Significant Legislative Rule Analysis
WAC 246-840-010 through WAC 246-840-420
Proposed rules amend advanced registered nurse practitioner requirements
To recognize clinical nurse specialist (CNS) and add licensure requirements for CNS.
October 5, 2015

Describe the proposed rule, including a brief history of the issue, and explain why the proposed rule is needed.

An Advanced Registered Nurse Practitioner (ARNP) is a registered nurse (RN) prepared in a formal educational program to assume primary responsibility for continuous and comprehensive management of a broad range of patient concerns and issues. An ARNP must be licensed as a RN. They have advanced academic and clinical training at the master’s or doctoral level. In Washington State, ARNPs are independent practitioners and provide medical and nursing care without physician oversight, supervision or collaborative agreements. Licensed ARNPs may prescribe controlled substances (Schedule II-V) and legend drugs and medical devices, may order therapies, and direct medical care of patients. There are currently 6,100 licensed ARNPs in the Washington State.

The Washington State Nursing Commission currently recognizes three ARNP designations: Nurse Practitioner (NP), Certified Nurse Midwife (CNM), and Certified Registered Nurse Anesthetist (CRNA). The Nursing Commission is proposing a rule to establish a new clinical nurse specialist (CNS) ARNP designation. The proposed rules include educational, licensing, practice, and prescriptive authority requirements for CNS ARNPs. The proposal also establishes monitoring and enforcement processes for new graduates, out-of-state endorsements, out-of-country endorsements, renewals, and application processes for those with inactive or expired licenses for all ARNP designations, including CNS.

All advanced practice nurses are prepared by education and certification to assess, diagnose, and manage patient problems order tests, and prescribe medications. The overall roles and responsibilities for ARNP are similar. A primary difference between the four designations is the specialty area and the type of national certifications available.

- The NP is educated in advanced practices independently in a range of settings and in one of the six described populations. NPs are accountable and responsible for health promotion, disease prevention, health education, counseling, diagnosis, and management of acute and chronic diseases. They provide initial, ongoing and comprehensive care to patients in family practice, pediatrics, internal medicine, geriatrics, and women’s health. NPs are prepared to practice as primary care NPs or acute care NPs which have separate national competencies and unique certifications.
- The CNS is educated at an advanced level to care for patients in one of the six described populations and across the continuum of care. The role of the CNS encompasses the...
patient, the nurse and nursing practice, as well as the healthcare organization and system. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups and community.

- The CRNA is prepared to provide the full spectrum of patients’ anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illness or injury. This care is provided in diverse settings, including hospital surgical suites.

- The CNM provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted diseases and reproductive health. Care is provided in diverse settings which may include home, hospital, birth center, and variety of ambulatory care settings including private offices and community and public health clinics.

A CNS who practices in an advanced practice role is educated at the master's or doctoral level in a specialized area of nursing. The CNS is an expert clinician practicing in a wide variety of settings including hospitals, community health, educational institutions, long-term care facilities, mental health, occupational health, and private practice. Population foci may include family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related, or psychiatric/mental health. CNS practice competencies apply to three interacting spheres of influence: the patient/client sphere, the nurses/nursing sphere, and the organization/system sphere. Seven CNS practice options function within the specialty chosen by that particular CNS in which core competencies are enacted.

Background

The National Council of State Boards of Nursing (NCSBN) recognized four advanced practice roles in the Advanced Practice Registered Nurse (APRN) Consensus Model (2008) endorsed by forty-eight professional nursing and stakeholder groups. It provides a framework for regulation of advanced practice roles and is an integral part of the Institutes of Medicine report on the Future of Nursing (2010). Many nursing boards have, or are working, to align with the model. The “Journal of Nursing Regulation” (July 2014), summarized the progress made across the states in the inclusion of nurse practitioner, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialist under the umbrella of advanced practice. Mississippi, New Hampshire, Virginia, and Washington State are the only states that do not currently recognize the advanced practice CNS designation.

The Nursing Commission voted to support alignment with the model in March 2011 to add the CNS to existing ARNP rules. It allows nurses to practice to the full extent of their education and expertise and promotes access to quality and safe care for the public.

Surveys and information from national certification agencies indicate about three hundred nurses in our state may qualify for the CNS designation. The research, surveys, and interviews show that CNSs are hesitant to move to Washington State to practice, and those educated here are leaving. A significant barrier includes the lack of definition of role expectations and limitations to scope of practice. CNSs move to Oregon, Idaho, and other states where CNSs have a well-
defined scope of practice. Providing autonomy and a full scope of practice for CNSs would improve access and expedite comprehensive, quality patient care. The CNS has the potential to play a large and important role in assuring the delivery of high-quality health services, but has often struggled with attaining recognition, reimbursement, and recognition as an ARNP. The health care industry does not always seem to understand the value and potential of the CNS, in part attributable to the varied roles the CNS may play. Some markets limit the CNS to a single role (typically, the nurse educator), whereas others use the CNS to their fullest potential as clinical expert, involving their CNS employees in quality monitoring and improvement, and implementation of evidence-based practices in the workplace, and as expert clinical practitioners in primary, secondary, and tertiary care.

CNS Competencies (regardless of specialty or setting):

1. Using knowledge of differential illness diagnoses and treatments in comprehensive, holistic assessments of patients within the context of disease, diagnoses, and treatments.

2. Providing innovative interventions to achieve quality, cost-effective, nurse-sensitive outcomes by designing, implementing, and evaluating individual and/or population-based programs.

3. Serving as a leader/consultant/mentor/change agent in advancing the practice of nursing among other nurses and across organizations to achieve outcomes.

4. Advancing nursing practice by applying evidence-based interventions, using best-practice guidelines, and modifying professional standards and policies that direct care of nursing personnel and other providers of health care to improve outcomes.

5. Acting as a leader for interprofessional groups to facilitate collaboration with other disciplines in the attainment of outcomes across the continuum of care.

6. Identifying resource needs at the system level for delivery of nursing care, and attaining those resources.

7. Expanding the practice of nursing through ongoing generation and acquisition of scientific knowledge and skills to maintain expert clinical competencies that leads to desired outcomes.

8. Demonstrating professional citizenship and fiscal responsibility in the health care system by focusing on health policy and/or resource management to ensure quality, cost-effective outcomes of nursing care.

Research regarding the role of the CNS demonstrates outcomes as follows:

- **Reduced hospital costs:** CNSs in advanced practice roles, decreased cost associated with Hepatitis B immunoglobulin by $25,430 per patient (72% decreases in cost) at the Portland Veteran’s Administration Medical Center; and also decreased the length of stay for insulin infusion patients by over two days resulting savings of over a million dollars.

- **Reduced frequency of emergency room visits:** An outpatient nurse managed program for children with asthma resulted in a statistically significant reduction in the frequency of emergency room visits.
• **Improved pain management practices:** Through the use of pain assessment and intervention, the use of CNS demonstrated increased consistency with pain management practices and patients expressed satisfaction with their pain management.

• **Reduced medical complication in critically ill patients:** At PeaceHealth St. John’s Medical Center, ventilator associated pneumonia dropped from 17% to 2%; and central line infections dropped from 12% to 0.5%.

• **Decreased hospital readmission rates:** Through comprehensive discharge planning and coordination, length of stay decreased from 12.6 to 3.7 days. Cost of care was cut in half.

• **Improved case management:** A retrospective review of 78 patients showed a trend in CNS case-management patient towards higher acuity and shorter length of stay. It appeared that CNS involvement in care negates acuity as a predictor of length of stay.

• **Cost effective primary care:** An analysis of three staffing models for low-risk prenatal care reveals that the clinic staffed by CNSs had the greatest client satisfaction and the lowest cost per visit; increased return to work; and decreased smoking through individual counseling provided by a CNS.

