



NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

April 30, 2014

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Ave., NW
Washington, DC 20580

RE: Health Care Workshop, Project No. P131207

Via Commission Website - <http://www.ftc.gov/os/publiccomments.shtm> and /or
<https://ftcpublishcommentworks.com/ftc/healthcareworkshop>

Honorable Secretary Clark,

On behalf of the 70,000 clinical nurse specialists in the country, the National Association of Clinical Nurse Specialists (NACNS) is pleased to respond to Federal Register Notice *FR Doc. 2014-03765* published February 24, 2014. Clinical Nurse Specialists (CNSs) is one of the four advanced practice registered nurse roles (APRN). CNSs are licensed registered nurses who have graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist. They have unique and advanced level competencies that can meet the increased needs of improving quality and reducing costs in our healthcare system. They are leaders of change in health organizations, developers of evidence-based programs to prevent avoidable complications, coaches and direct care providers of those with chronic diseases to prevent hospital readmissions, facilitators of teams in acute care and other facilities to improve the quality and safety of care, including preventing hospital acquired infections and reducing length of stays. In addition, growing numbers of CNSs are providing Medicare Part B services to beneficiaries and have prescriptive privileges in most states.

NACNS applauds the Commission for their interest in the competitive implications of professional regulation in health care. We are providing comments in hopes to assist the Commission informing itself of new ways in which professional regulations governing the scope of practice for health care providers may affect competition. Professional regulation plays a critical role in patient protection, patient safety, maintenance and improvement of quality of care, and can help inform consumers about the health care practitioners they are choosing. But, in efforts to provide this public service, regulatory bodies may tip the balance to the side of over regulation. Over regulation restricts the ability of any provider to practice to the full extent of their training and can exclude them from important practice environments. This can occur between provider groups, such as physicians and non-physician providers, and also between providers within the same the same professional category. NACNS supports the comments made by the general nursing community in regards to our concern about the current political and regulatory environment that is driving the practice restrictions for all APRNs and other non-physician health care professionals. In response to the questions posed by the FTC, we will limit our comments to the unintended consequences of efforts of the APRN community to respond to these external challenges,

specifically with the adoption of the [Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education](#).

Questions Posed by NCSBN We Will Address:

- **What recent developments have occurred in the regulation of health care professionals, particularly with respect to accreditation, credentialing, licensure, and supervision/cooperation requirements?**
- **What are the consequences of such regulations? To what extent are these regulations necessary to protect consumers or serve other important state interests? How do they affect the supply of services, patient safety, costs, care coordination, and quality of care?**
- **Is there evidence that quality of care is improved when professional regulations are narrowly tailored to protect patient safety while facilitating greater deployment of non-physician or non-dentist health care professionals?**
- **Do professional regulations affect staffing decisions at health care facilities? If so, how?**
- **To what extent might professional regulations unnecessarily restrict the scope of practice of non-physician or non-dentist health care professionals?**
- **What is the relationship between professional regulations and competition? Would changes to professional regulations enhance competition among health care providers? If so, what changes would be desirable?**
- **What is the relationship between professional regulations and access to care, especially for vulnerable and underserved patient populations?**
- **To what extent do professional regulations vary by state? Does state-by state variation affect patient health, health care spending, or other important measures?**
- **How do current regulations concerning licensure and credentialing affect the ability of health care professionals to relocate or practice in more than one geographic area, particularly across state lines?**
- **Would greater state-to-state licensure portability improve competition? What affect reimbursement for health care services? Do professional regulations lead to reimbursement policies that reduce incentives for health care competition?**
- **What is the relationship between accreditation of education programs and professional regulation? To what extent do accreditation standards affect competition? Would changes to accreditation standards enhance competition among health care providers? If so, what changes would be desirable?**
- **Are there other factors that should be considered when analyzing the competitive implications of professional regulation in health care.**

In an effort to advance the APRN role and improve continuity of practice from state to state, the nursing community engaged in an effort to develop a practice model that addressed legislation, accreditation, certification and education. The model that resulted from this work is known as the [Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education](#), (APRN Consensus Model) which was released July 7, 2008. The model for APRN regulation that is articulated in this publication is considered the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The foundational work began in

the 1990's as APRN and other nursing stakeholder organizations struggled to find a solution to the barriers found across the nation to APRN's practicing to the full scope of their practice. The state licensing and regulatory framework did not allow and still does not allow easy movement of APRNs from state to state. NACNS did endorse this model in hopes that this would provide opportunities to work with the colleague nursing organizations to work out the challenges facing the CNS role.

