REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

Testimony to

Federal Trade Commission

June 11, 2003

Presented by

Brenda L. Lyon DNS, RN, CNS, FAAN

on behalf of the **National Association of Clinical Nurse Specialists**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- FOCUS OF TESTIMONY –
  - Noerr-Pennington doctrine violations and anticompetitive concerns regarding actions of the National Council of State Boards of Nursing* and its member boards to create insurmountable barriers for **Clinical Nurse Specialists** that substantially limit the economic and professional opportunities of this practitioner.

*** An "association" <u>not</u> a regulatory body**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

Background on Clinical Nurse Specialists:

- A Clinical Nurse Specialist (**CNS**) is a Registered Nurse (**RN**) who holds a **masters degree in nursing** from an accredited School of Nursing that prepares CNSs for *specialty practice in nursing*.

- Currently there are **over 40 specialty areas of practice** that have evolved over time to meet societal needs for expert nursing care (e.g. oncology, orthopedics, HIV/AIDS, rehabilitation, women's health, wound/ostomy/incontinence, diabetes).

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

CNS background continued:

- It is estimated by the DHHS Division of Nursing and the American Nurses' Association that there are **over 60,000 CNSs in the U.S.**

- **CNSs have been providing expert nursing services to the public for over 50 years -- practicing within the scope of practice authorized by the RN license.**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

CNS background continued:

- **CNS practice is characterized by expert nursing practice within the <u>domains of practice authorized by the RN license</u>:**
  - Provision of research/theory-based **"direct" patient care** for patients who need specialty nursing care;
  - Bridging gaps between new knowledge and actual practice at the bedside by staff nurses – **advancing the practice of nursing**; and
  - **Facilitating "system" changes on a multi-disciplinary level** that help hospitals and other health care facilities improve patient outcomes cost-effectively

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

CNS background continued:

- There are **some CNSs (e.g. Psychiatric CNS, Congestive Heart Failure CNS, Diabetes CNS) who have obtained prescriptive authority so that they may order medications to help patients manage/control symptoms or functional problems in conjunction with an MD specialist.**

  Prescriptive authority for medications extends beyond the scope of practice authorized by the RN license and therefore additional regulation such as licensure for these CNSs is warranted.

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

CNS background continued:

- **Currently there is a critical shortage of CNSs in the U.S.** (Some hospitals are offering $20,000 sign-on bonuses.)

- **Recently the number of universities & colleges offering masters degree programs preparing CNSs has increased from 187 to over 200.**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- The regulatory credentialing issues:

Some state boards of nursing (e.g. Texas, Ohio, Minnesota, Arkansas) are **requiring ALL CNSs to obtain a second license to practice – this requirement:**

1. Represents **over-regulation for the vast majority of CNSs;** and

2. Creates **insurmountable barriers** for the CNS to practice (with or without prescriptive authority) when obtaining the 2nd license requires specialty certification as a CNS by exam thus **denying the public access to needed services.**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- Regarding the issue of **over-regulation -**

1. **There is NO evidence over the past 50 years of a public safety issue regarding CNS specialty nursing services**

2. **The level of regulation needed for CNS practice without prescriptive authority is *designation/recognition.***

This level of regulation would provide for title protection and a scope of practice that makes clear the distinctions between CNS and Nurse Practitioner practice. Additionally this level of regulation would provide for CNS title protection so that persons do not misrepresent themselves as CNSs and would also meet requirements of 3rd party payers for reimbursement of CNS services.

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

The issue of **insurmountable barriers**

- **The requirement to obtain a 2nd license and to be certified, by exam, as a CNS adversely affects the majority of CNSs who practice within the domains authorized by the RN license.**
  - **There are over 40 CNS specialty areas of practice**
  - **Only 9 CNS specialty exams exist**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

The issue of **insurmountable barriers continued**

- Therefore the **vast majority of CNSs will never be able to obtain certification in their specialty area** --- it is not economically feasible to develop exams in areas where there are not large numbers of practitioners – thus, it is impossible for the vast majority of CNSs to meet this regulatory requirement

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

Consequences of insurmountable barriers continued – examples:

- In states such as Texas, Ohio, and Arkansas there are hundreds, if not thousands, of CNSs who have stopped practicing as CNSs because they cannot obtain recognition to practice OR are forced to go back to school to take Nurse Practitioner courses to learn competencies not used in their CNS practice.
- In states such as Texas there are Schools of Nursing who are closing much needed CNS programs because there is no certification exam in specialty area – example Women's Health CNS masters program at University of Texas at Austin.
- *It is also imperative to note that requiring certification, by exam, for entry into in a specialty area precludes the evolution of new specialties to meet evolving societal needs* **because certification exams are not developed in an a-priori manner.**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