Nurses, patients, and institutions benefit when length of stay is decreased; when complications of illness are prevented or recognized and treated early; when patients are satisfied and return to a practice or facility; when staff injury is prevented; when patients understand their disease and options for care; when cost-effective, safe, efficient equipment is selected and implemented; and when patient safety is addressed. The cost-effectiveness of the CNS is more than getting reimbursement from Medicare or an insurance company and cost savings: it is often an intangible, difficult-to-measure benefit to their patients, staff, and employers.

The CNS functioning as an independent licensed provider, expert clinician, consultant, and educator has consistently documented positive outcomes for improved quality of care, decreased costs, and improved patient satisfaction. Washington State needs individuals prepared to be agents of change, to improve current processes and outcomes, and to promote an environment of ongoing interprofessional assessment, and improvement of the health care delivery processes.

Analysis of interviews conducted with the three CNS graduate programs in Washington State indicated that the numbers of students choosing a CNS track in their education programs were dwindling due to lack of licensure in the state and the changing national certification exam picture. The conclusion was that licensure would assist Washington in both attracting more students to the programs and giving impetus to more CNS specific exams being offered at the national level.

NCQAC staff interviewed seven other states about the proposed rule. All states interviewed stressed the importance of aligning with the APRN Consensus Model guidelines to assure that the regulation identified qualifications needed for autonomy without duplication of services. In the interest of providing patient access to more providers the proposed rule would allow CNSs who meet the qualifications for licensure and certification to practice within their full scope of practice. With the implementation of the Affordable Care Act, the need for direct care providers has seen significant increases with the numbers of newly insured patients. The recognition of the CNS advanced practice role will improve access to quality care by allowing the CNS to practice up to the fullest extent of their scope of practice.
Is a Significant Analysis required for this rule?

A significant analysis is required for the proposed rules with the exception of:

**Non-Significant Rules**

<table>
<thead>
<tr>
<th>Rule Number</th>
<th>Concept</th>
<th>Analysis</th>
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</thead>
<tbody>
<tr>
<td>WAC 246-840-010</td>
<td>Definitions</td>
<td>Does not meet the criteria of a legislatively significant rule. Changes and additions made to definitions of terms used in the rule. There are no proposed changes that change the effect of the rule.</td>
</tr>
<tr>
<td>WAC 246-840-310</td>
<td>Use of protection of professional titles</td>
<td>Does not meet the criteria of a legislatively significant rule. Minor grammatical changes, formatting, and plain talk for clarification. There are no proposed changes that change the effect of the rule.</td>
</tr>
<tr>
<td>WAC 246-840-361</td>
<td>Continuing education for ARNP license renewal</td>
<td>Does not meet the criteria of a legislatively significant rule. Minor grammatical changes, formatting, and plain talk for clarification. There are no proposed changes that change the effect of the rule.</td>
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Clearly state in detail the general goals and specific objectives of the statute that the rule implements.

The general goals of the proposed rules authorizing statute include:

1. RCW 18.79.110 (1) Defining what constitutes specialized and advanced levels of nursing practice as recognized by the medical and nursing profession. regulating the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline and promote the delivery of quality health care to the residents Washington State,
2. RCW 18.79.050: Defining advanced registered nursing practice and identifies expanded scope of practice including the authority to prescribe legend drugs and controlled substances (Schedule II-V), and
3. RCW 18.79.160: Defining the authority to determine the required documentation for licensure for registered nurse RN and ARNP licensure.

The proposed rule implements the following objectives:

1. Establishes a new ARNP designation as CNS
2. Establishes the education, examination/certification, licensing, practice requirements, prescriptive authority requirements, monitoring and enforcement processes for new
graduates, out-of-state endorsements, out-of-country endorsements, renewals, and application processes for those with inactive or expired licenses for all ARNP designations, including CNS.

**Explain how the department determined that the rule is needed to achieve these general goals and specific objectives. Analyze alternatives to rulemaking and the consequences of not adopting the rule.**

The proposed rule achieves the authorizing statute’s goals and objectives to define an additional advanced practice role as CNS through regulating the competency and quality of ARNPs, including the CNS designation, practicing in an advanced practice role. This will promote quality and access to care to the residents in our state.

