CHAPTER 2

Advanced Practice Nursing: Moving Beyond the Basics

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CHAPTER OBJECTIVES

1. Define advanced practice nursing and explain how the term is currently expanding and evolving.
2. Articulate the history, similarities, and differences of each of the traditional roles categorized as advanced practice nursing.
3. Consider how the roles of entry-level nurses through advanced practice nurses should be conceptualized for the future.

INTRODUCTION

According to the *American Heritage Dictionary* (1980), the term *advanced* means "ahead of contemporary thought or practice or at the highest level of difficulty." *Practice* is defined as "the exercise of an occupation or profession." *Nursing* has been defined as "The diagnosis and treatment of human responses to actual and potential health problems" (American Nurses Association [ANA], 1995).

In the last century, nursing has undergone many changes that have reshaped and expanded what is considered to be basic nursing. As nursing's role has evolved, so has its scope of practice. Many of today's nursing functions were originally within the realm of medicine or other disciplines. This metamorphosis has been part of the profession's gradual evolution and maturity over time.

Advanced practice nursing is defined by Hamric, Spross, and Hanson (2005) as "the application of an expanded range of practical, theoretical, and research-based competencies to phenomena experienced by patients within a specialized clinical area of the larger discipline of nursing" (p. 89).

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This term was coined to encompass four major roles within nursing: clinical nurse specialist (CNS), nurse practitioner (NP), certified nurse–midwife (CNM), and certified registered nurse anesthetist (CRNA). It distinguishes these nurses with advanced skills from those who practice as more traditional staff nurses and allows for a distinction between the nurse functioning at a more specialized level than the registered nurse. These roles also have been considered to be equally complex or at the same level of advanced practice. A common characteristic of these roles is the application of a greater breadth of knowledge and complexity of decision making to the problems of nursing care. Although each of these roles is distinct with regard to the specific areas of knowledge and skills that it draws on, all of them require high levels of critical thinking, independence, and decision making.

Finally, use of the term "advanced practice" has allowed for legislative changes to proceed with a minimum of confusion over how advanced practice and staff nurses differed. This distinction has created opportunities for advanced practice nurses (APNs), but also established a new class of nurses who seemed to some to be more privileged than their peers.

Each of these roles evolved a bit differently. The CNM evolved from the historical role of the midwife, who even today can be a nonnurse. The CRNA role evolved from the experiences of nurses in the Civil War, who provided pain relief for soldiers (Hamric, Spross, & Hanson, 2005).

The CNS began to flourish in the 1950s and 1960s due to interest in promoting the highest level of nursing practice that coincided with the strong evolution of nursing theories and frameworks. This early CNS role had its roots in psychiatric nursing in the late 19th century and in specialist nursing roles in the early 1900s (Hamric, Spross, & Hanson, 2005). Initially, the CNS tended to work in hospitals or chronic care facilities caring for ill patients with specific health conditions. A major focus was the performance of indirect roles in nursing, such as consultation, research, staff education, and patient/family education. Much of the practice—though certainly not all of it—was also directed toward care coordination or institutional management of care. This specialty practice often dealt with symptom management or diagnosis of responses to illness rather than health promotion, and it focused on a unique set of problems emanating from illness. CNSs are highly competent nurses with a specialty focus who effectively meet the needs of patients in an increasingly complex healthcare system.

However, as cost-containment concerns became paramount and hospitals had to begin to cut costs in the 1980s, many of these CNS positions were eliminated even as staff nurses began to deal with sicker patients who had shorter stays in hospitals. In contrast, an increasing demand for nursing care in the community and long-term settings led to new opportunities for CNSs in home health care or specialized care for persons with HIV/AIDS or other chronic illnesses. At that time, CNSs began to function in community and long-term care settings as shortened hospital stays led to the "quicker and sicker" discharge of patients from hospitals or tertiary care facilities. In the past 10 years, the CNS has reemerged as an important component of patient care. The renewed interest in the CNS role has been fueled by regulatory and professional concerns. Pressures to demonstrate outcomes of care and to reduce risks such as patient injury or financial loss have generated a demand for the advanced practice knowledge and skills offered by the CNS (Heitkemper & Bond, 2004).

The NP role evolved from a shortage of primary care medical providers in underserved areas in the 1960s. Efforts to train NPs were spurred by progressive legislation of the Great Society era. As the federal government expanded financial access to care funded by Medicare, Medicaid, and community health center legislation, the need for more primary care providers became acute. The efforts to expand nursing

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practice were viewed by some in both medicine and nursing as a way for doctors to extend their care for patients using this new care provider.

This early concept of the NP role led many nurse educators to reject the idea of an advanced practice nurse and to close many avenues to university education. Thus, in the beginning years of NP role preparation, the majority of NP educational programs evolved outside of traditional nursing education in continuing education programs rather than in traditional master's degree programs. These early programs reflected the collaborative intent of nurses and more progressive doctors to create a new role for primary care practice. Through the NP role, the nurse's scope of practice expanded into realms that were previously only within the scope of medical practice, such as health assessment, medical diagnosis, and treatment of common and chronic illnesses. Most NPs functioned within the realm of primary care or generalist care, adding a strong health-promotion focus, while substituting for physicians who were not numerous enough to meet client needs. As the role has evolved, NPs have assumed greater responsibility in the management of more complex and chronic illnesses, and some have branched into specialty areas such as oncology, cardiology, or emergency care. When the NP role emerged, health promotion and disease prevention were being emphasized as an important component of primary care in all sectors of the healthcare system. As a result, NPs have a very strong foundation in direct patient care rather than in indirect nursing roles (Hamric & Hanson, 2003).

By the 1980s, the original community or public health focus of advanced practice was diluted as medical care became more individually focused and health financing failed to address public health needs. In this period, containment of healthcare costs was paramount in the minds of health policy makers, and the country was on the brink of replacing a public health focus with a system dominated by managed care. One exception was the community health CNS who continued to work in community settings such as Visiting Nurse Associations or home care agencies.

As more patients were discharged from the hospital due to shortened stays and prospective payment methodologies, the need for home care skyrocketed, and an entirely new sector of the healthcare system emerged. Cost-containment efforts of the 1980s were also a major force in the realignment of nursing roles. Diagnosis-related groups (DRGs) and cost-containment efforts led the public, insurers, and policy makers to demand more cost-efficient care. This changed the face of hospital nursing forever. Demands on nurses in inpatient settings increased exponentially. These developments led to nursing shortages and to periodic staffing crises, as were seen in 1989 and 2001.

Several occurrences led to fundamental changes in the mix of roles and the level of independence in nursing and to increasing difficulties in differentiating the various roles for nursing. An overarching factor was the women's movement, which reached its peak in the 1960s and 1970s, because it influenced the increased desire by nurses to have autonomy from other providers, such as physicians. This had a major effect on the nursing profession.

In the 1980s and 1990s, the NP role was viewed as a potentially cost-effective option to fill the growing need for healthcare services. It also received an enormous amount of attention in the public and professional press. Another important change was the increased movement of NPs into acute care and medical specialties from primary care settings. As NP education began to be housed in universities, the distinction between the NP and the CNS was blurred.

In the 1980s, the CNS role was seen as too costly by hospital administrations because of reduced reimbursements from Medicare and shrinking hospital budgets. Thus many CNS positions were lost across the country as hospitals eliminated any position viewed as providing indirect care. Education for the CNS specialty suffered from a lack of consistency across

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programs and confusion over the definition of terms. Educational programs reflected this confusion by using the designations NP and CNS interchangeably or by creating blended roles. The blended role was intended to combine the best of both roles, but it also confused those credentialing or hiring these advanced practice nurses (Hamric & Hanson, 2003; Hamric, Spross, & Hanson, 2005). Currently, the predominant view is that the CNS and the NP roles are distinct from each other and should have separate educational programs (Hamric & Hanson, 2003; NACNS, 2004).

Since the inception of advanced practice nursing, health policy and regulatory advances enabling practice have moved forward with unprecedented swiftness and congruity. These advanced practice roles seem to have captured the imagination and interests of nurses who want more independent decision making and relief from what has been an increasingly stressful hospital environment. Barriers to practice for advanced practice nurses have decreased greatly over the past 20 years as legislative reforms have swept the nation. Third-party reimbursement for services and legislation for prescriptive privileges are now almost universal for NPs, CNMs, and CRNAs. These regulatory reforms have been far-reaching and now have been adopted by virtually every state (Pearson, 2004; Towers, 2004).

