This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Define the terms and identify the criteria for certification, licensure, and credentialing.
2. Identify the currently debated questions on regulation of clinical nurse specialists (CNSs) and outline some proactive steps that can be taken to stay ahead of the current wave of change.

Editor's Note: In 2008, we will publish 6 articles for which 1 to 3 credit hours may be earned as part of a CNS's learning activities. Examination questions are provided at the end of this article for your consideration. See the answer/enrollment form after the article for additional information regarding the program.

Credentialing and Certification

Issues for Clinical Nurse Specialists

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This article will provide a brief overview of the concepts of credentialing and certification and will identify some of the issues around certification and credentialing for clinical nurse specialists (CNSs). The article will also describe some of the misconceptions about certification and licensure that cause problems to CNSs, identify the current questions on the debated regulation of CNSs, and outline some of the proactive steps that can be taken to stay ahead of the current wave of change anticipated with the suggested changes in the forthcoming regulation of CNSs. Information provided is pertinent for new graduates and seasoned CNSs and provides an opportunity for both to gain a better understanding of certification and credentialing.

KEY WORDS: advanced practice registered nurses, advanced practice regulation certification, credentialing

As new clinical nurse specialist (CNS) graduates enter the workforce, they are faced with the sometimes confusing issues related to establishing themselves in their first job. Establishing their role includes not only graduating from an accredited program and establishing credibility with the nursing staff and peers but also dealing with the concepts of certification and authorization to practice/licensure. In addition to this, the requirements in some settings for review by the medical staff include credentialing and potentially privileging. *Credentialing* and *privileging* are terms that have heretofore been reserved for nurse practitioners (NPs) and physicians. Adding these terms to the vocabulary used by CNSs makes the landscape even more confusing. Even seasoned CNSs are facing some of these issues for the first time in their careers as the complex areas of title protection, scope of practice, and regulation continue to evolve.[1] This article will provide a brief overview of each of these concepts, describe some of the misconceptions that cause problems to CNSs, identify the current questions on the debated regulation of CNSs, and outline some of the proactive steps that can be taken to stay ahead of the curve.

Because some of the terms such as *credentialing*, *certification*, and *licensure* have been misused or used interchangeably, it is important first to define them. *Credentialing*, used generally, is an umbrella term that incorporates licensure, certification, accreditation,

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recognition, and registration. The International Council of Nurses defines *credentialing* in the following way:

Credentialing is a term applied to processes used to designate that an individual, program, institution, or product have met established standards set by an agent (governmental or nongovernmental) recognized as qualified to carry out this task. The standards may be minimal and mandatory or above the minimum and voluntary. Licensure, registration, accreditation, approval, certification, recognition, or endorsement may be used to describe different credentialing processes, but this terminology is not applied consistently across different settings and countries. Credentials are marks or "stamps" of quality and achievement communicating to employers, payers, and consumers what to expect from a "credentialed" nurse, specialist, course or program of study, institution of higher education, hospital or health service, or healthcare product, technology, or device. Credentials must be periodically renewed as a means of assuring continued quality and they may be withdrawn when standards of competence or behavior are no longer met.[2]

Authorization for practice or licensure in the United States is the process by which an agency of the state government grants permission to individuals accountable for the practice of a profession to engage in the practice of that profession and prohibits all others from legally doing so.[3] It permits the use of a particular title and defines a scope and sets the boundaries of the practice profession. Authorization for practice/licensure further gives an individual a property right to practice his/her profession, based on fulfilling the conditions for the authorization for practice/licensure.[3] The main purpose is to protect the public by ensuring a minimum level of professional competence.

Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by an agency or association. Such qualifications may include (*a*) graduation from an accredited or approved program, (*b*) acceptable performance on a qualifying examination or series of examinations, and/or (*c*) completion of a given amount of work experience.[3] The purpose of certification is to assure members of the public that an individual has mastered a body of knowledge and acquired skills in a particular specialty.

Certification can be used for entry into practice, validation of competence, recognition of excellence, and/or regulation.[1,4] Certification can be mandatory or voluntary and can, in some instances, be seen as a mark of excellence in practice. More recently, certification at the advanced practice level has been used as a quasiregulatory mechanism by the state agencies that grant recognition to individuals who have met predetermined qualifications. Most states have developed some form of regulation of NPs that requires validation of competency for entry to practice through passing a national certification examination. Specific references to nursing certification have been incorporated into statute or into rules and regulations surrounding entry to practice and initial licensure as an advanced practice registered nurse (APRN). Unfortunately, CNSs are also often caught in the regulatory language issues and are also being required to meet the expectation of being certified in many states to have title protection and legal authorization to practice.

