside by influencing the care delivered to the patient. Multidisciplinary rounds can effectively be tailored to the population to promote best practice. Over 8 months, in two 24-bed ICUs, CNS-led critical-care rounds were completed on 193 patients. Five hundred thirty-one evidence-based recommendations were discovered and integrated into care during the course of these rounds.
Mahnke, K. (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Enhanced Preoperative Patient Education Improves Indwelling Urinary Catheter Removal Rates Postoperatively	Inpatient Preoperative patient	CNS led enhanced preoperative patient education positively impacted indwelling catheter removal rates postoperatively. 360 total joint replacement patient medical records were reviewed. There was a favorable change (60%) in indwelling catheter removal rates after enhanced education ($P = .0060$). There was a favorable change in the indwelling catheter removal rates after enhanced education. These preliminary data suggest that including the patient at the center of care planning with enhanced preoperative education may have improved indwelling catheter removal rates.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Phillips, J., (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Clinical Emergencies: Broadening the Scope of Emergency Response	Inpatient OB and perioperative patients	CNS for patient safety played a key role in the development of a successful Rapid Response System (RRS) in an academic medical center. Consultative role of the CNS was pivotal in the development of the Obstetrics Emergency Team and the Perioperative Intervention Team. The CNS led a multidisciplinary team to develop, implement, and evaluate the clinical emergency response in the outpatient facility. Process changes resulted in a decrease in response time from 8 to 3 minutes. Data demonstrated a dramatic increase in the number of calls in the first 2 years of operation, from 57 calls in fiscal year 2009 to 244 calls in fiscal year 2010.
Stamm, R., Muller, A., Gallagher, E., (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Clinical Nurse Specialist Innovation and Collaboration: Guiding Frontline Nurses to Implement New Evidence When the Research Changes	Inpatient Diabetic population	CNS led the development and implementation of a new glycemic protocol and target range in a cardiac surgical population based on the emergence of new evidence. There have been less hypoglycemic events reported since the implementation of the new protocol. The CNS was recognized as a change agent by evaluating and implementing new evidence at the unit level.
Wiley, K. (2011). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Navigating the First Year: Enhancing Knowledge and Promoting Confidence among New-to-Practice Nurses	Inpatient Novice nurses	Working within the nursing sphere of influence, the CNS provides pivotal support in bridging the gap from novice to advanced beginner nurse and beyond. . New-to-practice nurses benefit from innovative methods to increase support and confidence in caring for a specialized population. The CNS fosters professional development and confidence for them to reach maximum potential.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Winterbottom, F. (2011) . <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Building a Business Case for Investment in the Clinical Nurse Specialist	Inpatient CNS	Investment in a CNS saves the institution money. The CNS embodies innovative leadership and expertise by embracing cultural change, empowering nurses, enhancing professional practice, implementing research-based strategies, and measuring quality outcomes. CNS led project outcomes included : (1) Sepsis management resulted in a 30% decrease in raw mortality and estimated cost avoidance of \$2 million annually; (2) falls prevention program led to a 17% reduction in injurious falls and \$400 000 cost reduction; (3) critical-care orientation/education curriculum ameliorated turnover by 25% and reduced expenditures by \$325 000; (4) therapeutic hypothermia post-cardiac arrest improved survival to discharge from 20% to 65%; (5) neurology telemedicine program resulted in 17% improved time to thrombolytic therapy in eligible stroke patients and increased facility transfers; (6) palliative care program increased consults by 69% with 27% improvement in bereavement satisfaction; and (7) CNSs facilitated 7 journal clubs, 11 research studies, and 72 scholarly works in 2009.
Krom, Z., Batten, J., Bautista, C. <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice:</i> March/April 2010 - Volume 24 - Issue 2 - pp 54-59	A Unique Collaborative Nursing Evidence-Based Practice Initiative Using the Iowa Model: A Clinical Nurse Specialist, a Health Science Librarian, and a Staff Nurse's Success Story		This project involved collaboration of the CNS with a staff nurse, and a health science librarian that resulted in an effective approach in addressing the barriers to EBP for staff nurses. The staff nurse provided the real-time practice issues, the CNS gave extensive knowledge of translating research into practice, and the health science librarian retrieved the information from the literature. The resulting collaborative educational effort increased staff nurse exposure to and knowledge about EBP principles and techniques. The collaborative relationship among the CNS, health science librarian, and staff nurse effectively addresses a variety of barriers to EBP.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Jones, JS (2010). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Credentialing and Psychiatric Clinical Nurse Specialist. The Journal for Advanced Nursing Practice Practice	PMHCNS	Examining the transition of the role and credentialing of an APRN in PMHN-from PMHCNS to PMHCNS/NP toward PMHNP.
Mahler, A. <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice: January/February (2010) Volume 24 - Issue 1 - pp 18-23</i>	The Clinical Nurse Specialist. Role in Developing a Geropalliative Model of Care	Inpatient Geriatric population	Studied the CNS's role in the development and implementation of an interdisciplinary geropalliative model of care. The role of the CNS within this model of care, was directed at achieving quality outcomes of patient care, by influencing the practice of the nursing staff. This was achieved through a role on the consult team, as well as being a nursing mentor, consultant, and educator. The CNS has the opportunity and ability to influence nurse-sensitive outcomes of care by integrating a theoretical framework with evidence-based knowledge and advanced clinical expertise.
Mayo, AM, Omery, A, Agocs-Scott, LM, Fatemeh K, et al. (2010). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Clinical Nurse Specialist Practice Patterns	CNS	Practice patterns (activities, outcomes, and barriers) differed in terms of CNS specialty, years of experience, number of units covered, and CNS reporting structure
NACNS Board of Directors (2010) <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i>	Clinical Nurse Specialists—Practitioner Contributing to Primary Care: A Briefing Paper	CNS Primary care	CNS is a practitioner who can contribute services to primary care as an independent practitioner or as a member of a primary care team
Ryan, M. <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice. 2009; 23(4); 216-221.5</i>	Improving self-management and reducing readmission in heart failure patients.	Adults	CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness. Study documents their care of the those with heart failure.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Horner, S. (2008). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i> , 22(4), 192-198	Childhood Asthma in a Rural Environment	Children	CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness. Several studies document their efforts in care of the chronically ill, including those with asthma.
Hughes RG, editor (2008) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Chapter 43. Rockville (MD): Agency for Healthcare Research and Quality (US)	Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality	Acute care Adult patients	CNSs demonstrate competence and cost savings as case managers for patients transitioning from acute care to home care.
Duhamel, F (2007) <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i> , 21(1), 43-49.	A Qualitative Evaluation of a Family Nurse Intervention.	Community	CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness.
LaSala, C.A., Connors, P.M., Pedro, J.T. and Phipps, M. <i>The Journal of Continuing Education in Nursing</i> · November/December (2007) Vol 38, No 6	The Role of the Clinical Nurse Specialist in Promoting Evidence-Based Practice and Effecting Positive Patient Outcomes.	Inpatient	<ol style="list-style-type: none"> 1. The Clinical Nurse Specialist is able to directly impact patient care by responding to the needs of the patient, novice clinician, and expert practitioner. CNS is instrumental in contributions toward meeting organizational goals. 2. The CNS influences unit-based and organizational practice through direct care in both acute inpatient settings and outpatient areas. The CNS assists, implements and evaluates hospital wide quality initiatives, and is instrumental in promoting quality initiatives and cost effective patient care practices. 3. CNS support the ability of Massachusetts General Hospital to respond to a constantly changing healthcare environment 4. As clinical expert, collaborator, consultant, and educator, the CNS has a unique opportunity to positively influence patient care outcomes, continuity of care, and the professional development of staff through role modeling, mentoring, coaching, and direct care activities. The CNS promotes quality evidence based care and sense of clinical inquiry and critical thinking through research use and evidence-based practice.
McNellis, A. (2007). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i> 21(4), 195-202.	Concerns and needs of children with epilepsy and their parents	Children	CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness. Several studies document their efforts in care of those with epilepsy.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Vollman, K. (2006). <i>Critical Care Nursing Clinics of North America</i> , 18(4), 453-467	Ventilator-Associated Pneumonia and Pressure Ulcer Prevention as Targets for Quality Improvement in the ICU	Acute care Inpatient setting VAP	CNS demonstrate that by leading clinical teams they can implement evidence-based system-wide changes to reduce infections, medical errors and costs in acute care facilities, and reduce hospital acquired conditions. Studies have shown a decrease in complications and costs when CNSs develop evidence-based practice guidelines to effectively address pain and to reduce the incidence of preventable pulmonary complications including ventilator acquired pneumonia, another source of high costs.
Murray, T. (2005). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i> , 19(2), 80.	Ventilator-associated pneumonia as a nurse-sensitive outcome: the role of the Clinical Nurse Specialist in the development and implementation of clinical systems to reduce ventilator associated pneumonia	Acute care Inpatient setting VAP	CNS demonstrate that by leading clinical teams they can implement evidence-based system-wide changes to reduce costs in acute care facilities, and reduce hospital acquired conditions. Studies have shown a decrease in complications and costs when CNSs develop evidence-based practice guidelines to effectively reduce the incidence of preventable pulmonary complications including ventilator acquired pneumonia another source of high costs.
DeJong, S. (2004). <i>Clinical Nurse Specialist. The Journal for Advanced Nursing Practice</i> , 18(2) 72-79.	The effectiveness of CNS-led community based COPD screening and intervention program.	Chronically ill adults	CNSs have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness. Several studies document their efforts in care of the chronically ill, including those with chronic pulmonary disease.
Dobscha, SK, et al. American College of Physicians. 2001; www.acponline.org . Accessed August 16, 2003.	Effectiveness of an intervention to improve primary care provider recognition of depression	VA Hospital Depressed adults	Study demonstrated that CNSs work as members of the primary care team in providing care to improve the recognition of depression and its initial management in a VA.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Ahrens T, Yancey V, Lollef M. <i>Am J Crit Care</i> . 2003;12(4):317–323.	Improving family communication at the end of life: implication for length of stay in the intensive care unit and resource use	ICU adults	The study evaluated the effect of a communication team that included a physician and CNS on length of stay and cost of care for intensive care unit (ICU) patients at end of life. The patients who had the communication team intervention had shorter ICU stays (6.1 vs 9.5 days) and hospital stays (11.3 vs 16.4 days). They also had lower fixed costs (\$15,559 vs \$24,080) and variable costs (\$5087 vs \$8035).
Halm MA, Denker J. <i>Clinical Nurse Specialist. A Journal for Advanced Practice</i> 2003;17(1): 101–109.	Primary prevention programs to reduce heart disease in women.	Community Women with heart disease	The authors described developing and implementing a Woman’s Prevention Center by a multidisciplinary team including a CNS, cardiovascular fellow, exercise physiologist, and a cardiac rehabilitation/outreach leader. The CNS was able to practice in all 3 spheres of influence in this setting.
Smith EL, Whedon MB, Bookbinder M. <i>Semin Oncol Nurs</i> . 2002;18(1):36–43	Quality improvement of painful peripheral neuropathy.	Outpatient Pts treated with chemotherapy	CNSs used quality improvement methodology to improve assessment and treatment of neuropathic pain from chemotherapy-related nerve damage was described.
Newman, M. <i>Evidence-Based Nursing</i> . (2002). 5(2); 55-56.	A specialist nurse intervention reduced hospital readmissions in patients with chronic heart failure.	Across hospital settings Geriatrics	CNSs have demonstrated their effectiveness in transitioning care from hospital to home by preventing readmissions as documented in a study of discharge planning from hospital to home care for the elderly. Studies have also shown that programs developed by CNSs assist congestive heart failure patients with self-care to prevent hospital readmissions.
Duffy JR. . <i>Clinical Nurse Specialist. A Journal for Advanced Practice</i> 2002; 16(2):70–76.	The clinical leadership role of the CNS in the identification of nursing sensitive and multidisciplinary quality indicator sets	Inpatient population	The author described the CNS role in facilitating the inclusion of relevant quality indicators, preserving both multidisciplinary and nursing-sensitive approaches, and maintaining efficiency during the quality improvement process.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Eisenberg P, Painter J. <i>Clinical Nurse Specialist. A Journal for Advanced Practice</i> 2002;16 (4):182–186.	Intravascular therapy process improvement in a multihospital system: don't get stuck with substandard care.	Inpatient IV therapy patients	CNSs designed a program using research-based data, national recommendations, and benchmark data to improve the quality of intravenous therapy care
Adams, P.. <i>Nurse Clinicians of North America</i> . 2000; 35(2); 329-338.	Insight into a mental health prevention intervention	Private practice and Community setting Depressed women	CNSs provide behavioral health care to individuals in private practice and to communities through special programs. The Insight Program, which was implemented by CNSs in a community setting to address depression in women, had a statistically significant and clinically relevant improvement in scores on all tools used.
Brooten, D, et al. <i>American Journal of Managed Care</i> . (2001). 7(8); 793-803.	A randomized trial of nurse specialist home care for women with high-risk pregnancies: Outcomes and costs.	Home care, mothers at high for delivery of low birth weight infants, early discharge of low birth weight infants	Study examined prenatal, infant (194) and maternal (173) outcomes where half of the prenatal care was delivered in the home by CNSs. Results found that the group cared for in the home by CNSs experienced fewer fetal/infant deaths, fewer preterm infants, fewer prenatal hospitalizations, and fewer rehospitalizations compared to the control group. Researchers concluded that the CNS prenatal home care saved 750 hospital days or about \$2.5 million dollars.
Nancy Dayhoff, Clinical Solutions, LLC		Wellness Company Adults	CNSs improve access to wellness and preventive care by identifying early those at risk for costly chronic diseases, such as diabetes and heart failure, and provide care to keep people healthy and prevent chronic conditions. A wellness company, owned and managed by CNSs provides ongoing care to employees to help them stay healthy and to lower their risk for the development of disease. An employer, who has engaged the services of these CNSs, experienced decreased health care costs and noted an annual increase in the health insurance premiums in single digits, as opposed to previous double digit increases
Creason, H.. Lippincott's Case Management. 2001; July/August; 146-156.	Congestive heart failure telemanagement clinic	Across Settings hospital to home Geriatrics	CNSs have demonstrated their effectiveness in transitioning care from hospital to home by preventing readmissions as documented in a study of discharge planning from hospital to home care for the elderly. Studies have also shown that programs developed by CNSs assist congestive heart failure patients with self-care to prevent hospital readmissions.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Knox, D, Mischke, L. <i>Journal of Cardiovascular Nursing</i> . 1999; 14(1); 55-74.	Implementing a congestive heart failure disease mgmt program to decrease length of stay and cost	Across Settings hospital to home Geriatrics	CNSs have demonstrated their effectiveness in transitioning care from hospital to home by preventing readmissions as documented in a study of discharge planning from hospital to home care for the elderly. Studies have also shown that programs developed by CNSs assist congestive heart failure patients with self-care to prevent hospital readmissions.
Hanneman, SI, et.al. <i>American Journal of Critical Care</i> , 2(4), 331-338.	The indirect patient care effect of a unit-abased Clinical Nurse Specialist on preventable pulmonary complications.	Acute care Inpatient setting Adults with pulmonary complications	CNS demonstrate that by leading clinical teams they can implement evidence-based system-wide changes to reduce infections, medical errors and costs in acute care facilities, and reduce hospital acquired conditions. Studies have shown a decrease in complications and costs when CNSs develop evidence-based practice guidelines to effectively reduce the incidence of preventable pulmonary complications.
Badger TA, Gagan MJ, McNiece C. <i>Clin Nurse Spec</i> . 2001;15(3):95–102.	Community analysis for health planning with vulnerable populations	Community Community Vulnerable adults	Epidemiological research study undertaken by CNSs to determine the need for alternative healthcare delivery models for vulnerable populations using the framework derived from Anderson and Aday and Feretich, Phillips, and Verran. Results showed subjects lacked access to routine care, had little knowledge of disease prevention, and used few preventative services.
Baird KK, Pierce LL. <i>Rehabil Nurs</i> . 2001;26(6): 233–243.	Adherence to cardiac therapy for men with coronary artery disease.	Community Outpatient Adult men	The CNS authors used Orem’s Self-Care Deficit Theory of Nursing to identify factors facilitating and inhibiting adherence to a cardiac therapy program. Facilitative factors included developmental status, health state, healthcare system, and family system. Inhibitory factors included age, pattern of living, environmental factors, and resource availability and adequacy.
Barnason S, Rasmussen D. <i>Nurs Clin North Am</i> . 2000;35(2):395–403.	Comparison of clinical practice changes in a rapid recovery program for coronary artery bypass graft patients.	Inpatient Bypass patients	This outcomes research study was designed by CNSs to identify factors facilitating and inhibiting adherence to a cardiac therapy program. Results showed that groups differed in only 1 variable, oxygenation status. Fewer patients in the rapid recovery group requiring oxygen on Day 2.