The role of advanced practice nurses has expanded well beyond initial expectations, and demands on practice continue to increase. For example, prescription writing now is almost universal, and the types and breadth of prescribing have increased across all categories of NPs (Pulcini & Vampola, 2002; Pulcini, Vampola, & Levine, 2005). Moreover, practice barriers may be lowest in rural areas or other areas where there is a greater need for healthcare services.

EDUCATIONAL STANDARDS

Educational standards have evolved in different ways for each specialty. CNMs and CRNAs took the lead in establishing national standards for certification and program accreditation. The American Association of Nurse Anesthetists (AANA) established its own separate certification process in 1945 and an accreditation process in 1952 (AANA, 2004). The American College of Nurse Midwives (ACNM) established its certification process in 1971 and its own separate accreditation process in 1982 (ACNM, 2004). These efforts enabled these specialties to evolve with a consistency not seen in either NP or CNS educational programs, which expanded with less consistency and homogeneity.

Yet regulatory changes and reimbursement efforts for CNSs have lagged behind and are surrounded by controversy, such as whether prescribing should be part of the role (Lyons, 2004). Recently, CNSs have organized under the National Association of Clinical Nurse Specialists (NACNS) and have begun to standardize their education, regulations, and practice, publishing the NACNS's landmark document, *Statement on Clinical Nurse Specialist Practice and Education* (2004).

Master's degree education preparation for NPs became the norm by the mid-1980s. Educational programs for NPs have become more congruent as a result of the National Organization of Nurse Practitioner Faculties' (NONPF) *Advanced Nursing Curriculum Guidelines and Program Standards for Nurse Practitioner Education* (1995), the *Domains and Competencies of Nurse Practitioner Practice* (2002, 2006, 2011), the *Criteria for Evaluation of Nurse Practitioner Programs* (2008), and the *Nurse Practitioner Competencies in Specialty Areas* (2002). As more NPs entered master's programs, the indirect-role (e.g., consultation, education, research) content in NP programs increased. Currently, more than 90% of NPs are master's prepared, and virtually all NPs are educated in graduate-level programs (Berlin, Stennett, & Bednash, 2004). The concept of the NP tipped in the mid-1990s, to use Malcolm Gladwell's (2000) term, and is now mainstream within nursing education. Currently, 330 graduate programs in nursing offer NP programs, with a total of

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706 tracks, and 60% of master's program graduates are enrolled in NP programs (Berlin et al., 2004).

Another factor to consider is the new master's entry option that is popular in nursing education today. The number of graduate nursing programs offering this option, which allows a person with a non-nursing degree to earn a master's in nursing as an NP or CNS in 2–3 years, increased threefold from 1990 to 2002 (AACN, 2003). This development is important because originally most advanced practice nurses had experience in nursing before entering the advanced roles.

Finally, the members of the AACN endorsed the *Position Statement on the Practice Doctorate in Nursing*, which recommended that educational preparation for advanced practice nursing be extended from master's degree preparation to the doctoral completion by 2015. Currently, there are 210 doctor of nursing practice (DNP) programs in the United States, with another 100 under development. This latest trend, which has the potential to revolutionize health care, is the topic of much debate among nursing leaders and members of other healthcare disciplines. Chapters 4, 5, and 6 discuss the role of the DNP in greater detail.

THEORETICAL ISSUES AND CHALLENGES

The latest shifts have been important factors in shaping the current nursing environment. The key issue is that there are now entry-level advanced practice nurses. However, our understanding of "advanced" has not moved with this paradigm shift. What has occurred is that many of the skills involved in advanced practice roles have moved into the mainstream. Most new nurses see these distinct skills as basic rather than being unique to advanced practice. For example, many baccalaureate nursing programs now integrate physical assessment, pathophysiology, pharmacology, and health promotion, similar to advanced practice program curricula. Currently, the CNS, the CRNA, and the CNM are still viewed within the advanced practice role in the United States. But in many countries, a clear precedent has been set for basic nurses to have the skills of the nurse–midwife.

