September 20, 2016

Standard Occupational Classification Policy Committee
U.S. Bureau of Labor Statistics, Suite 2135
2 Massachusetts Avenue, NE
Washington, DC 20212

Submitted electronically to: regulations.gov

RE: 2018 SOC; Notice of Standard Occupational Classification Policy Committee Recommendations to OMB and solicitation of comments [SOC Docket number 1-0210]

Dear Members of the Standard Occupational Classification Policy Committee:

On behalf of the American Nurses Association (ANA), we are pleased to comment on the Notice of Standard Occupational Classification Policy Committee (SOCPC) Recommendations to OMB and solicitation of comments, published in the Federal Register on July 22, 2016. As the premier full-service professional organization representing the interests of the nation's 3.6 million registered nurses, ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members also include the four advanced practice registered nurse roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1] ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

ANA strongly supports the National Association of Clinical Nurse Specialists (NACNS) with respect to reversing the initial SOCPC decision published in Docket number 1-0210. In this regard ANA endorsed the application for a new detailed occupation submitted by the NACNS in 2014. ANA believes strongly in the value of APRNs and their contribution to improving access to health care services. ANA has promoted specialty nursing practice since the 1950's; the ANA certification program was established in 1973. ANA's first advanced practice certification exams were the Psychiatric Mental Health Clinical Nurse Specialist and the Pediatric Nurse Practitioner in 1974. Clinical Nurse Specialist is a separate occupation of long standing within the domain of APRNs.

[1]The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

ANA now endorses the NACNS response to Docket number 1-0210. ANA concurs that NACNS has demonstrated that their proposed SOC revisions for Clinical Nurse Specialists meet the requirements of SOC Classification Principle 2, being based on the work performed and education/training needed to perform their work at a competent level. CNS educational preparation and training enable them to diagnose patients and to prescribe pharmaceuticals for those patients as part of a treatment plan. Those are skills not currently recognized for registered nurses without APRN educational preparation.

The Consensus Model for APRN Regulation notes the following, applicable to each of the four APRN roles:

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across at least one of the six population foci;
- include at a minimum, three separate comprehensive graduate-level courses (the APRN Core) in:
    - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
    - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
    - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

The SOCPC previously has created separate SOCs for Nurse Practitioners, Certified Nurse-Midwives, and Certified Registered Nurse Anesthetists. CNS training programs must meet the same specifications as those for NPs, CNMs, and CRNAs. Robin P. Newhouse, PhD, RN, NEA-BC, FAAN is Dean and Professor of the Indiana University School of Nursing and Associate Vice President for Academic Affairs, IU Health, and an expert on clinical performance and outcomes of APRNs. She has indicated that although the subject matter of the educational programs of

the four distinct APRNs does vary, all four of those educational programs are performed at an equally high level of rigor.

In 1997 Congress recognized the value of the services provided by each of the four APRN roles potentially benefitting Medicare beneficiaries. As a result, Congress separately included each of the four APRNs services in the Medicare Part B benefit package (NPs, 42 CFR 410.75; CNMs, 42 CFR 410.77; CRNAs, 42 CFR 410.69; CNSs, 42 CFR 410.76).

In fact, there are more CNSs than CRNAs and CNMs combined. Not distinguishing CNSs from RNs in the employment statistics collected by Bureau of Labor Statistics in the Occupational Employment Statistics and other surveys hides those relative magnitudes and biases upward the estimates of average RN earnings. These statistical distortions would be eliminated by correctly identifying CNSs as APRNs in their own SOC.

If you have questions, please contact Peter McMenamin, Ph.D., Senior Policy Advisor-ANA Health Economist, Health Policy (peter.mcmenamin@ana.org).

Sincerely,

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Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer