Washington State Board of Nursing (WABON)
Advanced Practice Subcommittee Meeting Agenda
July 17, 2024 7:00 p.m. to 8:00 p.m.

Join the Meeting
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United States: +1 (253) 205-0468
Meeting ID: 828 7004 9914
Passcode: 700935

Committee Members:	Ajay Mendoza, CNM, Chair Bliss Ali, RN, MN, ARNP, CNM, MPH Wendy E. Murchie, DNP, CPNP-AC Bianca Reis, DNP, MBA, ARNP, PMHNP-BC Michelle Dedeo, DNP, ARNP-CNS, ACCNS-AG, CCRN, CNRN, SCRN Cyd Marckmann, DNP, ARNP Jeffery Ramirez, Ph.D., PMHNP, CARN-AP, CNE, FNAP, FAANP, FAAN Molly Dutton, MS, MN, ARNP-BC Aaron Eastman, DNP, CRNA, ARNP Kelli Camp, MSN, CRNA, ARNP
Staff:	Mary Sue Gorski, PhD, RN, Director, Advanced Practice and Research Lohitvenkatesh Oswal, Research Assistant Heather Hamilton, Research Assistant

Questions
Please contact us at (564) 669-3933 if you:
- have questions about the agenda.
- want to attend for only a specific agenda item.
- need to make language or accessibility accommodations.

Language and Accessibility
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Meeting Minutes

To request this document in another format, call 1-800-525-0127.
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WABON records meetings to help write accurate minutes. Minutes are then approved at the WABON business meeting. WABON posts minutes on our website nursing.wa.gov.

All minutes and recordings are public record. They are available on request from DOH at doh.wa.gov/about-us/public-records. The minutes of this meeting will be posted on our website after they have been approved at the **September 13, 2024** WABON meeting.

If attending remotely, please mute your connection in order to minimize background noise during the meeting. Comments from the public will be taken at the end of the meeting. Use the question box on the meeting control panel to submit questions.

I. 7:00 PM Opening – Ajay Mendoza, Chair
Call to order

- Introduction
- Public Disclosure Statement
- Roll Call

II. Standing Agenda Items

- Announcements/Hot Topic/WABON Business Meeting Updates
- Review of Advanced Practice Draft Minutes: April 17, 2024

III. Old Business

- AP Compact updates

IV. New Business

- New Opioid Dosing law
- CNS Position Statement on APRN Compact (Jaclyn Wiggins)

V. Ending Items

- Public Comment
- Review of Actions
- Meeting Evaluation
- Date of Next Meeting – August 21, 2024
- Adjournment – 8:00 PM or Earlier if Business is Finished

Washington State Board of Nursing (WABON)
Advanced Practice Subcommittee Meeting Minutes
April 17, 2024

Subcommittee Members Present:	Ajay Mendoza, CNM, Co-Chair Michelle Dedeo, DNP, ARNP-CNS, ACCNS-AG, CCRN, CNRN, SCRN Cyd Marckmann, DNP, ARNP Molly Dutton, MS, MN, ARNP-BC Wendy E. Murchie, DNP, CPNP-AC Bianca Reis, DNP, MBA, ARNP, PMHNP-BC Jeffery Ramirez, Ph.D., PMHNP, CARN-AP, CNE, FNAP, FAANP, FAAN
Absent:	Jonathan Alvarado, ARNP, CRNA, Co-Chair Emerisse Shen, MSN, CNP, FNP, ARNP Molly Altman, PhD, CNM, MPH, FACNM Kimberley A. Veilleux, DNP, RN, ANP-BC
Staff Present:	Mary Sue Gorski, PhD, RN, Director, Advanced Practice and Research Anthony Partridge, MPPA, Assistant Director of Regulatory Affairs Lohitvenkatesh Oswal, Research Assistant Jessilyn Dagum, Policy Analyst

I. 7:00 PM Opening – Ajay Mendoza, Co-Chair

Call to Order

- Ajay Mendoza called the meeting to order at 7:00 PM. The Advanced Practice Subcommittee members and support staff were introduced. The Public Disclosure Statement was read aloud for the meeting attendees.

II. Standing Agenda Items

- Announcements/Hot Topic/WABON Business Meeting Updates
  - Mary Sue Gorski introduced Ajay Mendoza as Co-Chair for the Advanced Practice Subcommittee.
  - Mary Sue Gorski gave an update on the AP Compact recommendations workgroup and asked for more volunteers to serve on the workgroup.
- Review of Advanced Practice Draft Minutes: February 21, 2024
  - Reviewed, with consensus to bring to the July 11, 2024 WABON business meeting for approval.

