

Professional Roles for the Advanced Practice Nurse

The chapters in Part 1 of this book consider the role of the advanced practice nurse from historical, present-day, and future perspectives. This content is intended to serve as a general introduction to select issues in professional role development for the advanced practice of nursing. As students progress in the educational process and develop greater knowledge and expertise, role issues and role transition should be integrated into the entire educational program.

In Chapter 1, the editors define advanced practice nursing from a traditional perspective and trace the history of the role. Traditionally, advanced practice has been limited to clinical roles that include the clinical nurse specialist, nurse practitioner, certified nurse-midwife, and certified registered nurse anesthetist; to practice, the last three roles require a license beyond the basic registered nurse (RN) license. This book, however, uses an expanded definition of advanced practice

nursing that reflects current thinking. As you read this chapter, keep in mind this expanded definition and appreciate the development of the advanced clinical roles for nursing practice. This discussion lays the foundation for a deeper understanding of the historical development, current practice, and future opportunities for advanced practice in nursing.

In Chapter 2, Stewart discusses the tipping point for nurse practitioners as we enter the age of healthcare reform and the role nurse practitioners will play in providing cost-effective, quality primary care to a demographically changing population. Stewart's quantitative and qualitative research resulted in the Stewart Model of Nurse Practitioner that reflects key attributes that make nurse practitioners unique. Much has transpired related to the role and education of nurses for advanced practice. Most revolutionary is the mandate to have by 2015 the clinical doctorate be the required degree for advanced clinical

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practice nursing (American Association of Colleges of Nursing, 2004). With this change, many master's programs for advanced practice nurses will transition to the doctoral level. The rationale for this position by the American Association of Colleges of Nursing (AACN) is based on several factors:

- The reality that current master's degree programs often require credit loads equivalent to doctoral degrees in other healthcare professions
- The changing complexity of the healthcare environment
- The need for the highest level of scientific knowledge and practice expertise to ensure high-quality patient outcomes

In an effort to clarify the standards, titling, and outcomes of clinical doctorates, the Commission on Collegiate Nursing Education (CCNE)—the accreditation arm of AACN—has decided that only practice doctoral degrees awarding a Doctor of Nursing Practice (DNP) will be eligible for accreditation. In addition, the AACN has published the *Essentials of Doctoral Education for Advanced Nursing Practice*, which sets forth the standards for the development, implementation, and program outcomes of DNP programs.

Needless to say, this recommendation has not been fully supported by the entire profession. For instance, the American Organization of Nurse Executives (AONE, 2007) does not support requiring a doctorate for managerial or executive practice on the basis of expense, time commitment, and cost benefit of the degree. It also suggests that nurses may migrate toward a master's degree in business, social sciences, and public health in lieu of a master's degree in nursing. Further, AONE suggests there is a lack of evidence to support the need for doctoral education across all aspects of the care continuum. In contrast, doctoral and master's-level education for nurse managers and executives is encouraged.

For other advanced practice roles, including those of the clinical nurse leader, nurse educator, and nurse researcher, a different set of educational requirements exists. The clinical nurse leader as a generalist remains a master's-level program. For nurse educators, the position of AACN—although not universally accepted within the profession (as demonstrated by the existence of master's programs in nursing education)—is that didactic knowledge and practical experience in pedagogy are additive to advanced clinical knowledge. Nurse researchers will continue to be prepared in PhD programs. Thus, there will be only two doctoral programs in nursing, the DNP and the PhD. It is important for readers to keep abreast of this movement as the profession further develops and debates these issues because the outcomes have implications for their own practice and professional development within their own specialty. The best resource for this is the AACN website and the websites of specialty organizations.

The next three chapters in Part 1 discuss the future of advanced practice nursing and the evolution of doctoral education—in particular, the practice doctorate. Within today's rapidly changing and complex healthcare environment, members of the nursing profession are challenging themselves to expand the role of advanced practice nursing to include highly skilled practitioners, leaders, educators, researchers, and policymakers.

In Chapter 3, Chism defines the DNP degree and compares and contrasts the research doctorate and the practice doctorate. The focus of the DNP degree is expertise in clinical practice. Additional foci include the *Essentials of Doctoral Education for Advanced Nursing Practice* as outlined by the AACN (2004), which include leadership, health policy and advocacy, and information technology. Role transitions for advanced practice nurses prepared at the doctoral level call for an integration of roles focused on the provision of high-quality, patient-centered care.