This situation creates difficulty for those CNSs for whom there is no specialty certification examination and is the cause of much debate in the CNS world.

Certification has also taken on new meaning in that it is required for reimbursement through the Center for Medicaid and Medicare Services (CMS). At this time, CMS will only accept billing from providers who are certified. In addition, much work has been done at the national level to ensure that CNSs are recognized providers and are able to bill the CMS and that codes exist that are specific to the care provided by CNSs. Although the process is not as fully developed as it needs to be, it is improving with the development of the ABC codes and the ability of CNSs to recognize that their services can be billed. ABC codes provide billing codes to healthcare practitioners whose treatments currently lack an accurate Current Procedural Terminology description code as defined by the American Medical Association. As CNSs develop billing procedures and begin to bill for services and workload, being identified as a provider that is recognized for billing will become an even more important component for consideration.

Although providing a solution is not the focus of this article, it is important to note that such a solution is being developed. The National Association of Clinical Nurse Specialists, in collaboration with the American Nurses Credentialing Center, is creating a core CNS certification examination. The core CNS certification test is under development, with an anticipated first test being offered in March of 2009. This examination will provide a basic venue for assessment of core CNS competencies. In partnership with a portfolio or other legally defensible and psychometrically sound mechanism that validates specialty competencies and population served, the CNS core certification examination will provide validation of initial competency. The work on the core examination will assist those individuals for whom there is no current certification examination.

Credentialing as previously defined is an umbrella term that incorporates licensure, registration, certification, accreditation, and recognition. When the word credentialing is used within a hospital, however, it has another meaning. In this sense, credentialing is a process of procuring, verifying, and analyzing the eligibility and qualifications of the APRN provider to execute healthcare services.[5,6] The credentialing process verifies the integrity of the data submitted by the APRN (the certification, licensure, education, etc) and becomes the basis for privileging decisions.

Finally, privileging is used by a facility or employing organization to monitor the clinical activities that a provider is authorized to perform in that facility and is the process of authorizing a healthcare professional to perform (order) specific diagnostic or therapeutic services. Privileges are granted for the healthcare provider to provide specific care and services in an organization within well-defined limits. The granting of privileges is based on the following factors: state practice acts, agency regulations, license, education, training, experience, competence, health status, and judgment.[7]

The above mechanisms, either all or in some combinations, are intended to work together to provide the highest level of reliability that the practitioner is providing safe,

competent care. Clearly, even with all of these mechanisms in place, there can be no "guarantee" that the advanced practice nurse is providing competent care. Multiple factors contribute to competent care and its outcomes, and even the most "competent" person can find himself/herself in a situation wherein something went wrong. One major area, which may be assumed but may not be stressed enough in this process and during actual clinical practice, is that of personal and professional responsibility and accountability. It is the responsibility of the individual practitioner to know his/her own limitations and the state practice act limitations for his/her specialty scope of practice and to practice within those limits. It is not only a legal issue but also a professional, ethical issue and must be taken seriously by each APRN.

There is current discussion and debate among regulators, certification bodies, and educators about how and at what level that APRNs should be regulated and just what elements indicate that the person is a safe and competent practitioner.[1,8] Questions arising from these discussions include the following: does graduation from an accredited school provide enough assurance of safe practice? Should there be additional validation of that safety through a certification examination? Does certification in a specialty provide enough assurance of safe practice? At what level should the certification examination be focused (entry to practice or expert clinician)? What role does the employer or facility play in all this with the processes of credentialing and privileging? How many safety nets and filters do we need? And finally, who should assess competency, how should it be assessed, and how often should it be assessed?

The current processes for CNSs entry into practice are (1) to graduate from an accredited master's or doctoral level program that prepares the student for practice as a CNS with a specialty and (2) to secure employment. According to the National Association of Clinical Nurse Specialists, this is the most appropriate pathway because this recognizes the value of the additional credential earned through advanced educational preparation. Some states have additional requirements such as (3) to pass the certification examination in the specialty (currently, 28 states require CNSs to pass a national certification examination [J Rust, personal communication, March 5, 2007]) and/or (4) to apply for licensure or authorization to practice in a state where title protection is in place. Some states do not require national certification but do have a separate state validation of CNS education and subsequent title protection. For those CNSs who are working within a hospital or clinic setting and who have prescriptive authority for pharmacologic interventions, they may be required to complete (5) the credentialing and privileging process if necessary or if required by the facility in which the CNS works.

