

Credentialing, Certification, and Competence: Issues for New and Seasoned Nurse Practitioners

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As new nurse practitioner (NP) graduates enter the workforce, they are faced with the sometimes confusing issues related to establishing credibility in their first job as an advanced practice nurse (APN). Establishing this credibility incorporates not only graduating from an accredited NP program but also dealing with the concepts of certification, licensure, or authorization to practice, and the issue of credentialing and privileging. Even seasoned NPs are facing some of these issues for the first time in their careers as the complex areas of competence, scope of practice, and regulation continue to evolve. This article will provide a brief overview of each of these concepts, which are especially important for the new APN graduate; describe some of the misconceptions that cause problems for APNs; identify the current questions on regulation of APNs being debated; and outline some of the proactive steps that can be taken to stay ahead of the curve.

TERMINOLOGY

Because some of the terms that have been mentioned are misused or used interchangeably, it is important first to define them. Credentialing, used generally, is an umbrella term, which incorporates licensure, certification, accreditation, recognition, and registration. The International Council of Nurses (1998) defines credentialing in the following way:

Credentialing is a term applied to processes used to designate that an individual, program, institution or product has met established standards set by an agent (governmental or non-governmental) 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 Credentials must be periodically renewed as a means of assuring continued quality and they may be withdrawn when standards of competence or behavior are no longer met.

Licensure in the United States is the process by which an agency of 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 (Committee for the Study of Credentialing in Nursing, 1979). It permits the use of a particular title and defines a scope and sets the boundaries of the practice profession. Licensure further gives an individual a property right to practice his/her profession, based upon fulfilling the conditions of licensure (Committee for the Study of Credentialing in Nursing). The main purpose of licensure is to protect the public by ensuring a minimum level of professional competence.

Certification is the process by which a nongovernmental agency or an 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 (Committee for the Study of Credentialing in Nursing, 1979). The purpose of certification is to ensure various publics 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 for regulation (Hickey, 1999). Certification can be mandatory or voluntary. Certification has become a moderate form of regulation, which grants recognition to individuals who have met predetermined qualifications set by a state agency. The majority of the states have developed some form of regulation of advanced practice that requires passing of a national certification examination, and in many states, specific references to nursing certification have been incorporated into statute or into rules and regulations. Certification has also taken on new meaning in that it is required for reimbursement through the Center for Medicare and

Medicaid Services. Credentialing as previously defined is an umbrella term, which incorporates licensure, registration, certification, accreditation, and recognition. When the word credentialing is used within a hospital or health maintenance organization/managed care organization (HMO/MCO), it has another meaning. In this sense, credentialing is a process of procuring, verifying, and analyzing the eligibility and qualifications of the advanced practice registered nurse (APRN) provider to execute healthcare services (Joint Commission on Accreditation of HealthCare Organizations [JCAHO], 2002, 2004). The credentialing process verifies the integrity of the data submitted by the APN (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 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 practitioner 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 (Jones-Schenk, 1998).

All of the above mechanisms work together to provide the highest level of reliability that the practitioner is providing safe, competent care. (Notice I did not say “guarantee” competent care. We all know that multiple factors contribute to competent care and its outcomes, and even the most “competent” persons can find themselves in a situation where something went wrong.) One major area that 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 practitioners to know their own limitations and their state practice act limitations for their 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 not be taken lightly.

PROCESSES

There is current discussion and debate among regulators, certification bodies, and educators about how and at what level APNs should be regulated and just what elements indicate that the person is a safe practitioner. Questions arising from this discussion include the following: Does graduation from an accredited school along with certification in a specialty provide enough assurance of safe practice? At what level should the certification examination be focused? Should there be a general exam for all APNs (like the NCLEX model), or should we continue with the specialty practice exams for APNs. And what constitutes a specialty versus a subspecialty? Is there core knowledge that can be tested for the role of an NP, a clinical nurse specialist (CNS), or both? What is that core knowledge, and is it already being tested in the process of certification? What role does the employer or facility play in all this with the processes of creden-

tialing and privileging? How many safety nets and filters do we need? These are some of the questions being investigated and debated at the present time.

The current process for APNs for entry into practice is (1) graduate from an accredited program, (2) pass the certification exam in the specialty (the majority of states require passing a national exam), (3) apply for licensure or authorization to practice in a state, (4) secure employment, and (5) complete the credentialing and privileging process. Steps 2–4 may occur simultaneously, and the credentialing portion of step 5 is now mandated by JCAHO requirements. One could add a sixth step, which would incorporate application for authorization to bill for reimbursement through Medicare, Medicaid, or various insurance carriers. This is a topic for another article.

COMMON MISCONCEPTIONS

There are several misconceptions related to licensure and certification and the relationship between the two. The following discussion will touch briefly on a few of these misconceptions.

Misconception #1: If an APN went to an accredited school, that is all that is needed to ensure baseline knowledge for advanced practice.

Although one might expect this to be true, there are inconsistencies across the country in programs at the master’s and post-master’s level. For example, clinical experiences vary across schools, settings differ, and preceptors vary in knowledge and teaching ability.

The national certifying bodies, along with the Alliance for Accreditation, a group initiated by the American Association of Colleges of Nursing (AACN), have worked to ensure that accrediting bodies incorporate the National Task Force Criteria for Evaluation of Nurse Practitioner Programs into their accreditation standards when reviewing NP programs. The Masters Essentials document (AACN, 1996) also requires the advanced practice core courses (advanced pathophysiology, advanced health assessment, advanced pharmacology, and 500 clinical hours). Last, the Nurse Practitioner Primary Care Competencies in Specialty Areas (2002) developed and endorsed by numerous stakeholder organizations provide a framework for schools. These three documents are helping to drive consistency across programs.