In Chapter 4, White discusses emerging roles of DNP graduates as nurse educators, nurse executives, and nurse entrepreneurs and advanced practice nurses' increased involvement in public health programming and integrative and complementary health modalities.

In Chapter 5, Barker sets the foundation for advanced practice nurses to recognize and embrace their role as leaders and influencers of practice changes in healthcare organizations. Complexity science, organizational change theory, and transformational leadership are used as a platform for advanced practice nurses to realize their leadership potential and their role as agents of change.

Last, in Chapter 6, Ash and Miller provide an in-depth look at interdisciplinary and inter-professional collaborative teams as means to effect positive health outcomes. They discuss

both barriers to successful collaborative teams and factors for successful team development. Advanced practice nurse leaders educated at both the master's and doctoral levels are uniquely positioned to overcome the workforce and regulatory issues that might otherwise diminish the success of collaborative teams—in particular, those involving participants from the nursing and medicine disciplines.

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Introduction to the Role of Advanced Practice Nursing

Susan DeNisco and Anne Barker

CHAPTER OBJECTIVES

1. Describe the four roles used to define advanced practice nursing in the United States.
2. Identify the differences between the clinical nurse leader role and the traditional advanced practice nursing roles.
3. Recognize factors that currently influence the supply and demand of nurse educators.

INTRODUCTION

Considerable confusion exists regarding the terminology *advanced nursing practice*, *advanced nurse practice*, and *advanced practice registered nurse*. Based on the definition given by the American Association of Colleges of Nursing (AACN) and other widely accepted usages, the term *advanced practice registered nurse (APRN)* has been used to indicate master's-prepared nurses who provide direct clinical care. This term encompasses the roles of nurse practitioner (NP), certified nurse-midwife (CNM), certified registered nurse anesthetist (CRNA), and clinical nurse

specialist (CNS). The first three roles require a license beyond the basic registered nurse (RN) license. The role of the clinical nurse specialist requires a master's degree but does not require separate licensing unless the CNS is applying for prescriptive authority.

Complicating the titling and definition of roles, the AACN (2004) defined advanced practice nursing as follows:

Any form of nursing intervention that influences health care outcomes for individuals or populations, including direct care of individual patients, management of care for individuals and

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populations, administration of nursing and health care organizations, and the development and implementation of health policy. (p. 2)

The *Consensus Model for APRN Regulation* is a product of substantial work done by the APRN Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee in an effort to address the irregularities in regulation of advanced practice registered nurses across states. As defined in the model for regulation, there are four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered

nurse (APRN). APRNs are educated in one of the four roles and in at least one of the following population foci: family/individual across the life span, adult-gerontology, pediatrics, neonatal, women's health/gender-related, and psych/mental health (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, 2008) Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. The model further addresses licensure, accreditation, certification, and education of APRNs. **Figure 1-1** depicts the APRN Regulatory Model.

FIGURE 1-1 APRN Regulatory Model.

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National Council State Board of Nursing: The APRN Consensus Model 2008

OTHER ADVANCED PRACTICE NURSING ROLES AND THE NURSING CURRICULUM

Consequently, nurse administrators, public health nurses, and policymakers are considered advanced practice nurses albeit they do not provide direct care or obtain advanced practice licensure per the state they practice in. As this book goes to press, there is an initiative to expand and clarify the definition of and requirements for advanced practice nursing. No matter the final outcome of this deliberation, all nurses need the same set of essential knowledge. The Essentials series outlines the necessary curriculum content and expected competencies of graduates of baccalaureate, master's, and doctoral nursing practice programs and the clinical support needed for the full spectrum of academic nursing (AACN, 2006, 2011a, 2011b). Although the terms *advanced practice nursing*, *advanced practice nurses*, *advanced nursing practice*, and *advanced practice registered nurses* are used interchangeably throughout this text, the authors are addressing any students enrolled in master's or doctoral programs that are designed, implemented, and evaluated by the AACN Essentials. Chapter 2 provides an overview of the master's and doctoral essentials.

