

**CNS Position Statement on the APRN Compact**

Jaclyn Wiggins

A project submitted

in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

Seattle Pacific University

May 30, 2024

## **CNS Position Statement on the APRN Compact**

### **Background**

The intent of the Advanced Practice Registered Nurse (APRN) Compact is to create a multistate license for APRNs allowing for practice across state lines for both in-person and telehealth visits (National Council of State Boards of Nursing [NCSBN], 2024a). The aims of a multistate license include greater mobility for APRNs, increased access to care for patients, reduced licensing costs and redundancies, and protection of the public through standardized licensure requirements between party states. The National Council of State Boards of Nursing (NCSBN), the driving force behind the APRN Compact, revised the Compact language in 2019 and approved the current version in August 2020 in a third attempt to move the APRN Compact forward (American Association of Nurse Practitioners, 2022). As of May 2024, four states have enacted the APRN Compact (DE, ND, SD, and UT) and two states have pending legislation (AZ and MD) (NCSBN, 2024a). Seven states must enact legislation for the Compact to take effect.

### **Position**

NWCNS opposes adoption of the proposed 2020 APRN Compact and echoes the concerns raised by many Nurse Practitioner professional organizations including the 2,080-practice hour requirement and the concern the Compact commission does not include APRNs (ARNPs United Washington State, n.d.; American Association of Nurse Practitioners, 2023). However, there are additional issues unique to CNS practice that the APRN Compact fails to address.

The APRN Compact fails to address the disparities among states that do not recognize CNSs as APRNs or do not grant CNSs prescribing authority. NWCNS supports an APRN multistate license in theory, however, in states such as ID, OR, and WA where CNSs are licensed as APRNs with full practice and prescribing authority, the APRN Compact's vague language and failure to address these variations in party states without full practice scope threatens the full-practice authority that has been hard fought and raises questions about patient safety and legal issues about practicing in party states where full practice authority is not assured.

To be eligible for a multistate license, the APRN Compact requires APRNs to have graduated from an accredited graduate-level educational program in one of four APRN roles (certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP)), pass and maintain a national APRN certification, meet all home state licensing requirements, and have 2,080 APRN practice hours (NCSBN, 2024a). The APRN Compact's key provisions also specify that the multistate license holder can practice without a collaborative relationship with a physician and authorizes prescriptive authority for non-controlled substances, but defers to the individual state laws for prescribing controlled substances (NCSBN, n.d.). The APRN Compact also establishes a commission of administrators to oversee its management.

### **Supporting Information**

#### **Relevant Issues**

The APRN Consensus Model identifies four advanced practice nursing roles (Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA) and Clinical Nurse Specialist (CNS)) and validates that APRNs are ready for full practice authority at the time of graduation and successful board certification (NCSBN, 2024b). Despite the NCSBN's support of the APRN Consensus Model, the APRN Compact makes no mention of the Consensus Model as the standard for all party states joining the Compact and does not allow APRNs to practice to the full extent of their education and training. For Nurse Practitioners (NPs), this contradiction is demonstrated by the APRN Compact deferring controlled substance prescribing to state law instead of allowing for full practice authority and the 2,080 practice hour requirement prior to multistate licensure (NCSBN, n.d.). For CNSs, the practice implications of the APRN Compact extend much further.

The variability of APRN practice authority between states has a more significant impact for CNSs than for NPs. The four APRN Consensus Model roles are not recognized in all 50 states and U.S. Territories (NCSBN, 2024b; NCSBN, 2024c). The CNS role is not recognized as an APRN in Mississippi, New Hampshire, New York, Pennsylvania or American Samoa (see Appendix A) (New York State Education Department, n.d.; NCSBN, 2023b). In contrast, NPs are recognized as APRNs in all 50 states and five U.S. Territories (NCSBN, 2024c). Prescriptive authority for NPs is also well established and recognized in all U.S. states and Territories, although not all states allow NPs to prescribe independently (see Appendix B) (NCSBN, 2023a). Conversely, CNS do not have any prescriptive authority in eight states (AL, CA, MA, ME, NC, NE, PA, SD) (Commonwealth of Massachusetts, 2024; NCSBN, 2023c). The APRN Compact language fails to address these practice disparities for the CNS.