This model was developed prior to the advent of health care reform and while it in large part meets the goals established by the multiple groups working on the framework, it was reflective of the best thinking at the time. However, a number of the changes required in the APRN Consensus Model were not analyzed for the impact on competition, needed supply of APRN skills under the Affordable Care Act and the impact on consumers, particularly underserved and other groups. Some of the decisions made through development and implementation of this model has the impact of decreasing access of patients to high quality, experienced nurse providers. This effort to allow APRNs to compete better nationally with physicians in the current challenging environment has therefore unintentionally resulted in barriers for some of the APRN categories of providers. Among other significant changes, the APRN Consensus Model:

- Established the number of hours and required certain courses of study for the APRN;
- Established a new philosophy of education and certification based on population groups (adult health/gerontology, family/individual across the lifespan, psychiatric/mental health, pediatric, neonatal and women's health/gender specific) rather than traditional specialty as is utilized by other provider groups.
- Required a certification examination based on this new population for all APRN groups, despite the fact that certification examinations based on these new populations were not yet available for all APRN groups.

The stated goals of this work 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.

Impact of CNS Role to Date

The APRN Consensus Model was developed by nursing organizations that represented all four APRN roles, the state board regulators, the accreditors and the certifiers. The process has taken many years – beginning somewhere around 2002 or 2003 and is not yet completed. While the document that represented the APRN Consensus Model was ~~was~~ published in 2008, only 8 states have fully adopted changes to legislation and regulation that would allow them to come into alignment with the consensus requirements.

The APRN Consensus Model requires a significant education and certification change. Under the Model, the CNS will be educated based on role and population. Historically, as discussed earlier, the CNS education has been based on role and specialty. States have licensed APRNs differently, but the most common model for the CNS has been the acceptance of specialty certification, when it was available, as recognition for licensure.

The most significant national change that the APRN Consensus Model brings to state licensure is an approach that has a radical impact on the CNS – adoption of population-based certification for licensure rather than specialty based certification for licensure. In the past, many states accepted specialty certification, when it was available, as recognition for licensure. Under the APRN Consensus Model, the requirement will be for national certification based on role and population. There are currently six population groups noted in the APRN Consensus Model: Adult/Gerontology, Pediatrics, Neonatal, Psychiatric/Mental Health, Family/Individual Across the Lifespan and Women’s Health/ Gender Specific. Currently, the only national population-based certification exams available for the clinical nurse specialist are the Adult/Gerontology, Neonatal and Pediatrics. This means that any CNS whose practice most closely identifies with the Psychiatric/Mental Health, Family/Individual Across the Lifespan and Women’s Health/Gender Specific will not have a national certification examination to take for licensure.

There is no established date on the availability of other population certification exams for the clinical nurse specialist role. NACNS is working with certifiers and leaders within the APRN Consensus Model community to lay the groundwork for additional national population certification exams for the CNS. NACNS has developed Family/Individual Across the Lifespan clinical nurse specialist competencies and we are collaborating with the Association of Women’s Health, Obstetric and Neonatal Nurses to develop Women’s Health/ Gender Specific competencies. These projects are a huge investment in time and money but will provide the building blocks for future national population certification exams.

The certifiers are limited in the tests they can develop based on the criteria of their certifying bodies. Therefore, they require a certain number of individuals who are available to take the examination and must invest in studies prior to the development of an exam. No other option than the population-based certification examination has been offered for non-physician providers that fall into the population category that has no exam.

Economic Impact

The clinical nurse specialists, a well-established APRN role, has been the most severely impacted by the changes established in the APRN Consensus Model. There was no analysis or discussion of the economic impact of the adoption of licensure based on population certification exams rather than the many currently established specialty exams. This shift in philosophy has had a huge impact on the economic, educational and employment landscape for the CNS. Since 2008 we have seen:

- Closure of CNS programs that were based on specialty;
- The adoption of a population vs specialty education and certification model has resulted in the closure of CNS education programs and confusion over the practice and future of the CNS role and potential loss of employment for certain categories of CNSs
- Loss of jobs by employers because the CNSs they employed would not be eligible to take the population-based certification examination;
- State boards continuing to debate how they will grandfather currently employed CNSs. Some states have indicated that they will not accept a CNS, despite years of successful practice, unless they return to school and take the new, population-based program of study and pass a population-based certification exam for licensure.
- Despite the limited number of states that have adopted the APRN Consensus Model components to date – the certifiers have eliminated (retired) their certification examinations that coincided with prior educational preparation and are requiring all graduates to meet the new educational requirements.