Clinical Nurse Leaders

Clinical nurse leaders (CNLs) were not considered in the definition of *advanced practice* because the CNL role did not exist when the aforementioned roles were defined. Some argue that the CNL is a generalist, and thus CNL should not be considered an advanced practice role. The authors disagree. The clinical nurse leader role requires advanced knowledge and skill beyond that attained with the baccalaureate degree, and it requires a master's degree for certification.

According to the AACN (2007), the clinical nurse leader is responsible for patient care outcomes and integrates and applies evidence-based information to design, implement, and evaluate healthcare systems and models of

care delivery. The CNL is a provider and manager of care at the point of care for individuals and cohorts of patients anywhere healthcare is delivered (AACN, 2007). In fact, as recommended in the AACN white paper on the CNL role, all CNL curricula across the country require graduate-level content that builds on an undergraduate foundation in health assessment, pharmacology, and pathophysiology. In many master's-level programs, NP and CNL students sit side by side to learn these advanced skills. Also, the inclusion of these three separate courses—health assessment, pharmacology, and pathophysiology—facilitates the transition of master's program graduates into Doctor of Nursing Practice degree programs (AACN, 2007). Moreover, the CNL program graduate has completed more than 400 clinical practice hours, similar to number required of NP graduates, and is eligible to sit for the CNL Certification Examination developed by the American Association of Colleges of Nursing.

The clinical nurse leader, similar to the clinical nurse specialist (discussed next), has developed clinical and leadership skills and knowledge of statistical processes and data mining. The CNL brings evidence-based practice to the bedside, creates a culture of safety, and provides quality care. This aligns directly with the American Organization of Nurse Executives (AONE) guiding principles for the nurse of the future (Haase-Herrick & Herrin, 2007).

Clinical Nurse Specialists

Clinical nurse specialists (CNSs) have been providing care to patients with complex cases across healthcare settings since the 1960s. The CNS role originated largely to satisfy the societal need for nurses who could provide advanced care to psychiatric populations. Since the passage of the National Mental Health Act in 1946, the National League for Nursing (NLN) and the American Nurses Association have supported the CNS role. The first program at Rutgers University educated nurses

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for the role of psychiatric clinical specialist (McClelland, McCoy, & Burson, 2013). Following this implementation, the usefulness of the role became apparent, and schools of nursing began to educate nurses across specialties, including oncology, medical-surgical, pediatric, and critical care nursing.

The literature of the 1980s and 1990s shows that care provided by clinical nurse specialists produced positive patient outcomes related to self-management and early hospital discharge (Fulton, 2014). More recently, studies show improvement in patient satisfaction and in pain management, and reduced medical complications in hospitalized patients (McClelland et al., 2013).

The recent trend toward hospital and healthcare system mergers and the focus on cost containment force the CNS role into a precarious position. Hospital administrators

have a difficult time showing that CNSs decrease hospital costs, and they cannot bill for specialty nursing services. The AACN states that there are significant differences between the CNS and CNL roles; however, few differences are clearly articulated by those being educated in or practicing in these roles or in recent documents created by AACN (National Association of Clinical Nurse Specialists [NACNS], 2005). This has created role confusion and uncertainty regarding the role these nurses should play in the inpatient hospital setting. **Table 1-1** compares role competencies of the CNS and the CNL.

In addition, the APRN Consensus Model states that graduate nursing roles that do not focus on direct patient care will not be eligible for APRN licensure in the future (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee,

TABLE 1-1

Comparison of Select Role Competencies for the CNS and the CNL

Clinical Nurse Specialist	Clinical Nurse Leader
Direct care	Critical thinking/clinical decision making Assessment
Systems leadership	Nursing technology and resource management
Collaboration	Communication
Coaching	
Consultation	
Research	Assimilates and applies research-based information to design, implement, and evaluate client plans of care
Ethical decision making, moral agency, and advocacy	Ethics
	Accountability
	Professional values, including social justice
	Professional development

Sources: American Association of Colleges of Nursing. (2007). *White paper on the role of the clinical nurse leader*. Retrieved from <http://www.aacn.nche.edu/aacn-publications/white-papers/cnl-white-paper>; National CNS Competency Task Force. (2010). *Clinical nurse specialists core competencies: Executive summary 2006–2008*. Retrieved from <http://www.nacns.org/docs/CNSCoreCompetenciesBroch.pdf>

2008). This creates further challenges for the CNS, such as variability in state title protection, inconsistency among states grandfathering in the CNS role, lack of a regulatory approach to accepting grandfathered CNSs to practice in other states, and job loss based on misperceptions of the model (NACNS, 2005).