The APRN Compact language in Article III section h states that an APRN with a Compact license can practice without collaboration or supervision (NCSBN, 2020). Yet in section j, requires APRNs practicing in party states to follow all state practice laws, “except as otherwise expressly provided in this Compact” (NCSBN, 2020, p.6). The vague language of section h makes it unclear if NPs practicing and prescribing in party states that require collaborative agreements can ignore state law and practice independently. This is even more unclear for the CNS. The Compact fails to address the issue of states that do not recognize CNSs as APRNs or allow CNSs any prescriptive authority. CNSs in home states such as ID, OR, and WA have full practice and full prescriptive authority (Oregon State Board of Nursing, 2022). How would these CNSs navigate practicing in a party state that does not recognize the CNS as an APRN or allow for CNS prescribing? This puts CNS at risk and the onus on the APRN to

know each individual party states' law to ensure they are not practicing outside their scope of practice for that state.

There are also disparities between the number of board examination options for CNSs compared to NPs. NPs have five different certification boards to choose from with each board offering several different board exam options based on specialty population (American Association of Nurse Practitioners, 2024). CNSs have only two certification boards offering CNS board certifications, the American Nurses Credentialing Center (ANCC) and the American Association of Critical-Care Nurses (AACN), with only a total of four certification exam options (AACN, n.d.; ANCC, n.d.)

### **Patient Safety**

The variations in CNS practice authority nationally also raise questions about patient safety. For CNSs that graduated and completed their clinical practicum experiences in home states that do not have any prescriptive authority, but could through the APRN Compact, prescribe in party states that have full prescriptive authority, what measures are put into place to protect the public? The APRN Compact does not address this or take steps to validate that CNSs from home states with scope limitations have the knowledge and experience to safely prescribe in full practice authority states. The APRN Compact must be revised to acknowledge and address these inconsistencies in CNS practice authority. Failure to do so conflicts with the APRN Consensus Model and allows variation of practice standards across states to continue, holding CNS practice further back, which impedes the optimization of patient care.

### **Fiscal Impact of CNSs**

By failing to address the disparities or remove barriers to CNS practice across the country, the APRN Compact is missing the value the CNS brings to the healthcare system.

Unlike NPs, who primarily generate revenue through the provision of direct patient care and fee-for-service billing, CNSs produce financial benefit through evidence-based interventions that lead to cost avoidance and improved patient outcomes. Three examples of CNS-led interventions resulting in cost avoidance were noted in the literature. One CNS team at an academic 700-bed medical center in the northeastern United States developed a CNS scorecard to standardize and evaluate the fiscal impact of CNS-led projects and programs (Toth et al., 2024). At the end of FY'22, the CNSs had generated a revenue totaling \$29,890 for their facility and demonstrated a cost avoidance of \$2,854,807.30.

Further demonstration of CNS-led cost avoidance occurred in a step-down unit experiencing a high rate of falls. Falls among patients ages 65 and older totaled \$50 billion in 2015 (Florence et al., 2018). Implementing an evidenced-based fall prevention program has been associated with a total cost avoidance of \$14,600 per 1000-patient days of care (Dykes et al., 2023). To combat this costly healthcare problem, a CNS deployed a unit intervention to improve compliance with fall prevention interventions for high-risk patients. In one quarter, compliance with fall prevention interventions increased from 63% to 83% and falls in the unit steadily decreased over three years from 19 in 2019 to 5 in 2021, representing a 74% decrease in the number of falls (Little, 2024).

Another study demonstrated cost avoidance by implementing a CNS-led tracheostomy care management program for patients with new tracheostomies (Richardson et al., 2023). The CNS-led care resulted in a statistically significant decrease in time between tracheotomy placement and discharge, from 16 days down to 12.9 days ( $P = .02$ ). Reductions in overall length of stay and tracheotomy-related pressure injuries were seen as well, resulting in an estimated cost savings of \$2.2 million (Richardson et al., 2023).

The evidence from the literature demonstrates the CNS's positive fiscal impact on the healthcare system. When CNSs are recognized as APRNs and full practice scope supported, the results are demonstrable cost savings to the healthcare facility and improved patient outcomes. The importance of the CNS role must be recognized and supported in the APRN Compact language.