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Author, Journal, Date	Title	Study Setting and Population	Key Findings
Brandl KM, Langley KA, Riker MD, Dork LA, Qualls CR, Levy H. <i>Pharmacotherapy.</i> 2001;21(4):431–436.	Confirming the reliability of the sedation-agitation scale administered by ICU nurses without experience in its use.	ICU staff nurses and CNSs	The research study was designed to test the ability of nurses to use the SAS (sedation/ agitation scale) to accurately assess and describe consciousness and agitation resulting management problems and drug inconsistencies. Results showed statistically significant and clinically relevant improvement in scores on all tools.
De Vito Dabbs A, Curran CR, Lenz ER. <i>Clinical Nurse Specialist. A Journal for Advanced Practice Nurses.</i> 2000;14(4):174–183.	A database to describe the practice component of the CNS role	Inpatient Patients/ families	The study described the development of a comprehensive database and tested its usefulness in capturing CNS patient encounters and in describing CNS functions. The database profiled CNS practice during the 3 months of data collection and showed 424 clinical encounters with 98 patients/families where 787 problems were addressed and 1130 functions were performed. The database provided a way to efficiently summarize CNS practice activities.
Deisch P, Soukup M, Adams P, C. Wild M <i>Nurs Clin North Am.</i> 2000;35(2):417–425.	Guided imagery replication study using coronary artery bypass graft patients	Inpatient Post op bypass patients	CNS tested the use of guided imagery in patients who have had coronary artery bypass grafts. Results showed that use of guided imagery reduced pain, fatigue, anxiety, narcotic usage, and length of stay, and increased patient satisfaction.
Mayhew PA, Acton GJ, Yauk S, Hopkins BA. <i>Geriatr Nurs.</i> 2001;22(2):106–110.	Communication from individuals with advanced DAT: can it provide clues to their sense of self-awareness and well-being?	Community Patients with advanced dementia	The study to enhance understanding of communication from people with advanced dementia of the Alzheimers type (DAT) was conducted. During interviews with a gerontologic CNS, subjects seemed to be aware of their cognitive decline, displayed a sense of self, showed indicators of well-being, and displayed a range of emotions such as creativity and self-expression, relaxation, affectional warmth, and humor. Some subjects showed assertion of will, social sensitivity, initiation of social contact, and helpfulness.