Nurse Educators

The role of nurse educators may be one of the most contentious issues in nursing education. According to the National League for Nursing (2002), the nurse educator role requires specialized preparation, and every individual engaged in the academic enterprise must be prepared to implement that role successfully. Nurse educators are key resources in preparing the nursing workforce to provide quality care to meet the healthcare needs of a rapidly aging and diverse population. Whether in academic or clinical settings, nurse educators must be competent clinicians. However, whereas being a good clinician is essential, some would say it is not sufficient for the educator role. Much of the debate in nursing education centers on the fact that the nurse educator student primarily needs advanced knowledge and skills in clinical practice in order to teach, and therefore graduate

education should be directed toward enhancing clinical expertise. According to the AACN (2014), the master's-level curriculum for the nurse educator builds on baccalaureate knowledge, and graduate-level content in the areas of health assessment, pathophysiology, and pharmacology strengthen the graduate's scientific background and facilitate understanding of nursing and health-related information (AACN, 2014). In this model students are required to take courses beyond the graduate core curriculum and that provide content expertise in the "3 Ps" (pharmacology, pathophysiology, and physical assessment), similar to the education of nurse practitioners and clinical nurse leaders. On the other side of the argument, many clinicians who become nurse educators are already clinical experts and are content experts. They need the advanced degree to learn teaching/learning theories and strategies, curriculum development, and student evaluation content.

Nurse Educator Supply and Demand

The Health Resources and Services Administration (HRSA) has projected a large increase in demand for nurses, from approximately 2 million full-time equivalents in 2000 to approximately 2.8 million in 2020. See **Table 1-2**.

TABLE 1-2 Supply, Demand, Shortage of Nurses

	2000	2005	2010	2015	2020
Supply	1,890,700	1,942,500	1,941,200	1,886,100	1,808,000
Demand	2,001,500	2,161,300	2,347,000	2,569,800	2,824,900
Shortage	(110,800)	(218,800)	(405,800)	(683,700)	(1,016,900)
Supply ÷ Demand	94%	90%	83%	73%	64%
Demand shortfall	6%	10%	17%	27%	36%

Source: Data from U.S. Department of Health and Human Services, 2004.

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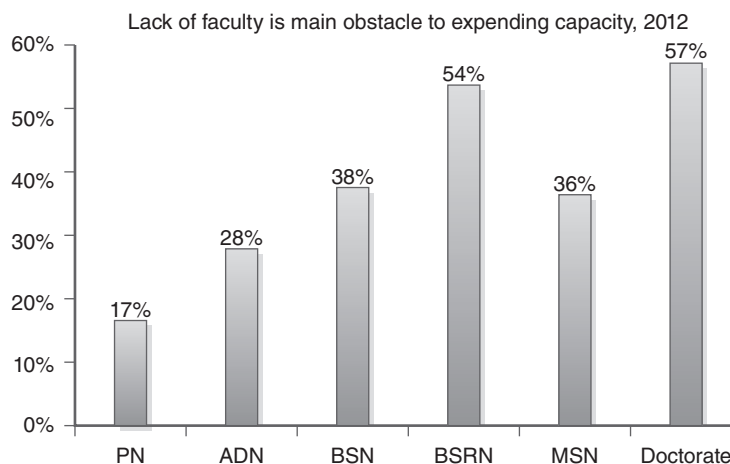
Meeting this projected demand will require a significant increase in the number of nursing graduates, perhaps by as much as 40%, to fill new nursing positions as well as to account for attrition from an aging workforce. This corresponds to an increase in the demand for nursing faculty. In 2008, approximately 13% of the nation's registered nurses held either a master's or doctoral degree as their highest educational preparation (AACN, 2011b). The current demand for master's- and doctorally prepared nurses for advanced practice, clinical specialties, teaching, and research roles far outstrips the supply.