In 2011, the Washington State Nursing Care Quality Assurance Commission conducted surveys and interviews with key stakeholders related to the proposed rule changes. A nursing doctoral student assisted in developing, administering, and analyzing the surveys previously described. Interviews with leaders of other state boards who regulated CNS helped the Nursing Commission understand the issues. Regulations from other state boards of nursing were used to compare regulatory language. Interviews with facility administrators who employ nurses as CNSs showed that not all of the nurses using the CNS title would need, want, or be qualified for ARNP licensure, especially CNSs doing the most direct patient care. Without the advanced practice designation, those in CNS roles currently practice at the RN level of scope of practice requiring direction by an authorized provider (such as an ARNP, physician, osteopathic physician, physician assistant, dentist, podiatric physician acting within their scope). Employers are hesitant to employ the CNS since they cannot be assured that they will be reimbursed for their services. Some nurses in CNS roles may be unnecessarily restricted in scope of practice since the CNS with the education, knowledge, skills, and ability to practice in an advanced level is not defined in nursing law or rule.

**Explain how the department determined that the probable benefits of the rule are greater than the probable costs, taking into account both the qualitative and quantitative benefits and costs and the specific directives of the statute being implemented.**

The probable benefits of the rule are greater than the probable costs. The new rule will allow nurses with advanced practice education, not previously recognized, to function at the fullest extent of their scope of practice. This will promote quality and access to care to the residents in our state. Nurses with the advanced practice CNS designation may be more employable since their services may be reimbursable. Research defined in the background of this document shows that the use of advanced practice CNSs demonstrates reduced costs, reduced length of stay, reduced frequency of emergency room visits, improved pain management practices, reduced medical complications, reduced readmission rates, improved case management, and more effective primary care. The addition of the CNS designation fits in with the triple aim of the Affordable Care Act: Reduced costs, improved outcomes, and patient satisfaction.

The proposed rule package includes fourteen (14) significant rules that are analyzed below.

**WAC 246-840-020 Credentials issued to nurses in Washington.**
Rule Overview:
The proposed rule language adds language related to ARNPs ARNP who meets the qualifications for a credential under the designation of a CNS. The proposed language also changes the title of the rule from “credentials issued to nurses in Washington state” to “credentials issued to a LPN, RN, or ARNP in Washington state.”

Rule Cost/Benefit Analysis:
There is no cost associated with the proposed rule amendment. The proposed language is necessary to be consistent with the remaining rule proposals for CNS inclusion.

WAC 246-840-300 Advanced registered nurse practitioner (ARNP) scope of practice

Rule Overview:
The proposed rule language clarifies that ARNPs function within their scope of practice and align with the commission-approved certifying body’s standard of care. The proposed rule moves existing rules currently contain language in WAC 246-840-302 that allows ARNPs to limit scope of practice and propose to move that language to this WAC. Minor title change from spelling out advanced registered nurse practitioner and using the abbreviation to be consistent throughout the document.

Rule Cost/Benefit Analysis:
There is no cost associated with the proposed rule amendment. The proposed rule language recognizes the certifying body’s standards of care and moves language in another section to this section.

WAC 246-840-302 ARNP designations, certification, and approved certification examinations.

Rule Overview:
The proposed rule language adds the newly established CNS designation to the current list of recognized ARNP designations. It defines the approved certifying agencies that provide the examinations for CNS certification through The American Nurses Credentialing Center (ANCC), the American Association of Critical Care Nurses (AACN), or the Oncology Nursing Certification Corporation (ONCC). The proposed rule updates the list for other ARNP designations as an overall rules clean-up to add ANCC, AACN, and ONCC NP designations to recognize additional certifying agencies not previously identified to provide consistency as these certifying agencies provide NP and CNS certification. The proposed rule change recognizes official name changes for the National Certification Corporation and the National Board of Certification and Recertification for Nurse Anesthetists.