There are several misconceptions related to licensure and certification and the relationship between the two. They are as follows.

Misconception 1: Certification equals licensure. Originally, certification was considered to be a mark of excellence in clinical practice. That perspective has changed, and now certification at the advanced practice level serves as a quasiregulatory mechanism and as a proxy to assist nursing regulatory boards in determining if an individual should be granted authority to practice as an APRN. Certification itself does not guarantee licensure as an APRN. Individual nursing regulatory boards determine eligibility for licensure or state-level certification to practice as an APRN. Not all states require certification to grant authority or licensure (California, New York, and Oregon to name a few). Each state has jurisdiction over the process used to license or certify an individual's practice as an APRN.

The purpose of a certification examination takes on new meaning when used in a regulatory environment as a proxy for licensure. The examination must not only assess competency for practice, it must also be psychometrically sound and legally defensible, as it assesses the standards of practice. The examination becomes mandatory and an entry-level requirement for initial licensure or authority to practice. Subsequently, there are other standards and accreditations that certifying bodies must meet or comply with when making changes or updating the examinations. Another barrier that arises is that the potential customer base for a certification examination is driven by the regulatory agencies. States may choose to recognize one examination versus another, which impacts the desirability of the examination by candidates and drives the economics and market for that examination. Other states may recognize one specialty certification examination and not another, whereas a neighboring state may recognize both. Other states may require an examination when none exists for a given specialty. This addition of a business interface with the world of certification can have both beneficial and detrimental effects as the market and economic forces begin to drive the professional processes.

Misconception 2: Certification allows an APRN to do everything learned in school plus skills learned on the job. Certification examinations are based on national role delineation studies (job analyses) conducted with individuals who have been in the role for a period that reflects entry level, usually 3 to 5 years. The job analyses look at entry-level knowledge, skills, and abilities (minimum competence). States have the authority to limit scope of practice. This is commonly seen in the range of prescriptive activities allowed that vary from one state to the next. Having authority to practice broadly in one state does not necessarily grant the same authority in another state. In addition to limitations applied by the state, there can also be additional limitations or freedoms placed by an employing facility. The CNSs' responsibility is to know what the state nurse practice act allows and practice within the guidelines provided by the state.

Misconception 3: Licensure or recognition as an APRN will allow a CNS to work anywhere in the United States. The one exception to this is the federal system. You can work within the federal system if you are licensed/authorized to practice in any of the states or territories, but this is clearly an exception. Typically, just as certification does not grant universal practice rights, neither does licensure/authorization to practice. Each state grants its own rights within the confines of its nurse practice act. Some practice acts are very broad and allow nurses and CNSs to practice with few constraints, whereas others are very specific and limiting. It is not unusual for a CNS who has functioned for many years in one state as a competent

clinical expert to move to another state that will not recognize his/her practice. This may be because the CNS was living in a state that did not require national certification or there was no national certification available that met his/her specialty needs. If the new state requires certification, it may mean that the CNS has to go back to school to attain the eligibility requirements to sit for a national certification examination so that he/she will be able to be licensed in the new state.

The Registered Nurse Multistate Compact, which was introduced several years ago, has opened the door to allow for mobility for registered nurses across state lines. States who agree to the tenets of the compact allow nurses to work in their state without getting a separate license. There is also an Advanced Practice Compact (APRN) covering all 4 categories of advanced practice—NPs, CNSs, certified nurse midwives, and certified registered nurse anesthetists—which was introduced in 2004. Utah and Iowa are the only 2 states that have joined the compact for APRNs as of October 2007 and only for the purpose of recognizing NPs and CNSs. Certified nurse midwives and certified registered nurse anesthetists are not recognized for purposes of mobility between the states. The idea of mobility for advanced practice is much more complex than that for registered nurses because of the variety of state regulations. Scope of practice is an individual state prerogative, and in many states, there are either liberties or restrictions that are placed on the various APRN roles. It is likely that the process will take many more years to come together from a regulatory perspective.

