My name is Gina Crudden G-I-N-A C-R-U-D-E-N. I am a Clinical Nurse Specialist (CNS) with certification in Adult Gerontology. I have experience in acute care and my practice specialization is Hematology-Oncology. I am currently employed in an inpatient hospital-based setting and am also an adjunct faculty member in the CNS Doctor of Nursing practice program.

I have held licensure as a CNS in both Oklahoma and Virginia prior to relocating to Nebraska. Nebraska has the most restrictive practice environment of the three states. The CNS role is the most versatile of the four APRN roles, even though we are all trained in physiology, pharmacology and physical assessment, we are also prepared in addition to our areas of specialty, which we typically practice at minimum 3-5 years in our specialty prior to CNS training. We are versatile meaning that CNSs are prepared and qualified for practice roles varying from more than just direct patient care, Clinical nurse specialists provide diagnosis, treatment, and ongoing management of patients. CNSs are educated and trained to move between the system, patient, and nursing staff levels to attain the best possible outcomes for patients, other nurses, and the organization.

I am by no means underemployed or underutilized in my current practice role. I want this committee to understand, however, that the role and skills, including prescriptive authority that I previously relied upon for practice does and cannot exist in this state owing to the restrictions that are imposed by the current Nebraska CNS Practice Act. In short, as the law is written a CNS like myself cannot practice to the full extent of my education, certification and experience with a chronic disease patient population.

In Oklahoma, oncology training qualified me to administer chemotherapy, provide consultations, treat patients directly in the infusion center, inpatient in the hospital, and in the phase 1 clinical research center. I was also involved in all the patient’s care from the initial diagnosis, to treatment, through their palliative and hospice journeys respectively, up to and including discharge planning. Full prescriptive authority not only enabled me to prescribe a full range of medications, including controlled substances for patients for the duration of their cancer care and pain management, but durable medical equipment and supplies for hospice and end-of-life care as well.

In Virginia, my practice was also in a hospital-based service, but limited to a nurse educator/nurse administrator role. The need for an advanced practice nurse with my clinical skill set in oncology was clearly evident in that setting. I was astounded when I realized that no process existed under state statutes for facility privileging that would have provided an advanced practice nurse with much needed authority to prescribe in order to practice effectively in a direct care role.

Prescribing is not a distinct act outside of, or differentiated from advanced nursing practice. It is practice. Prescriptive authority is solely and effectively regulated by state law in accordance with APRN role, education and certification. Prescriptions must be for appropriate therapeutic purposes and must conform to the standards of acceptable and prevailing practice. Prescribers must also have the means to properly document assessment of the patient in a medical record and maintain records of prescriptions.
Prescriptive authority, particularly controlled substance prescribing, has been unfortunately misrepresented by the opposition in this Credentialing Review. Controlled substance prescribing is not only subject to all the preceding but limited by federal law and Drug Enforcement Agency (DEA) registration for prescribers at all levels of licensure. In addition, facilities may impose educational requirements for controlled substance prescribing including annual mandatory opioid prescribing requirements, pain management, naloxone prescribing, and prescription drug monitoring programs (PDMP). As a CNS pain management is not only our common practice but continuing education is required. I surpass this requirement yearly by licensing requirements and have done so for the entirety of my practice as a CNS as I was licensed before LB731 which mandates prescriber education for opioids was passed in Nebraska.

In summary, as a clinical nurse specialist my goal is to best inform the public that we are trained at the masters and doctoral levels in health policy, advocacy, cost containment, and evidence-based practice. Direct care, quality, and safety of those in need are at the forefront of our practice as it is for all health care providers. I implore those at this professional roundtable to reconsider the effect that this review can have for the current CNSs practicing in Nebraska and for their patients. As future CNS’s are about to graduate, I hope that they too may have a seat at this table.

Thank you for allowing me to testify today and having the honor to share with you my experience as a clinical nurse specialist.