Rule Cost/Benefit Analysis:
Nurses that elect to obtain a CNS designation will have to pay the cost for one of the certifying bodies. Current Certification costs vary depending on the credentialing agency. For example, the initial certification from ANCC is $395.00 and offer reduced fees: $270.00 for members of the American Nurses Association and the National Association of Clinical Nurse Specialists charges...
$340.00. ONCC charges $406.00 for the initial credential of a nurse who is a non-member of the Oncology Nursing Society (ONS) or the Association of Pediatric Hematology/Oncology Nurses (APHON); $286.00 for a ONS/APHON member under 65 years of age and $215 for nurses 65 years and older; and $305 for non-members 65 years and older. Renewal fees are slightly lower. Nurses may choose not to become certified and may continue to practice at an RN practice level. The proposed rule amendment updates the current lists of certifying agencies currently recognized as the national industry standard and adds those that are specific to CNS certification. The benefit of the rule is that it recognizes the CNS advanced practice role that will improve access to quality care by allowing the CNS to practice up to the fullest extent within their scope of practice.

**WAC 246-840-304 ARNP designations, certification, and approved certification examinations.**

**Rule Overview:**

The proposed rule language repeals this section. The current rule defines certification as a form of credentialing, under sponsorship of a commission approved certifying body and defines what a certification program must include. The commission does not have authority to define the certifying agency program requirements, and therefore, cannot enforce the existing rule.

**Rule Cost/Benefit Analysis:**

There is no cost associated with the proposed rule. The repeal only removes an unenforceable section.

**WAC 246-840-311 ARNP previously adopted specialties.**

**Rule Overview:**

The proposed rule language removes a previously existing certification category of ARNP. The current rule was established to “grandfather” in ARNPs many years ago. It clarifies that the ARNP must have an active license without sanctions or restrictions and clarifies that an ARNP with an expired license, previously identified in this specialty, would not be able to be relicensed as an ARNP with this certification. The Psychiatric Mental Health Clinical Nurse Specialist is no longer applicable as the certifying agency(s) retired this category. Washington State currently does not have an ARNP licensed in this category. The remaining existing rule in this section will remain unchanged; anyone with this specialty area will not be eligible for ARNP licensure. The remaining “grandfathered” categories of ARNP were not removed as there are still a few nurses practicing under this rule in our state.

**Rule Cost/Benefit Analysis:** There are no costs associated with this rule. The benefit would be to clarify and remove ineligible and non-applicable categories.

**WAC-246-840-340 ARNP application requirements for new graduates of advanced registered nursing programs.**

**Rule Overview:**

The proposed rule language includes a title change to, “Application requirements for initial ARNP licensure.” The proposed rule establishes the ARNP with licensure requirements (to include the new designation CNS).
The proposed rule

- Removes programs recognized by the Council of Higher Education Accreditation program because the commission does not monitor or enforce this rule and the certifying agencies will not allow a nurse to be certified without the meeting the requirements for education;

- Further clarifies the educational standard to be a graduate degree in advanced practice, and clarifies that ARNPs must also have an active RN license to practice as an ARNP;

- Redefines the clinical practice hour requirements, including the process if a person with the required education applies later than one year from graduation or does not meet clinical practice requirements. To be licensed as an ARNP, the nurse must obtain two hundred fifty practice hours every two years. On occasion, a person with the educational requirements may not get their initial license within the first year. That means they have not had any clinical practice. Some individuals meeting the educational requirements may not have the required clinical practice hours;

- States CNSs must obtain one hundred and twenty-five hours of advanced clinical practice for each additional year following graduation, not to exceed one thousand hours;

- Establishes a process for nurses to get supervised practice hours and clarifies that the supervisor must be an ARNP, physician or osteopathic physician in the same practice specialty area who has practiced two or more years without current disciplinary action on their license;

- Clarifies who cannot supervise an individual seeking licensure (cannot be a relative, have a personal relationship with the applicant, or have current disciplinary action on their license); and

- Requires approval by the Nursing Commission of the site and supervisor as well as requiring the supervisor to submit a written Evaluation verifying successful completion of the supervised practice hours and that the applicant’s knowledge and skills are adequate to practice as an ARNP. It allows for the option of a site visit as appropriate.