Consequently, to increase the supply requires a major expansion of nursing faculty and other educational resources. With the "graying" of the current pool of nursing faculty, efforts we make must persuade more nurses and nursing students to pursue academic careers, and to do so at an earlier age. Careers in nursing education are typically marked by long periods

of clinical practice prior to being educated for a faculty role. The idea of advanced practice nurses with clinical doctorates versus research doctorates working in academia has been supported by the National Organization of Nurse Practitioner Faculties, NLN, and AACN. The Doctor of Nursing Practice degree may be the answer to imparting advanced knowledge in evidence-based practice, quality improvement, leadership, policy advocacy, informatics, and healthcare systems to clinicians, managers, and educators. The DNP-prepared educator is poised to educate a future nursing workforce that can influence patient care outcomes. The nursing faculty shortage contributes to the problem of nursing programs turning away qualified applicants across graduate and undergraduate programs. See **Figure 1-2**.

This text addresses the essential content that nurses pursuing advanced degrees need to learn to prepare to be nurse educators. Competence as an educator can be established,

FIGURE 1-2 Faculty shortage.



Source: National League for Nursing. 2013. Annual Survey of School of Nursing, Fall 2012.
www.nln.org/research/slides/index.htm.

Data from National League for Nursing (2012). Lack of Faculty is Main Obstacle to Expanding Capacity, 2012.

recognized, and expanded through master's and doctoral education, post-master's certificate programs, continuing professional development courses, mentoring activities, and professional certification as a faculty member. Each academic unit in nursing must include a cadre of experts in nursing education who provide the leadership needed to advance nursing education, conduct pedagogical research, and contribute to the ongoing development of the science of nursing education.

Nurse Practitioners

Nurse practitioners have been providing care to vulnerable populations in rural and urban areas since the 1960s. The role was born out of the shortage of primary care physicians able to serve pediatric populations. Initial educational preparation ranged from 3 to 12 months, and as the role developed and expanded so did educational requirements. By the 1990s, the master's degree was endorsed as entry-level education for nurse practitioner specialties. In 2004, the AACN took a position recognizing

the Doctor of Nursing Practice as the entry-level degree for advanced practice nursing, stating the following:

Advanced competencies for increasingly complex clinical, faculty and leadership roles . . . enhanced knowledge to improve nursing practice and patient outcomes . . . enhanced leadership skills . . . better match of program requirements . . . provision of an advanced educational credential . . . parity with other health care professionals . . . enhanced ability to attract individuals to nursing from non-nursing backgrounds; increased supply of faculty for clinical instruction; and improved image of nursing. (AACN, 2004, p.7)

Today, nurse practitioners are the largest group of advanced practice nurses. More than 192,000 NPs are licensed and practicing with some level of prescriptive authority in all 50 states and the District of Columbia (American Association of Nurse Practitioners, 2013). Nurse practitioners work, are educated, and hold board certification in a variety of specialty areas, including pediatrics, family, adult-gerontology, women's health, and acute care, to name a few. (See **Table 1-3**.)

TABLE 1-3 Distribution, Mean Years of Practice, Mean Age by Population Focus

Population	Percentage of NPs	Years of Practice	Age (years)
Acute care	6.3	7.7	46
Adult*	18.9	11.6	50
Family*	48.9	12.8	49
Gerontological*	3.0	11.6	53
Neonatal	2.1	12.2	49
Oncology	1.0	7.7	48
Pediatric*	8.3	12.4	49
Psych/mental health	3.2	9.1	54
Women's health*	8.1	15.5	53

*Primary care

Source: Data from the 2010 AANP National Practice Site Survey.

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A federal initiative continues to exist to increase the number of primary care providers in the United States. The 2010 consensus report entitled the *Future of Nursing* developed by the Institute of Medicine (IOM) and the Robert Wood Johnson Foundation (RWJF) calls for a transformative change in nursing education. It calls for nurses to “practice to the full extent of their education and training” and for “nurses to achieve higher levels of education and training through an improved education system” (Institute of Medicine, 2010). This analysis and recommendation coincided with the passage of the legislation for the Patient Protection and Affordable Care Act (2010), which is estimated to increase the need for qualified primary care providers to 241,200 by 2020. The supply of primary care NPs is projected to increase by 30%, from 55,400 in 2010 to 72,100 in 2020 (Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, 2013). This coupled with a demographically aging and ethnically diverse population makes the demand for primary care providers, in particular, nurse practitioners, greater than ever. It is well known that nurse practitioners provide high-quality, safe, and cost-effective care. Excellent educational programs are needed to increase this pool of healthcare providers to improve access to care and strengthen care provided for elderly and other vulnerable populations.