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Literature Review Submitted by CNS Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
Manworren RCB. <i>Pediatr Nurs.</i> 2000;26(6):610–614	Pediatric nurses' knowledge and attitudes survey regarding pain.	Inpatient Staff nurses	A pediatric pain management CNS identified pain management knowledge deficiencies through descriptive survey of nurses. The deficiencies were identified in areas of assessment, pharmacologic management with opioids, nonopioids, and adjuvant medications, risks of addiction, risks of respiratory depression, nonpharmacologic pain interventions, and treatment of procedural pain, surgical pain, and cancer pain.
Wheeler EC. <i>Clinical Nurse Specialist. A Journal for Advanced Practice Nurses.</i> 2000;14(4): 159–169.	The CNS's impact on process and outcome of patients with total knee replacement	Inpatient Knee replacement patients	The study determined whether differences existed in patients with total knee replacement in hospital units with and without CNSs and found patients on the units with CNSs received more nursing care interventions more frequently, had shorter total lengths of stay, and had fewer complications. Length of stay correlated positively with acute pain processing instrument (APPI) scores and negatively with high risks for disuse syndrome process instrument (HRDSPi) scores. Complications correlated negatively with HRDSPi scores.
Willoughby D, Burroughs D. <i>Clinical Nurse Specialist. A Journal for Advanced Practice Nurses.</i> 2001;15(2):52–57.	A CNS-managed diabetes foot-care clinic: a descriptive survey of characteristics and foot-care behaviors of the patient population.	Community Diabetic patients	The study described the characteristics and foot-care behaviors of people with diabetes who attended a CNS managed foot-care clinic and findings revealed that clinic patients were more likely to have foot pathology, were more likely to have their feet examined at each healthcare visit, and to use appropriate foot-care practices.
Cisar NS, Mitchell A. <i>Clinical Nurse Specialist. A Journal for Advanced Practice Nurses.</i> . 2001;15(1):25–33.	Development of a program to manage costly outliers.	Inpatient All patients	A way to manage patients with hospital costs exceeding \$50,000 was described by the CNS authors. Steps included identification of clinical characteristics of the outliers, development of a screening tool, delineation of the role of the APN in managing screened patients, and dissemination of the results showing the impact of the program. Reduced hospital stay and decreased hospital costs during the program occurred.
Inouye SK, Bogardus ST, Baker DI, Leo-Summers L, Cooney LM. Hospital Elder Life Program. <i>J Am Geriatr Soc.</i> 2000;48(12): 1697–1706.	The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients	Inpatient Geriatric patients	A hospital elder life program designed to prevent cognitive and functional decline in older hospitalized patients was described using the geriatric CNS