### **Recommendations/Next Steps/Call for Action**

- The APRN Compact must be revised and expressly state the APRN Consensus Model as the standard by which all party states joining the Compact must adhere to, which includes title recognition as an APRN, independent practice and independent prescribing for all four APRN roles to include the CNS.
- The NCSBN should target APRN Compact legislation in states with full practice authority that follow the APRN Consensus Model.
- CNS professional groups should publish position statements in opposition to this version of the APRN Compact to highlight the implications and significant impact on the CNS.
- CNSs must be recognized as key stakeholders when the APRN Compact is revised so that practice issues specific to the CNS are addressed.
- CNS professional organizations must call upon the NCSBN to support APRN-CNS full practice authority in all 50 states and U.S. Territories.
- CNSs in Washington State should consider joining the Washington State Board of Nursing (WABON) Advanced Practice Subcommittee that is currently looking to establish a workgroup to advance the recommendations of the APRN Compact Workshops that were held earlier this year to ensure the CNS voice is heard and included in this work (WABON, 2024).

## **Conclusion**

Clinical Nurse Specialists should support an APRN multistate license in theory, however, the current version of the APRN Compact has vague language that fails to address the variations of CNS practice in several states which threatens full-practice authority for the CNSs working in states with independent practice. Until the APRN Compact language is revised to address these issues, the Compact cannot be supported.

## References

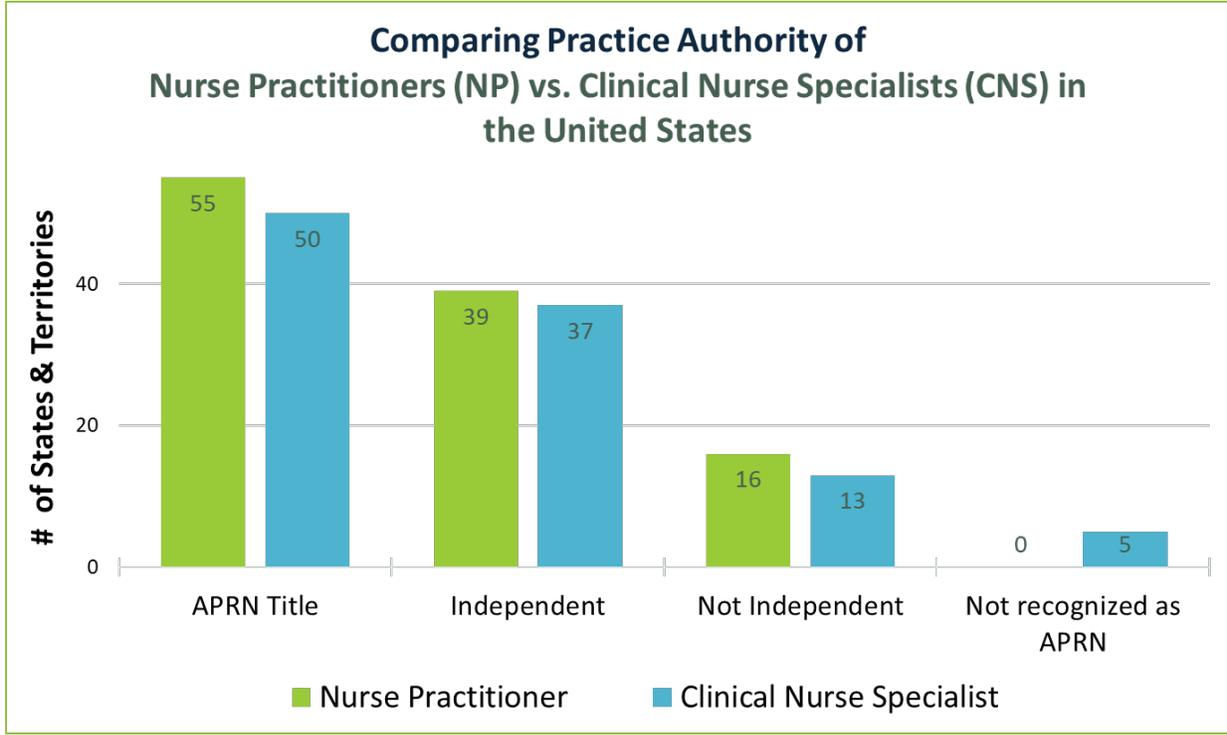
- American Association of Critical-Care Nurses [AACN]. (n.d.). *Initial certifications*.  
<https://www.aacn.org/certification/get-certified>
- American Nurses Credentialing Center [ANCC]. (n.d.). *Our certifications*.  
<https://www.nursingworld.org/our-certifications/?q=CNS&Filter=Apply+today#FilterForm>
- American Association of Nurse Practitioners [AANP]. (2022, May 18.) *Proposed APRN compact: Concerns and considerations* [Video]. YouTube.  
<https://www.youtube.com/watch?v=fV9sowEUIIE>
- American Association of Nurse Practitioners [AANP]. (2023). *APRN compact licensure: The American Association of Nurse Practitioners® (AANP) opposes the revised APRN compact*. <https://www.aanp.org/advocacy/advocacy-resource/position-statements/aprn-compact-licensure>
- American Association of Nurse Practitioners [AANP]. (2024). *Nurse practitioner (NP) certification: Recognize your education, skills and professional expertise*.  
<https://www.aanp.org/student-resources-old/np-certification>
- ARNPs United Washington State [AUWS]. (n.d.) AUWS opposed the APRN compact.  
<https://auws.enpnetwork.com/page/38397-auws-opposes-the-aprn-compact>
- Commonwealth of Massachusetts. (2024). *Learn about advanced practice registered nurses (APRN)*. <https://www.mass.gov/info-details/learn-about-advanced-practice-registered-nurses-aprn>
- Dykes, P. C., Curtin-Bowen, M., Lipsitz, S., Franz, C., Adelman, J., Adkison, L., Bogaisky, M., Carroll, D., Carter, E., Herlihy, L., Lindros, M. E., Ryan, V., Scanlan, M., Walsh, M.