III. Old Business

- APRN Title Change
  - Ajay Mendoza and Mary Sue Gorski gave updates on this item and answered questions from subcommittee.

IV. New Business

- ARNP Education Requirements Rule
  - Jessilyn Dagum gave an update on this item.
- Death Certifier Communication
  - Wendi Gilreath and Tricia Swanson spoke about the transition from EDRS to WHALES for death registration and communication efforts

regarding the change, and answered questions from the subcommittee.

V. Ending Items

- Public Comment
  - The public was given the opportunity to comment on the agenda items.
- Date of Next Meeting – May 15, 2024
- Adjournment – The meeting adjourned at 7:32 PM.

Advanced Practice Subcommittee Work Plan				
Strategic Action Goals	**Lead (s)**	**Type**	**Progress**	**Complete**
Immediate Goals				
1. Draft Work Plan and Annual Report	Staff	Administrative	The APSC and staff will create a work plan and annual report	
2. Advanced Practice information on New Website	Staff	Administrative	APSC review advanced practice information on the new website to make sure it is current and up to date.	
3. Advanced Practice Communication	Staff/ Chair	Administrative	Review what type of communication should be sent out to ARNPs in Washington State. • Licensing Welcome Message • Reminder about National Certification • Etc.	
Short Term Goals				
4. Review Membership & Plan for Leadership Transition	All	Administrative	Consider representation from each of four roles. Current pro-tem representatives with active term dates listed. Adult Nurse Practitioner (NP): Cyd Marckmann, 07/01/2024-6/30/2025; Molly Dutton, 07/01/2024-6/30/2025 Pediatric Nurse Practitioner (NP): Wendy E. Murchie, 07/01/2024-6/30/2025 Psychiatric-Mental Health Nurse Practitioner (NP): Bianca Reis, 07/01/2024-6/30/2025; Jeffery Ramirez, 07/01/2024-6/30/2025 Geriatric Nurse Practitioner (NP) Certified Nurse-midwife (CNM): Ajay Mendoza, 11/23/2022-06/30/2025; Bliss Ali, 07/01/2024-6/30/2025 Certified Registered Nurse Anesthetist (CRNA): Aaron Eastman, 07/01/2024-06/30/2025; Kelli Camp, 07/01/2024-6/30/2025 Clinical Nurse Specialist (CNS): Michelle Dedeo, 07/01/2024-6/30/2025	
Mid-Term Goals				
5. Advisory Opinion on Opening a Business	Staff/All	Subcommittee Review	Develop draft advisory opinion	
6. Acupuncture Advisory Opinion	Staff/All	Subcommittee Review	Develop draft advisory opinion	
7. Title change ARNP to APRN	Staff/All	Subcommittee Review	Title Change will be implemented June 30, 2027.	
8. Procedure to rule from JARRC recommendation	Staff/All	Subcommittee Review	The board approved JARRC recommendations in September. Interested Party focus groups through November.	
Long-Term Goals				
9. ARNP Rules	Staff/All	Subcommittee Review	The APSC is working on a few rule sets. Once those are completed an entire review of ARNP rules is needed.	
10. AP Compact education	Staff/All	Subcommittee Review	AP Compact recommendations workgroup is discussing implementation of recommendations from the AP Compact Education Brief approved by the Board on March 8, 2024.	

WA Board of Nursing

NOTICE OF NEW LAW RELATED TO PAID FAMILY MEDICAL LEAVE REQUESTS

May 3, 2024

NOTICE OF NEW LAW REQUIRING HEALTHCARE PROVIDERS TO RESPOND TO PATIENT REQUESTS FOR CERTIFICATION OF PAID FAMILY MEDICAL LEAVE WITHIN SEVEN (7) DAYS

Beginning June 6, 2024, healthcare providers, including nurse practitioners and certified nurse midwives, must submit certification of a serious health condition within seven (7) calendar days of receiving a patient request for certification. Such certification is required to qualify a patient for Paid Family Medical Leave benefits (Chapter 50A.15 RCW).

Health care facilities that require administrative review prior to allowing a provider to certify a serious health condition must implement and maintain policies and practices to ensure compliance with the seven-day requirement.

Providers licensed by the Department of Health must comply with this new law. Failure to provide certification and any related documentation within seven (7) calendar days as required may result in enforcement action related to unprofessional conduct (RCW 18.130.180(7)).

Questions

If you have any questions about this change, please contact WABONRules@doh.wa.gov.