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Literature Review Submitted by CNS Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
Junkin J. . <i>Nurs Clin North Am.</i> 2000;35(2): 339–347	Promoting healthy skin in various settings	Inpatient All patients	The CNS author described development of a program to improve skin health through standardized skin care across care settings.
Larsen LS, Neverett SG, Larsen RF. . <i>Clinical Nurse Specialist. A Journal for Advanced Practice.</i> 2001;15(1):15–22	Clinical Nurse Specialist. as facilitator of interdisciplinary collaborative program for adult sickle cell population	Inpatient Sickle cell clients	The evolution, implementation, and outcome evaluations of a collaborative interdisciplinary program to improve healthcare quality provided to adults with sickle-cell disease was described. The CNS role was described as one of facilitator.
Mian P. . <i>Clinical Nurse Specialist. A Journal for Advanced Practice.</i> 2000;14(5):229–234	The role of the clinical nurse specialist in the development of a domestic violence program.	Inpatient Staff	The author described the role of a CNS in the development of an innovative, hospital-wide, multidisciplinary domestic violence program. The program was thoroughly described and the CNSs subroles of expert clinician, consultant, educator, and researcher were addressed in relation to the program.
Mion LC, Palmer RM, Anetzberger GJ, Meldon SW. . <i>J Am Geriatr Soc.</i> 2001; 49(10):1379–1386.	Establishing a case-finding and referral system for at-risk older individuals in the emergency department setting: the SIGNET model	ED Geriatric	The development, implementation, and evaluation of the multidisciplinary systematic Intervention for a Geriatric Network of Evaluation and Treatment that resulted in improved case finding and linkages between several hospitals emergency departments and clinical agencies was described. Gerontologic CNSs had a prominent role.
Seemann S. . <i>Nurs Clin North Am.</i> 2000;35(2):405–415.	Interdisciplinary approach to a total knee replacement program	Inpatient Knee replacement	The Center for Advanced Nursing Practice Evidence-Based Practice Model was used to describe development, implementation, and evaluation of an interdisciplinary project to develop a program for care of patients following total knee replacement.
Seemann S, Soukup SM, Adams P. <i>Nurs Clin North Am.</i> 2000;35(2):361–373.	Hospital wide intravenous initiative	Inpatient Patients with IV therapy	The Center for Advanced Nursing Practice Evidence-Based Practice Model was used to describe development, implementation, and evaluation of a hospital-wide program to standardize intravenous equipment aimed at best practice.

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Literature Review Submitted by CNS Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
Selig C. <i>Nurs Clin North Am.</i> 2000;35(2):311–319.	Sexual assault nurse examiner and sexual assault response team (SANE/SART) program.	ED Sexual assault victims	The author used the Center for Advanced Nursing Practice Evidence-Based Practice Model to describe development, implementation, and evaluation of a sexual assault nurse examiner and sexual assault team program.
Wilson LC . <i>J Community Health Nurs.</i> 2000;17(1):39–48.	Implementation and evaluation of church-based health fairs	Community Patients at risk of cardiovascular disease and hypertension	A comprehensive health-needs assessment based on the Neuman Systems Model to develop, implement, and evaluate a health promotion program to increase awareness of cardiovascular disease and hypertension among residents of the target community was described.
Woods SS, Nass J, Deisch P. <i>Nurs Clin North Am.</i> 2000;35(2):385–393.	Selection and implementation of a transparent dressing for central vascular access devices.	Inpatient Patients with central access devices	The Center for Advanced Nursing Practice Evidence-Based Practice Model was used to describe development, implementation, and evaluation of a hospital-wide program that standardized transparent dressing protocols.

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APRN Advisory Committee**

Literature Review Submitted by CNM Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
MacDorman, M.F. & Singh, G.K. (1998) <i>Journal of Epidemiology and Public Health</i> , 52(5), 310-317.	Midwifery Care, Social And Medical Risk Factors, and Birth Outcomes In The US.	Birth certificate data from 1991 was examined for all singleton vaginal deliveries between 35 and 43 weeks. After controlling for socio-demographic and medical risk factors, the outcomes for MDs and CNMs were compared.	The risk for neonatal mortality was 33% lower for births attended by CNMs. The risk of delivering a low birth weight infant was 31% lower for CNM attended births. The mean birth weight was 37 grams higher for CNM attended births. The infant mortality rate was 19% lower for CNM attended births.
Rosenblatt, R. A., et.al. (1997). <i>American Journal of Public Health</i> 87(3): 344-351	Interspecialty Differences in the Obstetric Care of Low-Risk Women.	Differences in the practice of family physicians, obstetrician-gynecologists, and certified nurse-midwives caring for low-risk women were compared in a random sample of each category of provider in Washington State. Records of their low-risk patients beginning care between September 1, 1988, and August 31, 1989, were abstracted.	The cesarean rate for each provider was as follows: CNM = 8.8% Obstetricians = 13.6% Family physicians = 15.1% CNMs used 12.2% fewer resources than the physicians and were less likely to use continuous electronic fetal monitoring and had lower rates of labor induction or augmentation than physicians.
Cragin, L. & Kennedy, H.P. (2006). <i>Journal of Midwifery and Women's Health</i> , 35(6), 779-785.	Linking Obstetric and Midwifery Practice with Optimal Outcomes.	375 patients cared for by physicians and CNMs were compared to measure optimal perinatal outcomes using the Optimality Index-US, an instrument developed to determine if style of care affects outcomes of care. Of the 375 patients, 179 received physician care and 196 received nurse-midwife care. Health record data were extracted and scored using the Optimality Index-US to summarize the optimality of processes and outcomes of care as well as the woman's preexisting health status.	Midwifery patients had more optimal care processes, reflected in the use of less technology and intervention There were no differences in neonatal outcomes, even when preexisting risk was taken into account.

Report to the NC Board of Nursing APRN Advisory Committee

Literature Review Submitted by CRNA Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
AANA State Government Affairs Division January 2006	<u>Prescriptive Authority Handbook</u>		Summarizes issues related to Prescriptive Authority in general, as well as issues faced by individual states.
AANA (American Association of Nurse Anesthetists)	<u>CRNA Prescriptive Authority</u>		Explains how Prescriptive Authority is handled in other states.
Dulisse, B., Cromwell, J. 10.1377/hlthaff.2008.09 66 <i>Health Affairs</i> , 29, no.8 (2010):1469-1475	No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians	Medicare data for the years 1999-2005	A review of the data by economists with the Research Triangle Institute found there was no increase in inpatient deaths or complications when states opted out of the CMS physician oversight requirement for CRNAs. The authors recommend that CMS discontinue the requirement for physician oversight of CRNAs as a condition of participation for all states.

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APRN Advisory Committee**

Literature Review Submitted by NP Group

Author, Journal, Date	Title	Study Setting and Population	Key Findings
Mundinger, MO et al (2000). JAMA. 283(1): 59-68.	Primary care outcomes in patients treated by nurse practitioners or physicians.	NYC, NY (Manhattan). Measurement of primary care outcomes in patients with chronic illnesses when care was delivered by NPs and physicians.	Outcomes were the same <i>or better</i> for patients with chronic illnesses when cared for by nurse practitioners when compared to the care provided by physicians.
Lenz, ER, Mundinger, MO, Kane, RL, Hopkins, SC, and Lin, SX. (2004). Medical Care Research and Review. 61(3): 332-351.	Primary care outcomes in patients treated by nurse practitioners or physicians: two year follow-up.	Replication of the 2000 Mundinger study. Measurement of primary care outcomes in patients with chronic illnesses when care was delivered by NPs and physicians.	Outcomes were the same <i>or better</i> for patients with chronic illnesses when cared for by nurse practitioners when compared to the care provided by physicians.
Lugo, O'Grady, Hodnicki, Hanson. American Journal for Nurse Practitioners. 2007; 11(4).	Ranking state NP regulation: practice environment and consumer healthcare choice.	Ranking of all 50 states and the District of Columbia based on an analysis of state statutes and rules and their effect on access to NP care.	States with statutory and/or regulatory requirements for physician supervision of NP treatment and/or prescribing restrict patient access to NP care. North Carolina is described as 'severely restricts patient choice' and received a rating of 'F'.
Online Journal of Issues in Nursing. Vol. 12-2007. Number 2, May 2007. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN	Hudspeth, R. Survey of Advanced Practice Registered Nurses Disciplinary Action.	Review of state boards of nursing disciplinary cases.	State Boards of Nursing are consistent in defining areas of discipline and report low numbers of APRN discipline cases. These findings suggest the incidence of APRN discipline for chemical impairment, exceeding accepted SOP, unprofessional conduct, and patient abuse & neglect is minimal in the United States.
Pearson, L. http://webnp.net/ajnp08.html	The 2011 Pearson Report.	Annual review of NP practice statutes and regulations in all 50 states and the District of Columbia. 10+ years of data from the National Practitioner Data Bank and the Health Care Integrity & Protection Data comparing reports of incidents involving NPs, MD and DOs.	There is inconsistency across the country in state-granted authority for NPs to treat and prescribe. There is no data to support that restricting NP practice improves patient safety.