- Wien, M. & Bates, D. W. (2023). Cost of inpatient falls and cost-benefit analysis of implementation of an evidence-based fall prevention program. *JAMA Health Forum*, 4(1), 1-11. <https://doi.org/10.1001%2Fjamahealthforum.2022.5125>
- Florence, C. S., Bergen, G., Atherly, A., Burns, E., Stevens, J., & Drake, C. (2018). Medical costs of fatal and nonfatal falls in older adults. *Journal of the American Geriatrics Society*, 66(4), 693–698. <https://doi.org/10.1111/jgs.15304>
- Little, K. (2024). Intervention confirmation: A method to increase implementation of fall prevention interventions. *Clinical Nurse Specialist*, 38(1), 49-52. <https://doi.org/10.1097/NUR.0000000000000798>
- National Council of State Boards of Nursing [NCSBN]. (n.d.) *APRN compact: Key provisions*. [https://www.aprncompact.com/files/APRN\\_Key\\_Provisions-2022.pdf](https://www.aprncompact.com/files/APRN_Key_Provisions-2022.pdf)
- National Council of State Boards of Nursing [NCSBN]. (2020, August 12). *Advanced practice registered nurse compact*. [https://www.aprncompact.com/files/FINAL\\_APRNCompact\\_8.12.20.pdf](https://www.aprncompact.com/files/FINAL_APRNCompact_8.12.20.pdf)
- National Council of State Boards of Nursing [NCSBN]. (2023a, May 22). *CNP independent prescribing map*. <https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/cnp-independent-prescribing-map.page>
- National Council of State Boards of Nursing [NCSBN]. (2023b, June 8). *CNS independent practice map*. <https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/cns-independent-practice-map.page>
- National Council of State Boards of Nursing [NCSBN]. (2023c, June 8). *CNS independent prescribing map*. <https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/cns-independent-prescribing-map.page>

- National Council of State Boards of Nursing [NCSBN]. (2024a). *APRN compact: The best way forward*. <https://www.aprncompact.com/about.page>
- National Council of State Boards of Nursing [NCSBN]. (2024b). *APRN consensus model*. <https://www.ncsbn.org/nursing-regulation/practice/aprn.page>
- National Council of State Boards of Nursing [NCSBN]. (2024c, January 17). *APRN roles map: APRN roles recognized*. <https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/aprn-roles-map.page>
- New York State Education Department. (n.d.). *Frequently asked license questions for clinical nurse specialists*. <https://www.op.nysed.gov/professions/clinical-nurse-specialists/faqs>
- Oregon State Board of Nursing. (2022, October 24). *Interstate or cross jurisdictional practice of nursing: APRN cross walk*. [https://www.oregon.gov/osbn/Documents/Resource/APRN\\_InterstateCrosswalk.pdf](https://www.oregon.gov/osbn/Documents/Resource/APRN_InterstateCrosswalk.pdf)
- Richardson, J., Girardot, K., Powers, J., & Kadenko-Monirian, M. (2023). Clinical nurse specialist tracheostomy management improves patient outcomes. *Journal of Nursing Care Quality*, 38(3), 251-255.
- Toth, C., Miller, K., Hart, A., & Kidd, M. (2024). Clinical nurse specialist role advocacy: Quantifying the financial contributions via development of a scorecard. *Clinical Nurse Specialist*, 38(2), 91-97. <https://doi.org/10.1097/NUR.0000000000000802>