Nurse-Midwives

The first nurse-midwifery school was established in 1925 by Mary Breckenridge, who founded the Frontier Nursing Service (FNS) in Hyden, Kentucky, in response to the high maternal and child death rates in rural eastern Kentucky, an area isolated by geography and poverty. The midwives were educated to provide family health services, as well as childbearing and delivery care, at nursing centers in the Appalachian Mountains. As reported by the FNS (2014), by the late 1950s the FNS nurse-midwives had attended more than 10,000

births, and maternal and infant outcome statistics in rural Kentucky were better than those for the whole country during the nurse-midwives first three decades of service. The most significant differences were in maternal mortality rates (9.1 per 10,000 births for FNS compared with 34 per 10,000 births for the United States as a whole) and low birth weights (3.8% for FNS compared with 7.6% for the country).

Today, all nurse-midwifery programs are housed in colleges and universities. There are multiple entry paths to midwifery education, but most nurse-midwives graduate at the master's degree level and several programs culminate in the DNP degree. These programs must be accredited by the American College of Nurse-Midwives (ACNM) for graduates to be eligible to take the national certification examination offered by the American Midwifery Certification Board (AMCB). Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the autonomous primary care management of women's health, focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning, and gynecologic needs of women.

CNMs are licensed, independent healthcare providers who have prescriptive authority in all 50 states, the District of Columbia, American Samoa, Guam, and Puerto Rico. CNMs are defined as primary care providers under federal law. Although midwives are well known for attending births, 53.3% of CNMs identify reproductive care and 33.1% identify primary care as their main responsibilities in their full-time positions (Fullerton, Schuiling, & Sipe, 2010). Examples include performing annual exams; writing prescriptions; providing basic nutrition counseling, parenting education, and patient education; and conducting reproductive health visits. According to the American Midwifery Certification Board, there are 13,071 CNMs and 84 CMs in practice in the United States. Since 1991, the number of midwife-attended births in the United States has nearly doubled. In

2012, CNMs or CMs attended 313,846 births—a slight increase despite a decrease in total U.S. births compared with births in 2011.

In 2012, CNMs or CMs attended 91.7% of all midwife-attended births, 11.8% of all vaginal births, and 7.9% of total U.S. births (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013). **Figure 1-3** shows birth data from 2000 to 2012. Whereas the majority of midwife-attended births occurs in hospitals, some occur at home and in freestanding birth centers. See **Figure 1-4**.

Allowing CNMs to have hospital privileges as full, active members of the medical staff would promote continuity of care, and birth certificate data would more accurately reflect provider type and outcomes (Buppert, 2012).

Medicaid reimbursement for midwifery care is mandatory in all states and is 100% of the physician fee schedule under the Medicare Part B fee schedule. The majority of states also mandates private insurance reimbursement for midwifery services. It is clear that nurse-midwives have improved primary healthcare services for women in rural and inner-city areas. It is imperative that nurse-midwives be given a larger role in delivering women's health care for the greater good of society.

Nurse Anesthetists

According to the American Association of Nurse Anesthetists (AANA), nurses have been providing anesthesia services to patients in the

FIGURE 1-3

Percentage of births attended by certified nurse-midwives and certified midwives, 2002–2012.

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Martin, J., Hamilton, B., Osterman, M., Curtin, S., & Mathews, T. (2013). Births: Final data for 2012. *National Vital Statistics Reports*, 62(9). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf

FIGURE 1-4

Site of births attended by certified nurse-midwives and certified midwives, 2012.



FPO

Martin, J., Hamilton, B., Osterman, M., Curtin, S., & Mathews, T. (2013). Births: Final data for 2012. *National Vital Statistics Reports*, 62(9). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf

United States for more than 150 years. The first anesthesia administered to patients was chloroform used for the treatment of wounded soldiers during the American Civil War. The shortages of physicians qualified to administer anesthesia during wartimes continued, and nurse anesthetists were the main providers of anesthesia care for U.S. military personnel on the front lines for World War I, World War II, the Korean War, and the Vietnam War; nurse anesthetists also provide care in the current conflicts in the Middle East (Keeling, 2009).