Report to the NC Board of Nursing APRN Advisory Committee

Comprehensive APRN Review Articles

Author, Journal, Date	Title	Study Setting and Population	Key Findings
Newhouse RP, Stanik-Hutt J, White KM, Johantgen M, Bass EB, Zagaro G, ... Weiner JP. (2011) (in press). CNE Series: Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review. Retrieved from Nursing Economic\$ website: https://www.nursingeconomicomics.net/ce/2013/article3001021.pdf	Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review.	Sixty-nine studies published between 1990 and 2008	The report provided results of a systematic review comparing the outcomes of three types of advanced practice registered nurses (nurse practitioners, certified nurse midwives and clinical nurse specialists) to those of physician groups. Overall, the study found that the outcomes of the three APRNs were similar to or better than those of physicians.
O'Grady, E. (2008). Chapter 43, advanced practice registered nurses: The impact on patient safety and quality. In Hughes, R.G. (Ed.), <i>Patient safety and quality: An evidence-based handbook for nurses</i> . Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ahrq.gov/QUAL/nursesfdbk	Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality	Chapter in AHRQ (Agency for Healthcare Research and Quality) publication on patient safety and quality	The chapter reviews the definition and roles of advanced practice nurses and a selected sample of the literature regarding APRN care and patient safety and quality of care. Findings suggest that care delivered by APRNs across settings is at least equivalent to care delivered by physicians regarding safety and quality.

Report to the NC Board of Nursing

APRN Advisory Committee

EXCERPTS FROM THE CONSENSUS MODEL FOR APRN REGULATION

The following excerpts from the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, (2008), are provided as basic information to prepare for the first meeting of the APRN Advisory Committee. Copies of the complete document will be distributed at the meeting.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but shares the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards-governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

The goals of the consensus processes were to:

- strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- develop a vision for APRN regulation, including education, accreditation, certification, and licensure;
- establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and
- produce a written statement that reflects consensus on APRN regulatory issues.

A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Report to the NC Board of Nursing

APRN Advisory Committee

EXCERPTS FROM THE CONSENSUS MODEL FOR APRN REGULATION *continued*

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification, and education (LACE) must work together. Expectations for licensure are listed below:

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 except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse-midwives and midwives jointly);
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;
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.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification, and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

Report to the NC Board of Nursing APRN Advisory Committee

APRN Model Act: Comparison with State Act

Objective:

Compare current NC APRN Laws* with the APRN Model Act.

**Note: If no reference was found in law, rules were then cited, if applicable.*

Outline of document:

This document is separated into the following seven (7) sections according to the Model Act:

- Section 1 – Practice of APRNs
- Section 2 – Licensure of APRNs
- Section 3 – Titles and Abbreviations for APRNs
- Section 4 – APRN Nursing Education Programs
- Section 5 – Prescribing and Ordering
- Section 6 – Discipline
- Section 7 – APRN Implementation – “grandfathering”

Each section designates the following columns:
NCSBN Model Act, CRNA, NP, CNM, CNS

Current Regulatory Landscape for NC APRN

Abbreviation	Type	Current Regulatory Authority	State Act
CRNA	Certified Registered Nurse Anesthetist	NC Board of Nursing	Nursing Practice Act (NPA)
NP	Nurse Practitioner	Jointly regulated by the NC Board of Nursing and NC Medical Board	Medical Practice Act (MedPA) §90-18.2, §90-18.3
CNM	Certified Nurse Midwife	Midwifery Joint Committee	Midwifery Practice Act (MidwPA)
CNS	Clinical Nurse Specialist	Not regulated; however, <u>voluntary</u> recognition by the NC Board of Nursing may be obtained.	Nursing Practice Act (NPA)

Report to the NC Board of Nursing APRN Advisory Committee

Major Differences in NC APRN Regulation As Compared to APRN Model Act (Law) **Article XIX APRN – NCSBN Model Act**

Section 1: Practice of APRN

	CRNA	NP	CNM	CNS
APRN licensure	No	No	No	No
Scope of Practice	No (in rule)	No (in rule)	Yes	No (in rule)
Primary care providers of record	No	No	No	No
Licensed independent practitioners	No Specific language not used but <u>rule</u> states CRNA maintains accountability for own actions	No Supervising physician required	No Supervising physician required	No

Section 2: Licensure of APRN

	CRNA	NP	CNM	CNS
Completion of approval – graduate level program	No	No (in rule)	No	No (in rule)
National certification	No (in rule)	No (in rule)	Yes	No (in rule)
Endorsement	No	No	No	No
Renewal of APRN License	No	No	Yes	No
Reinstatement – after period of inactivity	No	No (in rules)	No	No

Section 3: Titles and Abbreviations for APRN

	CRNA	NP	CNM	CNS
Titles – APRN plus role abbreviations	No	No	No	No

Report to the NC Board of Nursing APRN Advisory Committee

Section 4: APRN Nursing Education Programs

	CRNA	NP	CNM	CNS
APRN Education Program Standards	No	No	No	No

Section 5: Prescribing and Ordering

	CRNA	NP	CNM	CNS
Granting prescribing and ordering authority through the APRN license	No	Yes	Yes	No

Section 6: Discipline

	CRNA	NP	CNM	CNS
	No	No	Yes	No

Section 7: APRN Implementation – “grandfathering”

	CRNA	NP	CNM	CNS
Any person holding a license to practice nursing as an APRN in this state that is valid on December 30, 2015 shall be deemed to be licensed as an APRN under the provisions of this Act...	Not addressed	Not addressed	Not addressed	Not addressed

Report to the NC Board of Nursing APRN Advisory Committee

APRN Model Rules/Regulations: Comparison with State Rules/Regulations

Objective:

Compare current NC APRN Rules/Regulations with the APRN Model Rules/Regulations.

Outline of document:

This document is separated into the following sections according to the Model Rules/Regulations:

- 19.1 Standards Related to the APRN
- 19.2 Licensure as an APRN
 - 19.2.1 Application for initial licensure as an APRN
 - 19.2.2 Application of an Internationally Educated APRN
 - 19.2.3 Application for Licensure by Endorsement – Requirements as an APRN
 - 19.2.4 Application for Renewal of License as an APRN
 - 19.2.5 Quality Assurance/Documentation and Audit
 - 19.2.6 Reinstatement of APRN License
- 19.3 Titles and Abbreviations of APRNs
- 19.4 APRN Nursing Education
 - 19.5.1 Requirements for prescribing and ordering authority
 - 19.5.3 Distribution of Samples
- 19.6 Discipline
 - 19.7.1 APRN Implementation

Each section designates the following columns:

NCSBN Model Rules/Regulations, CRNA, NP, CNM, CNS

Current Regulatory Landscape for NC APRN

Abbreviation	Type	Current Regulatory Authority	Rules
CRNA	Certified Registered Nurse Anesthetist	NC Board of Nursing	21 NCAC 36 .0226 Nurse Anesthesia Practice
NP	Nurse Practitioner	Jointly regulated by the NC Board of Nursing and NC Medical Board	21 NCAC 36 .0800 Approval and Practice Parameters for Nurse Practitioners 21 NCAC 32M .0100 Approval of Nurse Practitioners
CNM	Certified Nurse Midwife	Midwifery Joint Committee	21 NCAC 33 .0100 Midwifery Joint Committee
CNS	Clinical Nurse Specialist	Not regulated; however, voluntary recognition by the NC Board of Nursing may be obtained.	21 NCAC 36 .0228 Clinical Nurse Specialist Practice