Rules Cost/Benefit Analysis:

There may be the cost of an occasional site visit associated with this rule. The proposed rule will impact individuals with the CNS and other ARNP designations that do not meet the required practice hours for licensure. The cost could include those associated with meeting the practice hour requirement. This could include transportation cost, and cost of meeting the hourly practice requirement in addition to other cost associated with meeting the practice requirement. Other costs could also include loss in job opportunities if the advanced practice designation is not obtained. The benefit of the rule is that it may increase access and ensuring safe, quality care.

WAC 246-840-342 ARNP application requirements for licensed advanced practice nurse applications from other states or jurisdictions.

Rule Overview:
The proposed rule language clarifies licensure requirements for ARNP applicants from other states or jurisdictions. It recognizes that in other states or jurisdictions, a nurse may be practicing in an advanced practice role and have the required educational requirements and practice hours, but not have the title “ARNP.” The proposed rule adds CNS to the list of ARNP designations. It defines the requirements for those nurses from other states or jurisdictions that meet the educational requirements but not the clinical practice hour requirements referencing proposed rule WAC 246-840-340. The proposed rule changes the title from to be more succinct, but does not change the intent to use “interstate endorsement” to identify nurses applying for licensure from other states or jurisdictions.

Rule Cost/Benefit Analysis:
Other than the costs for applying for the license, there are no costs associated with this rule. The proposed rule would allow nurses from other states practicing in an advanced practice role, who meet the educational, certification, and practice hours to be licensed as an ARNP (including the CNS designation) even if the other state or jurisdiction uses a different licensure title or does not have a licensure title. The proposed rule also recognizes there may be individuals that have the CNS or other ARNP designations that may not meet the required practice hours for licensure and provides a way for RNs with the educational qualifications to get these practice hours. The benefit of the rule is that it will ultimately increase access by removing a barrier for nurses from other states and jurisdictions to relocate to Washington while ensuring safe, quality care.

WAC 246-840-344 ARNP application requirements for advanced practice nurse applicants educated and licensed outside the United States.

Rule Overview:
The proposed rule language defines the educational, certification, and practice hours required for ARNP licensure of nurses applying from outside the United States. It requires a RN license issued by a regulatory entity outside of the United States to present evidence of their practicing in an advanced practice role. It recognizes that in other states or jurisdictions, a nurse may be practicing in an advanced practice role and have the required educational requirements and practice hours, but not have an ARNP title. It requires the same practice hours as for nurses applying in state and those who are endorsing from other states or jurisdictions. It defines the requirements for those meeting the educational requirements but not the clinical practice hour requirements referencing proposed rule WAC 246-840-340. The proposed rule changes the title to add ARNP to the title for clarification.

Rule Cost/Benefit Analysis:
Other than the cost for applying for the license, there are no costs associated with this rule. The proposed rule would allow nurses from other countries that are practicing in an advanced practice role, who meet the educational, certification and practice hours to be licensed as a CNS and other ARNP designations, even if they received their educated in another country or if they are using a different licensure title. The benefit of the proposed rule is that it provides a way for RNs from other countries that have the educational qualifications to get the required practice hours, thereby ultimately increasing access and ensuring safe, quality care.

Rev. January 2014
WAC 246-840-350 Application requirement for ARNP interim permit.

Rule Overview:

The proposed rule language repeals this section to reduce redundancy and inefficiencies. The current technology allows for the commission to process applications in a rapid turnaround time and thus the interim permit option is no longer needed.

Rule Cost/Benefit Analysis:
Other than the cost for applying for the license, there are no costs associated with this rule. The benefit is it will streamline the process for application and endorsement and save costs through LEAN processes.

WAC 246-840-360 Renewal of ARNP License

Rule Overview:

The proposed rule language clarifies the renewal requirements for an ARNP license in the State of Washington, including need for nurses to have an active RN license. It clarifies the definition of advanced clinical practice. It clarifies nurses only need to have thirty hours of continuing education hours when they have more than one certification and if the hours are applicable to each area of practice. It clarifies the documents the nurse must submit. This includes the documentation of the practice hours. The proposed rule allows ARNPs who teach advanced nursing practice to count hours for advanced clinical practice if the faculty member is providing patient care or serving as a preceptor in a clinical setting.