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Important Updates to the Opioid Dose Calculator and Implications for Prescribers

Washington Medical Commission sent this bulletin at 06/28/2024 03:50 PM PDT

AMDG Implements Updated Opioid Dose Calculator to Align with Best Practices and Evidence-Based Guidelines

On February 1, 2024, the AMDG (Agency Medical Directors' Group) updated the Opioid Dose Calculator to reflect evolving best practices and evidence-based guidelines for opioid prescribing. The following changes were made:

- Updated hydromorphone conversion factor to 5
- Updated tramadol conversion factor to 0.2
- Added buprenorphine transdermal product with a conversion factor of 2.2

The WMC has received concerns about these changes, which increased the MED conversion rates for Tramadol, Hydromorphone, and Methadone. The primary worry is that stable patients might be unnecessarily tapered off their medications because prescribers may not be aware of the change in conversion calculations. This lack of awareness could lead to misunderstandings about the actual dosage patients are receiving, potentially resulting in inappropriate dose reductions and destabilization of patients who have been effectively managing their pain with their current medication regimen.

Actions Prescribers Should Consider:

- Familiarize themselves with these updates and carefully consider the implications for their patients.

- Communicate clearly with patients about any changes in their treatment plan is essential to avoid unintended consequences.
- Exercise caution when using these new conversion factors, as they reflect the latest clinical evidence and may result in different dosing recommendations compared to previous versions.
- Closely monitor patients for efficacy and safety, particularly during the transition to the updated calculator.

With this change, prescribers should be aware of the following:

- **Drugs count for more MED:** This means assigning a higher MED value to certain drugs, making them appear more potent or risky when calculating total opioid dosage.
- **Trigger a threshold response:** In many monitoring systems, there are thresholds of total MED that, when exceeded, prompt specific actions, such as increased monitoring, a warning to the prescriber, or an intervention to prevent potential overdose or misuse.

Conditions for an allopathic physician (MD) or physician assistant (PA) to consider tapering or referring the patient for a substance use disorder evaluation:

- Patient requests tapering.
- Deterioration in patient's function or pain.
- Noncompliance with the written agreement.
- Indication of other treatment modalities.
- Evidence of misuse, abuse, substance use disorder, or diversion.
- Severe adverse event or overdose.
- Unauthorized escalation of doses.
- Escalation in opioid dosage without improvement in pain or function.

Refer to WAC 246-919-950 for MDs and WAC 246-918-900 for PAs for detailed guidance.

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 Credentialling 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 demonstratable 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 Credentialling 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.) P*roposed 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

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

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

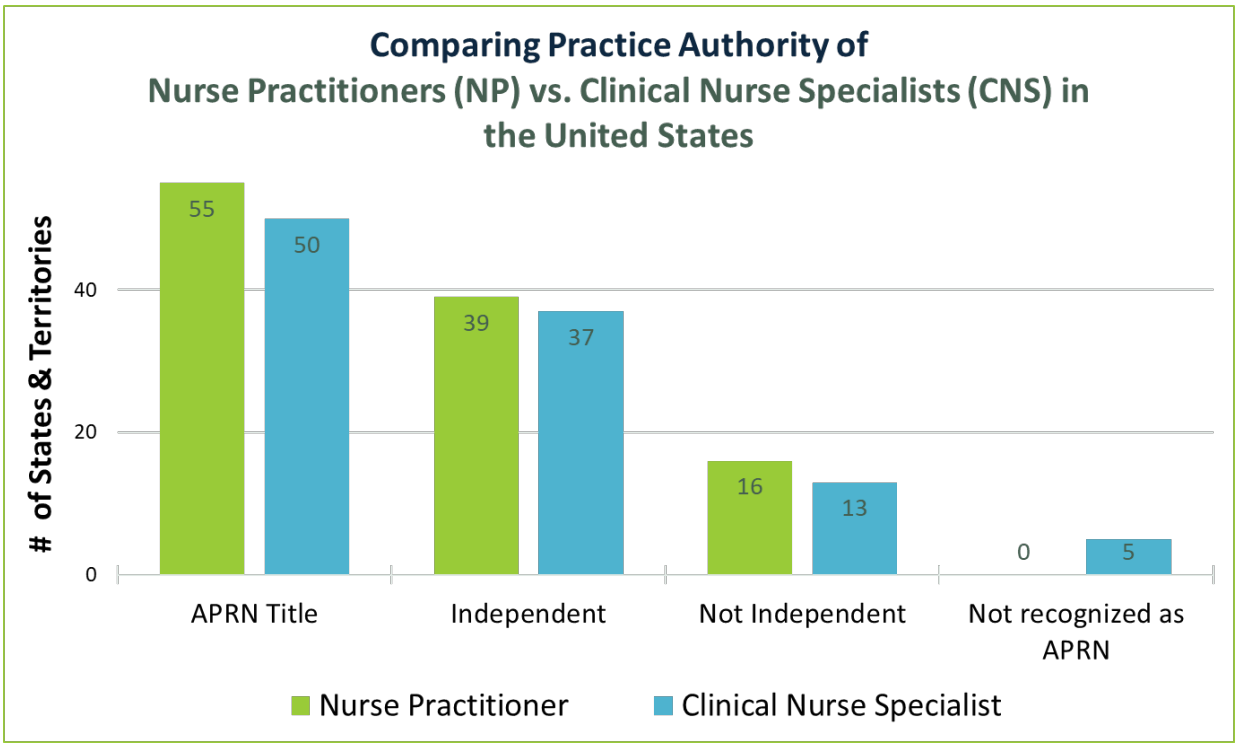
Oregon State Board of Nursing. (2022, October 24). *Interstate or cross jurisdictional practice of nursing: APRN cross walk.* https://www.oregon.gov/osbn/Documents/Resource_APRN_InterstateCrosswalk.pdf