### Appendix A

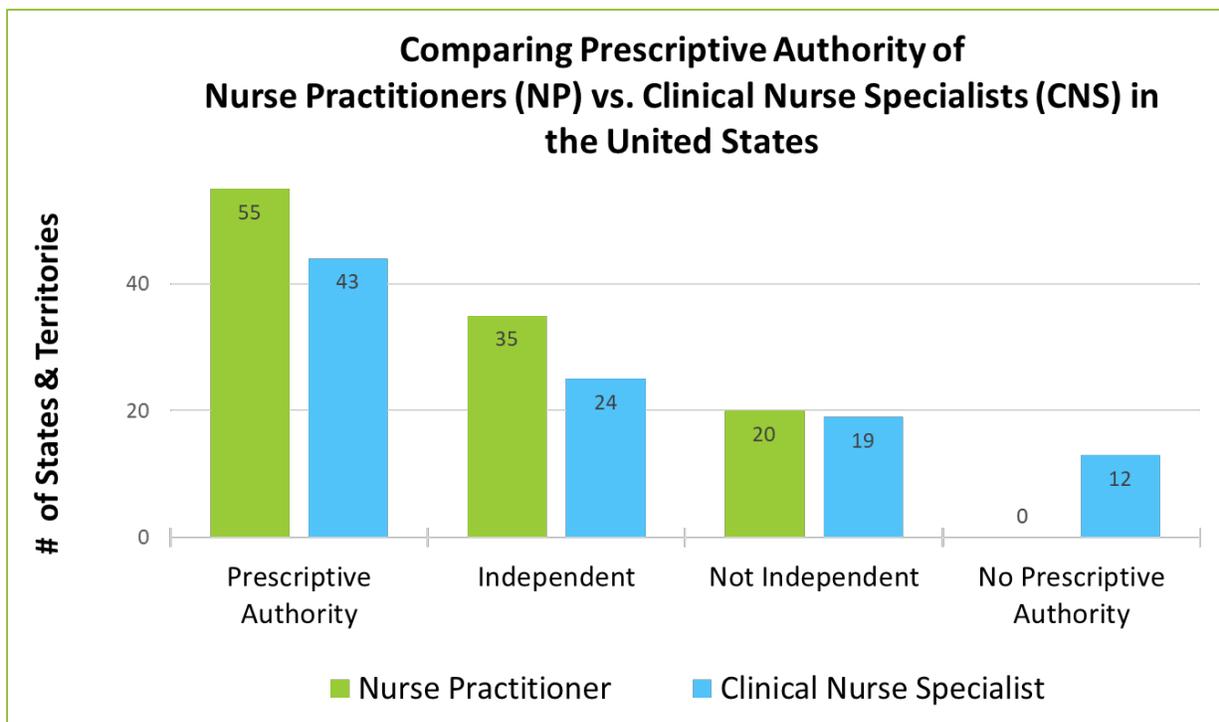
#### Comparing the Practice Authority of Nurse Practitioners (NP) vs. Clinical Nurse Specialists (CNS) in the United States



*Note.* Comparison of the practice authority of Nurse Practitioners (depicted in green) versus Clinical Nurse Specialists (depicted in blue) in the United States. Fifty U.S. states and 5 U.S. territories were reviewed for n = 55.

## Appendix B

### Comparing the Prescriptive Authority of Nurse Practitioners (NP) vs. Clinical Nurse Specialists (CNS) in the United States



*Note.* Comparison of the prescribing authority of Nurse Practitioners (depicted in green) versus Clinical Nurse Specialists (depicted in blue) in the United States. Fifty U.S. states and 5 U.S. territories were reviewed for  $n = 55$ .