Misconception 4: Once certified, an APRN does not need to worry about that process anymore. Certification is time limited. Most certifying bodies have a renewal process that occurs every 3 to 6 years, with the average being 5 years. Certification renewal is an indicator of continued professional development, exposure to new knowledge, and maintenance of continued competence through current clinical practice. Continuing education (CE) and professional activities, along with practice, are the main requirements of certification renewal. Renewal of certification for the advanced practice nurse is as critical as renewal of licensure. It is a professional responsibility.

Although not needed by all CNSs, some may be required to be credentialed and privileged within their facility. Those who are required have another layer of safety regarding advanced practice because it encompasses state practice acts, agency regulations, licensure, education, training, experience, competence, and judgment of the practitioner. The credentialing process provides an opportunity for a thorough examination of the past practice of the CNS and requires a recollection of all states and practice domains wherein the CNS has been licensed and/or legally recognized for practice. Again, professional responsibility must be a part of the picture. It is the responsibility of the individual to maintain documents in support of the privileging process. Just as healthcare strives for evidence-based practice, "practice-based" evidence can support what one may or may not be allowed to do within an institution. Keeping records of practice-based evidence, CE credits, and lists of all training accomplished with verification of such training can make the privileging process easier. Joel[9] provides a detailed list of how to create a portfolio of experiences that can be used for the credentialing process. These include maintaining current and updated curriculum vitae and using of a learning management system that maintains a listing of all courses taken for a period of at least a year, possibly more.

CREATION AND MAINTENANCE OF CREDENTIALING FILES

To alleviate some of the pitfalls and be proactive about the processes discussed above, the following suggestions are offered:

1. Start a credentialing file. Do this as soon as you graduate. Include your license and certification information along with other pertinent information about your education, training, past employers, and all licenses and certifications. An online system for maintaining records is ideal and will allow you to scan and upload critical documents so that these are easily available and not likely to be lost or misplaced. An example of an online portfolio can be found at http://decisioncritical.com/.
2. Find a method to keep up with certification and licensure renewal dates. Because your license and certification expiration dates are more than likely not the same, it may be difficult to keep track of both. Licenses can expire yearly or can be active for up to 3 years. Most states have a 2-year cycle, and some are synchronized with the birth month. Certifications, on the other hand, are usually renewed every 5 years and synchronized with the month you took the examination. Although licensing and certification boards often send out reminders for renewal, it is your responsibility to keep up with these dates.
3. Know your state practice act, and keep a copy of this in your credentialing file. You can usually get this directly from your state board of nursing or from its Web site.
4. Consider getting certified immediately upon graduation or as soon as is possible if you are currently in practice and there is an appropriate certification examination available. Keep in mind that certification is required by a number of states and is currently needed to qualify for reimbursement.
5. Save job descriptions for positions you have held to document areas of responsibility. This will not only provide documentation for future job searches and interviews but will provide a good tool for writing your own evaluations and resumes. It may also be helpful if you need to verify your advanced practice during a certification or licensure audit.
6. Ask your supervisor to write a letter that documents your practice and place it in your records. Even if you do not plan to change jobs, you will have it for the future, and it is again a useful document if you are audited by your certifying agency and have to provide evidence of practice.
7. Keep copies of your CE and professional development. Certificates of attendance and programs help you see what you have done and what else you might need to do. Keep letters of recommendation, evaluations, and preceptor forms. All these things may help during the renewal of certification process. Pay particular attention to CE in pharmacology if your state allows prescriptive

authority for CNSs and you choose to attain prescriptive authority for pharmacologic interventions.
8. Keep a log of nonaccredited CE that can be used to document professional development. Things such as grand rounds at the facility where you work and educational sessions you presented or attended can show that additional CE is occurring.

Summary

As CNS graduates join their peers in the workforce, they are faced with the confusing issues related to establishing their ability to practice. The concepts of certification, licensure, and authorization to practice are difficult to grasp with the ongoing regulatory changes and debates that are continuing nationally.[1] Even seasoned CNSs are facing these issues for the first time in their careers as the complex areas of certification and regulation continue to evolve. The brief overview of these concepts provided in this article described some of the misconceptions that cause problems for CNSs, identified the current questions on the debated regulation of CNSs, and outlined some of the proactive steps that can be taken to stay ahead of the current and anticipated wave of change. The changing landscape of credentialing, certification, and licensure is difficult to keep up with, but by being proactive and continuing to be aware of the requirements, both new and existing CNSs can stay ahead of the requirements and be well prepared to demonstrate competency, excellence, and the exceptional patient outcomes for which they are known.

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