These insurmountable barriers will **only worsen with the–**

"UNIFORM ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSE/ AUTHORITY TO PRACTICE REQUIRMENTS" passed by The National Council of State Boards of Nursing (NCSBN) Delegate Assembly passed (August, 2002)

-- multi-state **compact** language for the recognition of advanced practice registered nurses (APRN) including Clinical Nurse Specialists, Nurse Practitioners, Registered Nurse Anesthetists, and Nurse Midwives that **only recognizes certifications exams as the mechanism for demonstration of competence.**

- -- Purpose of compact is to facilitate interstate practice
- -- States wanting to participate in the compact **MUST adopt the regulatory language as approved by NCSBN**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

The issue of **insurmountable barriers continued**

The NCSBN APRN Task Force has proposed that if there is not a CNS certification exam available in the CNS's specialty area then a more general exam such as " Medial-Surgical" CNS exam (one of the existing specialty exams) can be taken as evidence of competence.

- **There are important "legal defensibility" questions of requiring an exam that does NOT test for competencies in the specialty area**
  - E.g. Requiring an HIV/AIDS CNS or WOUND/OSTOMY/ INCONTINENCE CNS or ORTHOPEDIC CNS to take a medical-surgical exam that does not test for advanced practice nursing competencies required for the care of persons with these specialty needs.

REGULATORY CREDENTIALING BARRIERSFOR CLINICAL NURSE SPECIALISTS (CNS)

AFFECTS OF REGULATORY BARRIERS DESCRIBED ARE DEVASTING TO THOUSANDS OF CNSs and result in:

1. Denying public's access (patients & CNS employers) to much needed CNS services;

2. Schools of nursing not developing new graduate degree specialty programs to meet societal needs; and

3. Wasted $$ with CNSs taking unnecessary additional course work to become Nurse Practitioners (changing the scope of CNS practice to include competencies they do not use) to achieve advanced practice recognition so that they can provide CNS services.

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- **Currently the NCSBN Advanced Practice Task Force is advocating the development of a standardized "generalist" exam to evaluate safe advanced nursing practice. No other nursing group is supporting development of a uniform, generalist examination for advanced practice.**

- **The actions of the NCSBN as an "association" raise important** Noerr-Pennington **concerns**

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- **Noerr-Pennington concerns:**

1. The association, made up of members of state boards of nursing, has undue and inappropriate control over state regulatory processes.
2. The association process does not allow for input of other organizations – others may comment, but those comments are not incorporated into the deliberative process.
3. The association has a vested economic interest in changing the licensure process – examination or certification development (the association develops and provides “testing” products).

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- **Noerr-Pennington related <u>questions</u>:**

1. Is it appropriate to provide an association, which provides testing products to state licensing agencies, and mandates membership to obtain the testing products, with unfettered access to state licensing agency staff and appointed members?

2. Is it appropriate for such an association to develop policy, lobby its membership for adoption of the policy, and subsequently develop the required products for sale to its membership?

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- **Noerr-Pennington/anticompetition question:**

1. Is it appropriate for the association to develop the policy which would require the use of uniform standards for licensure, and the use of the standardized exam and subsequently, force the state boards of nursing to use its product by limiting access to a national disciplinary database or alternatively, work to undermine other competency certification products?

We do not believe the Noerr- Pennington exemption was created for this purpose.

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

We believe that:

1. The NCSBN exceeded the boundaries of the exemption when it developed policy inconsistent with state goals related to regulation – *protection of the health and safety of the public while not creating barriers to block the public's access to needed services*

2. The NCSBN has exceeded the boundaries of the exemption through its development of policy that would support NCSBN products for sale to State Boards of Nursing

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

1. State licensure boards, not the NCSBN, were designed to address the health and safety of the public.

2. Policy developed by an association with ties to state boards of nursing that can be anticompetitive, discriminatory and is unrelated to the primary standards of licensure (policy established for administrative ease rather than evidence of harm) is subject to antitrust challenges, that is ---

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- Anticompetitive concerns:

Changing the scope of CNS practice and/or creating insurmountable barriers to practice substantially limits the economic and professional opportunities of this practitioner, without providing a clear scientific or legal basis to do so. We believe that is anticompetitive. See Kreuzer v. Academy of Periodonotogy, 735 F.2d 1479 (D.C. Cir. 1984)

REGULATORY CREDENTIALING BARRIERS FOR CLINICAL NURSE SPECIALISTS (CNS)

- FTC should clearly speak to the role and limitations that should be placed on associations which mandate membership of government appointees to 1) adopt anticompetitive policies for regulation of CNSs and 2) obtain products and services.

- FTC should also address appropriate boundaries on association conduct related to policy that enhances their own ability to create, structure or limit the market for providing services to that government entity.