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

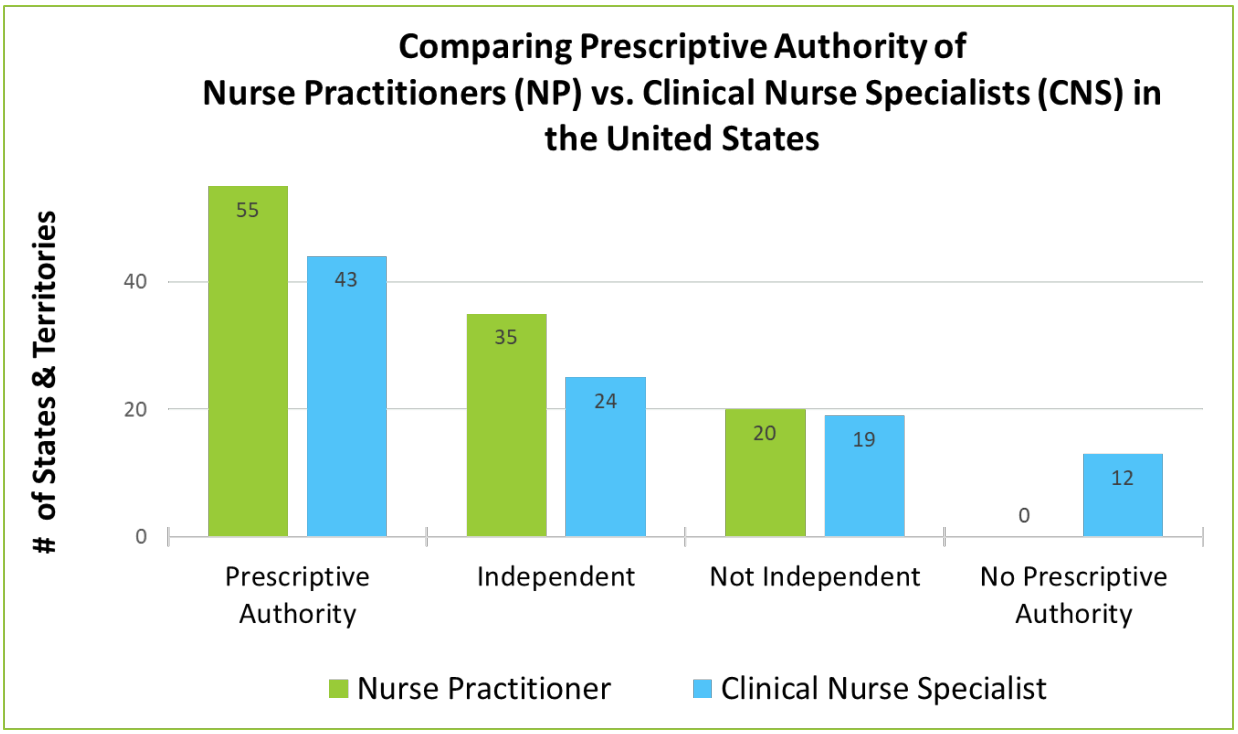
Comparing the Practice Authority of Nurse Practitioners (NP) vs. Clinical Nurse Specialists (CNS) in the United States



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.