Historically, nurse anesthetists have been the primary providers of anesthesia care in rural America, enabling healthcare facilities in medically underserved areas to offer obstetrical, surgical, pain management, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100% of rural hospitals. According to the U.S. Bureau of Labor Statistics

(2013), the states with the highest employment level for CRNAs are Texas, Tennessee, North Carolina, Florida, and Ohio.

The credential CRNA came into existence in 1952 when the AANA established an accreditation program to monitor the quality and consistency of nurse anesthetist education (Keeling, 2009). Today, CRNAs safely administer anesthetics in more than 34 million cases each year in the United States, according to the American Association of Nurse Anesthetists (AANA) 2012 Practice Profile Survey. There are more than 44,000 CRNAs practicing in the United States (AANA, 2011). The scope and standards of practice for CRNAs are similar to those for other advanced practice registered nurses. Nurse anesthetists are licensed as independent practitioners, and they provide care autonomously and in collaboration with surgeons, dentists, podiatrists, and anesthesiologists, among other

healthcare professionals. CRNAs provide evidence-based anesthesia and pain care services to patients at all acuity levels in a variety of settings for procedures, including, but not limited to, surgical, obstetrical, diagnostic, therapeutic, and pain management (AANA, 2013). Currently, CRNAs are qualified and have the legal authority to administer anesthesia without anesthesiologist supervision in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands; however, some states have put into place restrictions and supervisory requirements in some settings (Joel, 2013).

NURSE ADMINISTRATORS

The term *nurse administrators* is being used to simplify the below discussion. This includes roles such as the nurse executive, supervisor, director, nurse manager, and so forth. Since individuals in these roles are responsible for leading a successful work environment, it is ironic that educational requirements for nurse administrators are not as demanding as those for other advanced practice roles. The knowledge, skills, and attitudes needed to be successful as a nurse administrator are not included

in nursing baccalaureate programs, let alone associate degree/diploma programs, yet some of these exams are offered to experienced nurse managers without a baccalaureate and/or master's degree as noted in **Table 1-4**.

There are two organizations that certify nurse administrators: the American Nurses Credentialing Center and the American Organization of Nurse Executives. Both offer certification exams in basic and advanced nursing administration. Table 1-4 includes the educational requirement for each organization. Years and levels of experience vary for each certification exam and can be accessed on their websites (American Nurses Credentialing Center, 2014; American Organization of Nurse Executives, 2014).

Further complicating the preparation of nurse administrators are the practices of many organizations of:

- Promoting good “bedside” nurses to managerial positions without assessing or developing their leadership abilities
- Weak orientation/on-the-job training for new nurse administrators
- No requirements for an advanced degree for the position

TABLE 1-4

Educational Requirements for Nurse Administrator Certifying Organizations

	American Nurses Credentialing Center	American Organization of Nurse Executives
Basic certification	Hold a bachelor's or higher degree in nursing	Associate degree Diploma Bachelor's degree
Advanced certification	Hold a master's or higher degree in nursing, or hold a bachelor's degree in nursing and a master's in another field	Master's degree or higher

Source: Data from American Nurses Credentialing Center (ANCC). (2014). ANCC certification center. Retrieved from <http://www.nursecredentialing.org/Certification>; American Organization of Nurse Executives (AONE). (2014). About AONE credentialing center. Retrieved from http://www.aone.org/resources/certification/about_certifications.shtml

CONCLUSION

A national initiative exists to improve access to quality health care while reducing costs. This mandate will require the emergence of many new roles, not yet imagined for nurses. Recently, new roles to serve as coordinators of care, such as nurse navigators and healthcare coaches, have been established. In the future, these roles may require advanced degrees and certification. Opportunities for nurses to coordinate care throughout the continuum of care are likely to abound. The aging population will require nurses to be “chronic disease specialists” and “wellness coaches.” Population health, gender-specific health care, and global health specialties will become the norm. An understanding of the healthcare delivery system, healthcare policy, and care transition will need to be incorporated into graduate curricula. As this book goes to press, there is a push to expand and clarify the definition of and requirements for advanced practice nursing. No matter the final outcome of this deliberation, all nurses need the same set of essential knowledge and the ability to think outside the box.

DISCUSSION QUESTIONS

1. What are the differences between the terms *advanced practice nursing* and *advanced practice registered nurse*?
2. What emerging roles should be considered when describing advanced practice nursing?
3. Why was the APRN Consensus Model developed and what does it hope to do for the provision of health care?

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