Report to the NC Board of Nursing APRN Advisory Committee

Major Differences in NC APRN Regulation As Compared to APRN Model Rules

19.1 Standards Related to the APRN

	CRNA	NP	CNM	CNS
Quality assurance methods	No	Yes	Yes	No

19.2 Licensure as an APRN

	CRNA	NP	CNM	CNS
APRN Licensure	No (Board recognition)	No (approval to practice)	No (approval to practice)	No (voluntary recognition only)

19.2.1 Application for initial licensure as an APRN

	CRNA	NP	CNM	CNS
Graduate level education required	No	Yes	No	Yes
Board evaluation of APRN certification programs	No	No	No	No

19.2.2 Application of an Internationally Educated APRN

	CRNA	NP	CNM	CNS
Application of internationally educated APRN	No	No	No	No

19.2.3 Application for Licensure by Endorsement - Requirements as an APRN

	CRNA	NP	CNM	CNS
Endorsement for APRN	No	No	No	No
National certification required	Yes	Yes	Yes	Yes
Competence Assessment – refresher course required	No	Yes	No	No

19.2.4 Application for Renewal of License as an APRN

	CRNA	NP	CNM	CNS
Renewal of APRN License (NC does not have APRN licensure)	Board recognized – renewal required	Approval to practice – renewal required	Approval to practice – renewal required	No renewal with current certification

Report to the NC Board of Nursing APRN Advisory Committee

19.2.5 Quality Assurance/Documentation and Audit

	CRNA	NP	CNM	CNS
Random audits	No	No	No	No
QA documentation required	No	Yes	Yes	No

19.2.6 Reinstatement of APRN license

	CRNA	NP	CNM	CNS
Reinstatement of APRN license requirements	No (Board recognition)	Yes	No	No (voluntary recognition)

19.3 Titles and Abbreviations of APRNS

	CRNA	NP	CNM	CNS
Title – APRN	No	No	No	No

19.4 APRN Nursing Education

	CRNA	NP	CNM	CNS
APRN nursing education	Not regulated in NC			

19.5.1 Requirements for prescribing and ordering authority

	CRNA	NP	CNM	CNS
Prescribing authority	No	Yes	Yes	No

19.5.3 Distribution of Samples

	CRNA	NP	CNM	CNS
Distribution of samples	No	Yes	Yes	No

19.6 Discipline

	CRNA	NP	CNM	CNS
Discipline	RN disciplinary rules only	Yes and RN disciplinary rules	Yes and RN disciplinary rules	RN disciplinary rules

19.7.1 APRN Implementation

	CRNA	NP	CNM	CNS
“Grandfathering”	No	No	No	No

**Report to the NC Board of Nursing
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Border States

Border States	APRN Regulatory Information
South Carolina	<ul style="list-style-type: none"> -Compact state for RN license -BON regulates APRNs in collaboration with Medical Board -MD supv and protocols required -Rx authority requires separate application -One license—APRN license -CNS--no title protection -No legislation yet
Virginia	<ul style="list-style-type: none"> -Compact state for RN license -Joint Boards of Nursing and Medicine regulate APRNs -MD supv and protocols required -Two licenses—RN and NP (all APRNs are “NPs”) -Rx authority requires separate application -No legislation yet
Tennessee	<ul style="list-style-type: none"> -Compact state for RN license -BON has regulatory authority, but Medical Board has rules for MD supervision -MD supervision required if prescribing; on site protocols required -Rx authority requires separate application -Two licenses—RN and APN -State nurses assoc. sponsoring legislation for title change to APRN
Georgia	<ul style="list-style-type: none"> -Non-compact state for RN license -BON has regulatory authority -MD collaboration with protocols required -Rx authority -Only PMH CNS authorized -Two licenses

Report to the NC Board of Nursing

APRN Advisory Committee

Meeting Summaries

August 5, 2010

Materials	<ul style="list-style-type: none"> • Committee profile • NC APRN Laws and Rules • National Consensus Model and Model Act and Rules • PowerPoint entitled “Consensus Model for APRN regulation: Licensure, Accreditation, Certification, Education”
Activities	<ul style="list-style-type: none"> • Presentations given by Julie George (NCBON) and Nancy Chornick (NCSBN) • Committee members identified issues important to APRNs in North Carolina through a brainstorming exercise. • Like-titled APRNs, employers and public members met in small groups and prioritized the issues mentioned. The top four issues were as follows: <ul style="list-style-type: none"> • Autonomous practice (12 votes) • Practicing to full scope (12 votes) • Reimbursement (8 votes) • Consumer support (8 votes)
Next Steps	<ul style="list-style-type: none"> • Review Model Act and Rules in their entirety and identify gaps

November 22, 2010

Materials	<ul style="list-style-type: none"> • List of top four issues from August 2010 meeting • The current regulatory landscape for the NC APRNs • Major gaps between NC law and regulation and the Model Act and Rules. • Institute of Medicine Future of Nursing Report (Brief and Recommendations) • Annotated bibliography in advanced practice studies and articles would be provided after the meeting
Activities	<ul style="list-style-type: none"> • Committee reviewed the current regulations for NC • Committee reviewed major gaps between current regulations and Model Act and Rules • With the assistance of the facilitator, the committee developed a timeline (attached) for their work from January 2011 through October 2011. On the timeline, committee members wrote the goals believed to be important to achieve under the months presented. • Open Comment Period
Next Steps	<ul style="list-style-type: none"> • Committee homework – Each APRN role was asked to review the APRN Model Act and Rules and indicate their level of agreement according to the following categories: <ul style="list-style-type: none"> ○ Green – Endorse ○ Yellow – Cautious ○ Red – Oppose

Report to the NC Board of Nursing

APRN Advisory Committee

February 28, 2011

Materials	<ul style="list-style-type: none"> • Border State Handouts regarding regulation of APRNs in those states: What other Boards are doing regarding Consensus Model implementation (verbal report) • Healthcare Workers/Professions Other than RNs and LPNs Regulated by Board of Nursing • Staff Overall Interpretation of Responses regarding Model Act/Rules
Activities	<ul style="list-style-type: none"> • Committee homework review – Each APRN role subgroup provided further clarification of their analyses of the Model Act and Rules and addressed questions from committee members • With assistance of the facilitator, groups were paired for a solution-seeking exercise (subgroup pairings were as follows: CRNA and CNS, CNM and NP – employers and Public Members were also included in the groups). Groups were encouraged to discuss areas of concern and areas of agreement. • Recommendation to reconcile gaps – Using the Color Code Charts, each role presented areas of agreement and continued concerns – most of the concerns were resolved during the discussion • Open Comment Period
Next Steps	<ul style="list-style-type: none"> • Committee homework – Members to read literature review and speak to respective constituent groups to gain perspectives • Color Code Charts to be finalized and emailed to committee members

April 29, 2011

Materials	<ul style="list-style-type: none"> • Color Code Charts • Annotated bibliography from NCBON • O’Grady Chapter • The Role of the CNS in NC • Prescriptive Authority Handbook – AANA State Government Affairs Division • An Annotated Bibliography Reflecting CNS Practice & Outcomes • CNS Meeting the New Demands of a Reformed Healthcare System
Activities	<ul style="list-style-type: none"> • The remaining concerns were resolved and the Color Code Charts were reconciled • Committee members reported on literature review • Assessed readiness to move toward recommendations – Committee agreed they were ready to move toward making recommendations to the full Board • Reports from small groups – Within their role group, members discussed what one important item they wished to gain and one they wished to retain. • Open Comment Period
Next Steps	<ul style="list-style-type: none"> • Committee asked staff to develop a draft of recommendations to present at the June 6, 2011 APRN Advisory Committee Meeting for review.