Cost/Benefit Analysis:
Other than the cost for applying for the license, there are no costs associated with this rule. The proposed rule would clarify the practice and continuing education hours and make it enforceable.

WAC 246-840-365 Inactive credential.

The proposed rule language establishes the application process, educational, certification, and practice hour requirements for renewal of an inactive ARNP license in the State of Washington. To be eligible to reactive an inactive credential, nurse must have an active RN licensure. It requires the same number of practice hours as the nurses that are applying in state and those who are endorsing from other states or jurisdictions. It defines the educational requirements, but not the clinical practice hour requirements in regard to the proposed rule, WAC 246-840-340. The proposed rule changes the title for clarity to add inactive and reactivating an ARNP license.

Cost/Benefit Analysis: There are minimal costs associated with this rule. The process for reactivating the license will be the same as for other ARNPs. There may be prescribing costs through the Drug Enforcement Agency for registration which is currently $731.00 (three-year registration) for Schedules II-V controlled substances. This is required for all ARNP’s who wish to have prescriptive authority. The benefit is that nurses with an inactive credential would need to meet the same requirements (already defined in current rules) as those for renewals,
endorsements, applications, and prescriptive authority from other countries and makes the rules enforceable.

**WAC 246-840-367 Expired license.**

**Rule Overview:**
The proposed rule language establishes the application process, educational, certification, and practice hour requirements for individuals with an expired license who wants to return to practice as an ARNP. It includes the requirement for active RN licensure. Nurses with expired licenses that want to get an active license must have the same number of practice hours as the nurses applying in state and those who are endorsing from other states or jurisdictions. It defines the requirements for those meeting the educational requirements, but not the clinical practice hour requirements, referencing proposed rule WAC 246-840-340.

**Rule Cost/Benefit Analysis:**
Costs may include those for renewing an expired license. There may be costs associated to meet any requirements the candidate does not currently possess. This may include education, and certification. There may be prescribing costs through the Drug Enforcement Agency for registration, currently $731.00 (three-year registration) for Schedules II-V controlled substances. This is required for all ARNP’s who wish to have prescriptive authority. The benefit is that outdated language will be removed from the rule. The proposed rule also clarifies that nurses with an expired license need to meet the same requirements as those for renewals, endorsements, applications, and prescriptive authority from other countries.

**WAC 246-840-400 ARNP prescriptive authority.**

**Rule Overview:**
The proposed rule language authorizes ARNPs to prescribe drugs and medical devices. The proposed rule removes the term “therapies” as therapies are made by referral and not “prescribed.” Sometimes providers use a prescription pad to make a referral for therapies instead of a referral form or other type of process (e.g. physical therapists). They do not prescribe drugs or medical devices. It clarifies core competencies required for prescriptive authority.

**Rule Cost/Benefit Analysis:**
There may be prescribing costs through the Drug Enforcement Agency for registration, currently $731.00 (three-year registration) for Schedules II-V controlled substances. This is required for all ARNP’s who wish to have prescriptive authority. The benefit is that the rule clarifies the prescriptive authority for drugs and medical devices but allows ARNPs without prescriptive authority to authorize therapies that do not require a prescription. Without removing the word “therapies”, it is unclear whether an ARNP without prescriptive authority could make a referral for a specific therapy that does not include a prescription drug or medical device. This may unintentionally restrict scope of practice. The proposed rule clarifies core competencies that results in safe care.
WAC 246-840-410 Application requirements for ARNP prescriptive authority

Rule Overview:
The proposed rule language defines the requirements for ARNP prescriptive authority by simplifying language and preventing repetition. The proposed rule does not change requirements, but more clearly defines active ARNP license, contact hours, educational content, supervised practice, clinical practice, evidence of thirty contact hours, addresses requirements if ARNPs do not apply for prescriptive authority within two years of graduation, and pharmacology content. It defines the requirements for those meeting the educational requirements but not the clinical practice hour requirements referencing proposed rule WAC 246-840-340.