Misconception #2: Certification equals licensure.

Certification serves as a quasi-regulatory mechanism and is a proxy to assist state boards in determining if an individual should be granted authority as an APN. All states do not require certification to grant authority or licensure (California, New York, and Oregon, for instance, do not). To change the process within a state for recognition of APNs can be lengthy and time consuming. Regulation of advanced practice can be promulgated in law (statute passed by the state legislature) or in rules and regulations (easier to change). Some states do their own review of transcripts, education, and experience. Yet other states may recognize one specialty certification examination and not another, while a neighboring state may recognize both.

Misconception #3: Certification allows an APN to do everything learned in school plus skills learned on the job.

Certification exams are based on national role delineation studies (job analyses), which 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 variety of prescriptive activities allowed from one state to the next. Having authority to practice broadly in one state does not necessarily grant the same authority in another state. Besides limitations applied by the state, the facility in which one works can limit activities through their credentialing process as noted previously. The key is to know what your state nurse practice act allows.

Misconception #4: Licensure as an APN will allow an NP to work anywhere in the United States.

Just as certification does not grant universal practice rights, neither does licensure. Each state grants its own rights within the confines of its nurse practice act. Some practice acts are very broad and allow nurses and NPs to practice with few constraints, while others are very specific and limiting. Sometimes this is reflective of the influence of the medical board in that state. It is not unusual for an NP who has functioned for many years in one state as a competent practitioner to move to another state that will not recognize his/her practice. This may be because NPs were nationally certified and licensed during a time when certificate NP programs were accepted, or they were certified under a time-limited waiver program (such as when family and adult NPs were approved to sit for acute care NP exams based on experience in acute care settings).

The Registered Nurse Multi-State Compact, which was introduced several years ago, has opened the door to allow for mobility for registered nurses across state lines. States that agree to the tenets of the compact allow nurses to work there without getting a separate license. There is also an Advanced Practice Compact (for APRNs) covering all four categories of advanced practice—NP, CNS, certified nurse midwife (CNM), and certified registered nurse anesthetist (CRNA)—introduced in 2004. Only Utah has joined the compact for APRNs as of January 2005, and only recognizing NPs and CNSs, not CNMs or CRNAs. The idea of mobility for advanced practice is much more complex because of the variety of state regulations and the issues of prescribing and practice arrangements (collaborative, supervised, etc.).

Misconception #5: Once certified, an APN does not need to worry about that process anymore.

Certification is time limited. Most certifying bodies have a renewal process that occurs every 3–6 years, with the norm being 5 years. Certification renewal is an indicator of continued professional development and exposure to new knowledge. Continuing education and professional activities along with practice are the main requirements of certification renewal.

Renewal of certification for the APN is critical just as is renewal of licensure. It is a professional responsibility. In fact, because reimbursement requires a current certification, it is extremely important to renew both certification and licensure

in a timely manner. Billing without a current license or certification could be deemed fraud and lead to legal problems.

TIPS FOR PRACTICE

Credentialing and privileging within an institution offers another layer of safety regarding advanced practice because it encompasses state practice acts, agency regulations, licensure, education, training, experience, competence, health status, and judgment of the practitioner. Again, professional responsibility must be a part of the picture. It is the responsibility of the individual to maintain documents, which support the privileging process. Just as health care strives for evidence-based practice, “practice-based” evidence can support what you may or may not be allowed to do within an institution. Keeping records of this practice-based evidence, i.e., continuing education, lists of procedures learned, and all training accomplished with verification of such training, can make the privileging process easier. More detailed ideas on how to do this can be found in *Credentialing and Clinical Privileging in Advanced Practice* (Joel, 2004).

In order 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, if not before, realizing it is never too late to start (although the earlier the easier). Include your license and certification information along with other pertinent information about your education, training, etc. The chapter on credentialing and privileging in the book by Joel (2004) mentioned above provides a list of items that will help to maintain your professional records and assist you throughout your career.
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 renewal cycle (some states synchronize the license with the birth month). Certifications on the other hand are usually every 5 years and synchronized with the month you took the exam. Although licensing and certification boards often send out reminders for renewal, it is really the responsibility of the individual 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 their Web site.
4. Get certified immediately upon graduation or as soon as possible if you are currently in practice. Keep in mind that certification is required by the majority of states and needed for reimbursement. If you do not think you need it, never plan to move, or feel it is unnecessary, get certified anyway. It is difficult to predict the future, and

the old adage “it’s better to be safe than sorry” may certainly come into play.

5. Save job descriptions for positions you have held in order to document areas of responsibility. This will not only provide documentation for future job searches and interviews but 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 or collaborating physician 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 (which does happen).
7. Keep copies of your continuing education 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 continuing education in pharmacology because many state boards require updates in this area for relicensure.
8. Keep a log of nonaccredited continuing education, which can be used to document professional development. Things such as grand rounds at the facility you work, case presentations you attended, or informal education sessions held at your facility may not seem important but can definitely show that additional continuing education is occurring. You will probably be amazed at how much you really do.
9. Smile. You have just taken “one small step” as an NP to validate that you are maintaining continued competency. Just think, if we had all done this 20–30 years

ago (speaking for those of us with beaucoup years behind us as NPs), what rich data and documentation we would have about our role and impact on the health-care system. It could have been “one large step for NPs”!

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