- One category of CNSs – the Women’s Health CNS – has practiced successfully for years to meet the needs of women and infants. These groups of CNSs, originally seen as a specialty area for practice, have had no advanced practice-level specialty certification exam available. There is a certification examination in their specialty available for the registered nurse level of practice, but none for those at the graduate level. With the adoption of the APRN Consensus Model, this category of CNSs are left in a situation where their specialty is now considered a population – and all certifying organizations have declined, for business reasons, to pursue a certification exam for this provider. As of this date, the nongovernmental, group of organizations called “LACE” has not dealt with this issue. There has been an articulated understanding that the components of the APRN Consensus Model will not be altered in any way. Therefore, the adoption of a different mechanism of assessment for licensure has been declined by the “LACE” group. As a result, a critical sector of the state – unserved and underserved women and infants are left without access to women’s health clinical nurse specialists. These providers work directly within facilities and communities to decrease maternal and infant morbidity and mortality.
- This model has radically changed the entire education and certification/licensure environment for the clinical nurse specialist, a category of APRNs that state disciplinary and malpractice insurance claims show minimal claims or concerns.
- Endorsement and grandfathering recommendations were recently announced by the National Council of State Boards of Nursing (NCSBN) and is still being analyzed. This complex set of recommendations appears to provide numerous scenarios for requirements of an APRN if they move from one state to another state. A number of these recommendations put excessive financial and educational burdens on providers who have been practicing safely in their state for many years. These recommendations were released on April 21, 2014 and are still being analyzed. In an effort to implement uniformity rapidly, some of these recommendations appear to restrict the ability of APRNs to practice to the full extent of their training.

Under the previous individual state model, many states accepted specialty certification, when it was available, as recognition for licensure. As the APRN Consensus Model legislation is being considered, it is important to recognize that only 8 states have fully adopted its components. As we enter our third year of advocacy for these legislative and regulatory changes, it is becoming clear that adoption of the APRN Consensus Model may be slower than originally anticipated.

1. Certifiers are businesses and have no requirement to develop the needed tests.
2. During the development of the model – it was indicated that these issues would be worked out in implementation
3. NCSBN recently presented a recommended policy that would ask states to only approve endorsement for CNSs that have taken in the past and are currently nationally certified by an exam that was designed for the advanced practice level. This includes prior population exams as well as specialty exams.
4. During implementation the leadership of the LACE group (self-appointed volunteer group that is comprised of organizations that participated in development of the model) have determined that they will not agree to changes in the model at this point.
5. Nursing schools that prepare the CNS closed programs for a number of reasons but it is a common theme that the unknown and confusing future of CNS licensure and regulation is part of these decisions.
6. No proof through medical malpractice and/or state disciplinary actions that show that the CNS is unsafe –they have successfully practiced as a specialty based APRN group for years.

7. All APRN groups except NACNS have a certification arm – NACNS has never developed this entity.
8. All nursing certifiers have indicated their reluctance to pursue certification exams under the other stated population categories due to the cost of the examination development and the requirements from their certifying examiners to have a legally defensible certification exam. At the same time, the certifiers will not support the use of alternate certification approaches, such as portfolio development for CNS population examination.
9. There is no economic model available to estimate the cost for changes brought by the APRN Consensus Model.
10. There are no plans for the LACE organizations to engage in an evaluation of the model to see if the stated goals have been reached.

New Models of Health Care

In response to the ever-changing health care environment, new health models for health care delivery, creating additional competition for health services. New health models such as retail health clinics, increase competition for health care services and can bring significant cost savings and improve the quality and safety of health care delivery. Currently, retail clinics utilize different providers depending on the intensity of the visit. You will find nurse practitioners and physician assistants as well as pharmacists, nurses and nurse aides.

Convenience brings clients to retail clinics – and often this convenience makes loyal customers of retail clinic customers. The focus of retail clinics is primary care but may in the future expand to include primary and ongoing care of the chronically ill patient. This would include potentially clinics for diabetes care, hypertension follow up care, medication reviews and counseling for cardiac patients and/or others with serious, but stable diseases. As the retail clinics branch into this area of care, it would be reasonable to see the clinical nurse specialist (CNS) move into this health care environment. Clinical nurse specialists are experts in a clinical specialty and provide care through the continuum of wellness and illness. This can include primary care services for chronically ill patients. We can see the trend toward the care of the chronically ill patient as the most common reason families visit a retail clinical include a new illness or unfamiliar symptom, vaccination, prescription renewal, a physical exam and ongoing care for a chronic condition.

As the focus of the retail clinics shifts, it will be important to ensure that unneeded barriers are not put in place to exclude the CNS from this important care model.

Thank you for the opportunity to provide comments regarding competition in the health care market. NACNS supports other organizations that focused their comments on the interdisciplinary competition issues with physicians and APRNs and other health care professionals. We were pleased to have the opportunity to provide comments on how the struggle to achieve an equal competitive platform for APRNs and physicians, the nursing community has developed and is implementing a new model that changes accreditation, certification, and education. This strategy was well intended, working to ease the issues of APRN recognition across state lines and provide some common educational requirements to support the pursuit of prescriptive authority for these providers. Unfortunately, this multi-faceted Model has resulted in many unintended consequences that have an economic impact of different sectors of the APRN community, but most intensely impact the clinical nurse specialist role.

Thank you for the opportunity to provide these comments. Feel free to contact Melinda Ray, MSN, RN, Executive Director at mray@nacns.org or Jason Harbonic, Managing Director at jharbonic@nacns.org if you have further questions.

Sincerely,

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President

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