Report to the NC Board of Nursing

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Documents Submitted by CNS Committee Members

Document 1

Analysis of APRN Model, Nurse Practice Act and NC Rules and Regulations:
The role of a Clinical Nurse Specialist

Williams & Soltis-Jarrett

Introduction

As members of the Clinical Nurse Specialist (CNS) subgroup on the APRN Model Advisory Committee for the North Carolina Board of Nursing (NC BON), Susan Williams, DNS, RN and Victoria Soltis-Jarrett, PhD, PMHCNS/NP-BC will briefly summarize the processes used and the identified areas where gaps were evident in the intersection of APRN/LACE Model, North Carolina Nurse Practice Act and the North Carolina Rules and Regulations.

Process of Analysis

Both members (Drs Williams and Soltis-Jarrett) reviewed each of the documents that were provided to them by the NC BON separately to allow an independent review and analysis; and then subsequently met on two occasions to discuss their individual findings. Sources of information related to this analysis and review were based on: (a) personal experiences as educators and directors of CNS programs and (b) personal experience as an advanced practice nurse in Pennsylvania and North Carolina. Dr Williams is Director of the East Carolina University College of Nursing Program option for Clinical Nurse Specialists and is actively involved with CNS's across the state of North Carolina through her work establishing a state affiliate organization with the National Association for Clinical Nurse Specialist (NACNS). Dr Soltis-Jarrett is also Director of the UNC-CH School of Nursing PMH CNS and NP Program and sought consultation from Dr Patti Zuzelo who is the current President of the NACNS. Dr Soltis-Jarrett has participated on two panels facilitated by independent consultants (in conjunction with the NACNS) for the establishment of APRN/LACE model adaptation at the national level: Core Competencies for the CNS and Educational Requirements for the CNS Programs).

Key Areas of Agreement/Questions/Concerns

Overall, both Drs Williams and Soltis-Jarrett were in agreement with all points of concern as well as identified questions that need to be discussed further with the Advisory Committee. There are three MAIN areas of concern that we are in agreement about and that need to be addressed in order for the CNS role to be in line with the other APRN roles (NP, CCRN, CNM). They are:

- a) The notion of "grandfathering" those currently practicing CNS roles in NC (who are MSN prepared)
- b) Certification for CNS educated now and in the future
- c) Prescriptive authority

Questions:

There are pertinent questions that we have raised (and agreed upon) that need further discussion.

At this time, certification is an issue for the CNS as there are currently only nine CNS exams available for specific areas (seven exams with ANCC and two with the American Association of Critical Care Nurses).

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Current ANCC specialty exams:

- 1) Adult (will be revised to adult/gero in April 2011)
- 2) Adult and child/adolescent psychiatric/mental health
- 3) Diabetes
- 4) Gerontology
- 5) Home health
- 6) Pediatric
- 7) Public/community health

American Association of Critical Care Nurses exams:

- 1) Critical Care CNS
- 2) Pediatric/neonatal Critical Care CNS

Concerns that need further discussion due to GAPS:

- 1) Must distinguish between specialties and population language

The educational and certification requirements in the model addresses 'populations'

And the notion of 'specialties' are not addressed in the consensus model

Specialties are at the next level in the model; therefore, the CNS would actually need a general certification and then could specialize, i.e. in diabetes for example.

Current certification is through specialty exam: per the model the professional organizations will take care of the specialty exams

Listed below are the populations that are identified in the consensus model and whether there are CNS programs or certification exams available for these populations:

Adult/gero (exam available and being revised now)

Psych/mental health (exam available)

Family/individual across lifespan (no CNS programs in nation for this population, no CNS exam)

Pediatrics (exam available)

Neonatal (exam offered by CCNS for this)

Women's health/gender related (no CNS programs for this population, no exam for this population)

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2) We must look at the future CNS role. Points to consider for further discussion are:

There are no CNS programs for family/individual across lifespan, or women's health/gender related (currently there are CNS programs for "Perinatal" focus but not women's health). The programs that address perinatal do not fit into the model.

The CNS role has historically responded to the changing healthcare needs by developing new specialty practices (i.e. HIV).

What happens when new populations evolve that are not currently covered by one of the ANCC exams? With the model proposed there is no room for adaptation to change.

The consensus model requires that future CNS's fit into the model which then means that educational programs will not have the flexibility to address new populations (all programs will have to fit into the current model and be certified in one of the 6 populations listed).

It is possible that ANCC may need to re-institute the general CNS core exam for populations for which there is not a certification exam. However the current model does not allow for that.

➤ **We recommend that some type of credentialing beyond certification examinations be adopted for the CNS, (i.e. portfolios, specialty exams, etc that would serve as an option in lieu of the population certification).**

3) For **current practicing CNS** in NC (MSN prepared), we recommend that they would require 'grandfathering' in so that they may continue to practice. There are specific limitations that have prevented many practicing CNS from sitting for certification exams:

Current certification exam requirements and the limited number of exams make it extremely difficult for the CNS to sit for an existing exam:

1) ANCC requires that the CNS must have 500 clinical hours in an educational program and must have graduated from a CNS program in order to sit for an exam

2) Current practicing CNS may have graduated from a program that did not have a CNS track. Some MSN programs required that the student take a clinical component and chose a functional area such as education or leadership (many MSN programs 20-30 years ago did not have a CNS functional area).

3) The CNS may have graduated from a program that did not require 500 hours of clinical

4) With over 50 CNS specialties nationally – there are currently no exams for a majority of the specialties. The limited number of exams available prevent CNS from sitting for certifications exams in their specialty area (i.e. oncology, pulmonary, HIV, vascular, etc)

5) Thus, the number of certified CNS is small

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In addition, recertification and competency for these individuals is problematic for above reasons

➤ **Therefore we recommend that all MSN CNS who do not meet the Consensus Model be grandfathered in with the provision that they are:**

Not given a license as APRN

Can not move across state lines to practice

Must stay within their scope of practice

4) Prescriptive Authority

Currently CNS do not have prescriptive authority in NC

To practice to full scope of practice and to full extent of education need to have the ability to have prescriptive privileges CNS do have the education and ability to move into primary care – ie wound care, palliative care, management of chronic diseases where the ability to prescribe would be essential in follow-up visits, consultations, etc.

CNS in the hospital need the ability to have non-pharmacological prescriptive privileges: consultations, diagnostic tests, durable medical equipment, ordering home health, etc

➤ **Suggest that only those CNS who meet the requirements of the Consensus Model be given prescriptive privileges**

At a minimum allow the privilege to order non pharmacological interventions

Rationale for allowing the CNS to practice to the full extent of their ability:

Research has shown that the CNS is a safe and effective care provider and can:

- i) increase effectiveness of moving care from hospital to home and prevent readmissions
- ii) improve quality and safety of care
- iii) reduce health care costs by implementing evidence based system wide changes
- iv) educate, train and increase the nursing workforce
- v) increase access to community based care
- vi) increase availability of effective care for those with chronic illness
- vii) improve access to wellness and preventive care

Denying CNS the opportunity to practice to the full scope of their ability and education will deny the public access to their valuable skills.