Cost/Benefit Analysis:
There are no costs associated with this rule. The benefit of the proposed rule is that it clarifies ARNP prescriptive authority. Another benefit is that it clarifies that nurses with an expired license would need to meet the same requirements for prescriptive authority.

WAC 246-840-420 Authorized prescriptions by ARNP with prescriptive authority.

Rule Review:
The proposed rule language removes “therapies” from prescriptive authority to be consistent with the proposed language in WAC 246-840-410.

Rule Cost/Benefit Analysis:
There are no costs associated with this rule. The benefit is that prescriptive language is clarified and updated and ensures that ARNPs who chose not to have prescriptive authority may still make referrals for therapies.

Identify alternative versions of the rule that were considered, and explain how the department determined that the rule being adopted is the least burdensome alternative for those required to comply with it that will achieve the general goals and specific objectives.

The initial draft of the proposed rule was restricted to the addition of CNS as a new designation of ARNP. However, this did not address all of the issues regarding qualifications including the licensing process, enforcement, and educational concerns. A major concern that was not addressed was in the initial draft related to “grandfathering” CNSs who graduated before national certification was required. There are also concerns about nurses practicing in an advanced practice role who otherwise met all of the educational requirements, including those from other states, jurisdictions, and out-of-country applicants and Washington State.

Legal Concerns: Legal advisors weighed in with concerns that the rule was not written in a way that was clear and felt that it may not be legally defensible. Other legal concerns included formal documentation of clinical practice hours and measurements of core competencies. Their recommendations were to address the legal language of the document in order to clarify and streamline the language to provide risk-based recommendations.

Licensing Concerns: The department of licensing reviewed earlier versions and commented that the original document was a “logistical” challenge as written and would put an undue burden on licensing staff to interpret and implement. Because of this input a large section of the rules were
open including those that had been “problematic” in the past to facilitate simplification of the licensing language and process.

**Educational Concerns:** The APRN consensus model was published in July 2008. With the move towards this model, it required that educational institutions take a proactive approach in implementing the changing landscape in ARNP nursing education by 2015. Not all educational programs have implemented the necessary changes leading to the specialty of CNS. This presents a challenge in determining how potential candidates for CNS ARNP licensure will be considered if they have graduated prior to implementation of the Licensure, Accreditation, Certification, and Education (LACE) guidelines. In keeping with the consensus model for APRN LACE defines advanced nursing practice and proposes a regulatory model which identifies advanced practice titles, defines “specialty” and describes how new roles and population foci might develop. There are CNS graduates that do not meet the requirements for CNS ARNP licensure based on their educational course work and foci. The proposed CNS rule may not be able to address all of the possible educational variables for licensure. For this reason it was determined that we would have a review of the requirements for advanced registered nurse practice educational programs in Washington State which is now in process by the Nursing Commission’s Education Program. (WAC 245-840-455)

**Stakeholder Concerns:** Stakeholder concerns were identified and addressed throughout the process and involved clinical experts, faculty, and nursing associations both on a state and national level. Through this process, NCQAC has developed a rule that is a major step in becoming aligned with the APRN Consensus model to establish and oversee the new designation of CNS ARNP.

**Determine that the rule does not require those to whom it applies to take an action that violates requirements of another federal or state law.**

The proposed rule does not require those to whom it applies to take an action that will violate requirements of any federal or state law.

**Determine that the rule does not impose more stringent performance requirements on private entities than on public entities unless required to do so by federal or state law.**

The proposed rule does not impose more stringent performance requirement on private entities that on public entities.

**Determine if the rule differs from any federal regulation or statute applicable to the same activity or subject matter and, if so, determine that the difference is justified by an explicit state statute or by substantial evidence that the difference is necessary.**

This rule does not differ from any applicable Federal regulation or statute.

**Demonstrate that the rule has been coordinated, to the maximum extent practicable, with other federal, state, and local laws applicable to the same activity or subject matter.**
There are no other applicable laws.