Internationally, the advanced practice role is evolving in diverse ways depending on the historical, political, and social factors that have shaped the nursing role and educational programs in each country. The definition of advanced practice nursing being adopted by the International Council of Nurses (2002) is as follows:

> The Nurse Practitioner/Advanced Practice Nurse (NP/APN) is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level.

Many countries are beginning to develop advanced practice nursing programs. This role advancement is built on the strong role that nurses have in developing nations. The International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN), which is affiliated with the International Council for Nurses, has been instrumental in publishing definitions and scope and standards statements to guide nations in the development and expansion of advanced practice nursing. The challenge is to standardize practice definitions and educational standards while building and honoring the traditions of individual countries.

How do we, in 2011, reconceptualize the concept of advanced practice, given the current state of nursing education for APNs both in the United States and internationally? Is our old concept of advanced practice out of date? Can we reconceptualize what we consider to be the skills necessary for entry into nursing practice? If we have been operating with an outdated definition of advanced practice, what are the skills or competencies of advanced practice nurses that can be expected on entry into the profession? Does one need a specified number of years of experience

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before being called advanced, or are the skills that we once called advanced really mainstream or entry-level skills? If the latter is true, then we need to rethink the skills and competencies necessary for entry-level versus expert practice.

Grypdonck, Schuurmans, Gamel, and Goverde (2004) reconceptualize advanced practice nursing by making a distinction between nursing science and nursing practice. These authors point out that nursing science and nursing practice operate in different spheres and ways of thinking. For example, scientists base their decisions on the greatest possible degree of certainty, and clinicians deal with uncertainty every day. According to Grypdonck et al., expert advanced practice nurses effectively bridge that gap through their advanced education and practice experience. This is where the practice doctorate may really begin to fit into this complex continuum of advanced practice nurses.

In nursing, we have placed a great deal of weight on experience and position rather than on a specific level of knowledge. As we replace our current cadre of nurses with younger individuals, we would do best to see knowledge acquisition as forming a continuum, beginning with a set of basic practice skills and moving to expert practice that integrates scientific principles and research skills with ongoing teaching, mentoring, and expert consultation.

In the last 12 years, the cadre of generic master's programs or accelerated master's programs has grown threefold, and in many master's programs, these students account for the majority of graduates. We must welcome these relatively young nurses into the fold of advanced practice nurses rather than exclude them and continue to operate in old ways.

In our reconceptualization of advanced practice, we might consider some way to recognize advanced practice through internships or other mechanisms of recognition. We may want to reconsider career ladders or Benner's levels of novice to expert practice. An expert advanced practice nurse should effectively use and incorporate research-based practice with a goal toward engaging in independent or collaborative research. Requirements for advanced practice nurses to precept, teach, or mentor newer nurses could be part of the certification credential. High-level skills such as consultation or clinical teaching require a body of expert knowledge and mastery of the content and are clearly in the realm of expert advanced practice nursing. Certification itself could be reframed to recognize entry-level versus expert practices, as was its original intent.

As we progress in redefining advanced practice, new technologies and knowledge, such as genetics and informatics, will increasingly enhance the patient-centered approach. Clinicians now are guided by state-of-the-art knowledge, which can be at the clinician's fingertips at any moment in practice through technology. In this new paradigm, the needs and demands of knowledgeable patients as well as scientific evidence-based guidelines will guide practice.

CONCLUSION

The nursing profession is now in a period of change, a paradigm shift. Nursing educators and policy makers must recognize this shift in order to plan for the future. As in the past, societal healthcare needs will shape the future direction of advanced practice nursing, and it will be up to our profession to change to meet those needs (Thompson & Watson, 2003). Our profession's ability to manage change and to move to a new conceptualization of advanced practice nursing will determine our success or failure in meeting societal needs. It is time to revisit even basic documents, such as *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 2011) and *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008), which set the baseline definition of levels of nursing education. Our challenge now is to redefine advanced and recognize what is truly basic to all nursing practice.

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DISCUSSION QUESTIONS

1. Using the definitions of advanced practice nursing, should nursing administration, education, and research be considered advanced practice nursing?
2. List the similarities and differences between each of the roles discussed in this chapter.
3. What is the policy in your state related to licensure, reimbursement, and MD supervision for advanced practice nursing?
4. How can we reconceptualize what we consider to be the skills and knowledge needed for entry into practice as compared to those needed for advanced practice?

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