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Documents Submitted by CNS Committee Members

Document 2

The role of Clinical Nurse Specialist in North Carolina: The need for **title protection** and **clarity of role definition** for implementation of the APRN/LACE Model

Victoria Soltis-Jarrett & Susan Williams

Introduction to the issue: Title protection and regulation through licensure

Title protection and regulation (licensure) of a professional role such as "nurse" is essential to its viability and sustainability. Without it, the title could be exploited by anyone desiring the use and privilege of the role without the education, training and subsequent licensing (regulation). Title protection and licensure of the role of a registered *nurse* is critical to ensuring that the public are safe and that those who use the term registered "nurse" are authentic. The title protection, licensure and regulation of the role of registered *nurse* in North Carolina are all currently sanctioned by the North Carolina Board of Nursing (NCBON) through the NC Nurse Practice Act (NC NPA). Only **twenty nine states** nationally are known to have title protection for the generic term registered "nurse" (ANA, 2011) and this does include the state of North Carolina (CHAPTER 90. MEDICINE AND ALLIED OCCUPATIONS, ARTICLE 9A. NURSING PRACTICE ACT N.C. Gen. Stat. § 90-171.43). Using the title of registered *nurse* without the appropriate credentials and licensing in those 29 states listed is illegal, and is punishable by law.

Although the advanced practice roles of Nurse Practitioner (NP), Clinical Nurse Midwife (CNM) and Certified Registered Nurse Anesthetist (CRNA) are endorsed as a role (and have title protection) in North Carolina through the NCBON (NP and CRNA) and MIDWIFERY JOINT COMMITTEE (CNM), **there is currently no title protection for the role of Clinical Nurse Specialist**. In addition, the title of Clinical Nurse Specialist (CNS) has been used by organizations or individuals desiring the name but not meeting the criteria set forth by national standards. Until recently, the NC State Hospital System had used this classification (CNS) as part of their clinical career ladder, though they were not maintaining the necessary requirements set forth by the NCBON voluntary recognition standards. In other instances the role of a CNS has been filled by nurses with less than a BSN and with NPs, neither of whom are educated to function as a CNS. In other words, the NCBON has only been able to *recognize* the role of a CNS by way of voluntary identification. These are individual nurses, some of whom seek certification voluntarily (although it required for PMHN for reimbursement); provide information to the NCBON about their education and certification and subsequently then are placed on a state list as being "recognized" (21 NCAC 36 .0228 CLINICAL NURSE SPECIALIST PRACTICE).

To ensure integrity of the APRN/LACE implementation set forth by the National Council of State Board of Nursing (NCBON), the role of a CNS must be regulated and protected by title and role definition (as well as consideration of education, licensure and certification). Nationally, this process is already occurring as Health Care Reform (and the Affordable Health Care for America Act, H.B. 3962) will impact the ability of Americans to access health care and to be assured that their health care provider is authentic and credible (Hudspeth, 2009). As of 2008, there are ONLY six states that DO NOT HAVE TITLE PROTECTION for the CNS (including NC).

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Therefore, this brief position paper argues the need for immediate actions, to not only provide title protection for the role of the Clinical Nurse Specialist, but to explore the need for regulation of the CNS through licensing as an APRN in NC.

The planning and implementation of the APRN/LACE Consensus Model: Including the CNS

The APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee (2008) have introduced the notion of a consensus model for planning the future of Advanced Practice Registered Nursing (APRN) through a historic document. This document presents and discusses the planning and implementation of a uniform model for APRN licensure, accreditation, certification and education across the USA and has followed a logical process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies. Its goals, although broad and futuristic are as follows:

strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;

develop a vision for APRN regulation, including education, accreditation, certification, and licensure;

establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and

produce a written statement that reflects consensus on APRN regulatory issues (2008).

It is within these goals and guidelines that the role and title protection of the CNS must be addressed, planned and implemented as part of NC's adaption of the APRN/LACE model. When reviewing the current NC Policies and Procedures for APRN Practice, there are multiple gaps that reflect the need for development and implementation of an action plan for NC for the role of a CNS.

Evidenced Based Practice: Authenticating the education, role and practice of a CNS

There is a plethora of advanced practice nursing literature that identifies the role and practice of the CNS nationally and uses evidence based research to validate its authenticity as an APRN role (Altmiller, 2011; Fulton, & Baldwin, 2004; Gerard, 2010; LaSala, Connors, Pedro, & Phipps, 2007; Mayo, Omery, Agocs-Scott, Atemejkhafhani, Meckes, Moti, Redeemer, Voorhees, Gravell, & Ceunca, 2010; NACNS Board, 2011). In addition, the literature also demonstrates that the role of the CNS is instrumental and pivotal in ensuring that patients receive safe, quality and cost effective care (Brooten, 1996; Creason, 2001; Dayhoff, 2005; DeJong, 2004; Duhamel, 2007; Fulton & Baldwin, 2004; Hanneman & Horner 2008; Knox & Mischke, 1999; McNellis, 2007; Murray, 2005; NACNS, 2011, Naylor, 1994; Newman, 2004; Ryan, 2009; Vollman 2006).

To this end, the assessment and interventions of the CNS are population focused and implemented using similar competencies as those of the NP, CNM and CRNA. An example of this is best depicted in the NACNS Core Competencies for a CNS (under Direct Care) which supports prescriptive authority as a potential CNS intervention:

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Prescribes nursing therapeutics, pharmacologic and nonpharmacologic interventions, diagnostic measures, equipment, procedures, and treatments to meet the needs of patients, families and groups, in accordance with professional preparation, institutional privileges, state and federal laws and practice acts (NACNS, 2011, Competency A13).

Nationally, there are states (N= 34 jurisdictions) which approve the CNS (*non* psychiatric as well as psychiatric CNS) to prescribe within their scope of practice (Hudspeth, 2009). With the passage of the Health Care for America Act, H.B. 3962, the Department of Health and Human Services, Centers for Medicare & Medicaid Services is slated to provide reimbursement to providers of primary care (including Clinical Nurse Specialists) for Medicare services. In order for the CNS to be an equal participant in improving access and providing health care for Medicare and Medicaid recipients (as well as all citizens), the CNS in NC should be given the option of prescriptive authority through the regulatory umbrella of NCBON (AACN Public Policy, 2005; AACN, 1996; Bell, 2000; NACNS, 2005; Middelstadt, 2011).

Definitions of the role, scope and standards of practice as well as CNS core competencies are available to be used concurrently with the other APRN roles (NP, CNM, CRNA) to ensure its equivocal place in advanced practice (NACNS 2011). However there are areas where latitude is needed at this time (2011) in order to protect those APRNs in NC who are currently practicing and were educated as a CNS, but for whom there is no certification exam for their specialty or who have not been able to meet the current requirements for certification because of the evolution and inconsistencies in of the definition of the role and education of a CNS nationally (Jones, 2010; Fulton, 2010; Fulton, 2011). Therefore, the NCBON needs to consider a staging process of futuristic licensure (regulation), accreditation, certification and education of the CNS role as the APRN/LACE Consensus Model is implemented in NC. This process of staging will be one of the focuses driven by the NC BON APRN/LACE Advisory Committee and will reflect the inclusion of those CNS's who may not have received certification or the required hours of educational supervision that is now mandated by many programs across the USA. Creating an alternative method of evaluation in lieu of a certification award is necessary to allow for the inclusion of those CNS who have been educated at a master's level and worked as an APRN for multiple years (Lyon, 2004). In addition, the pursuance of obtaining title protection will be of utmost importance and will be required in order to be able to implement a future for the CNS in NC.

Summary*

In summary, the licensure, accreditation, certification and education of the APRN role of a CNS is essential to the development of the health care workforce in NC. The NC BON is mandated to protect the public and ensure patient safety for all individuals in NC. Through the NC BON mission, the role of a CNS will need to be authenticated through: (a) title protection; (b) regulation of the role through APRN licensure; (c) monitoring of educational requirements of CNS programs (d) development of a staging process of ensuring that certification has been awarded for those specialty areas that have exams and (e) creating a alternate method of evaluation for those who do not have certification exams available.

*References available upon request