3rd Edition

Advanced Practice Nursing

Core Concepts for Professional Role Development

Michaelene P. Mirr Jansen
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FOREWORD

It is with pride that I see a book that I originally helped develop now being continued by colleagues. Drs. Mirr Jansen and Zwygart-Stauffacher are to be commended for their efforts in extending the scope of the first two editions so that students in advanced practice programs will have the knowledge and skills needed to be proficient professionals.

When the first edition of *Advanced Practice Nursing* was published 10 years ago, initial efforts were being made in the nursing community to look at similarities among the four advanced practice roles rather than at what differentiated the roles. Since that time there has been an increased uniformity in both the education and legal requirements for the four advanced roles: nurse practitioner, clinical nurse specialist, nurse midwife, and nurse anesthetist. This has allowed the nursing community to move forward in identifying strategies to further enhance the roles and the ways that nurses with advanced education can contribute to improving the health care of the citizens.

In the third edition, Drs. Mirr Jansen and Zwygart-Stauffacher include the most recent content for preparing students for all advanced practice roles. Viewing these roles from within nursing is emphasized throughout the book. Nursing has established itself as a full-fledged profession. Inclusion of a section on evidenced-based practice substantiates the growing sophistication of nursing practice. While the independence of the advanced practice nurse is emphasized, the need for the collaborative role is addressed.

Nurses being prepared for these new roles often encounter difficulties shifting from roles in which they were *experts* to a new role in which they are *novices*. Often faculty members forget about the challenges and fears new graduates have about the transition. From their extensive background in teaching advanced practice nursing students, the editors are very aware of these challenges and have included chapters on transition to the new role and marketing the role. Not only will students find these chapters helpful, but it will prod faculty members to include class time to assist students to assume the new roles.

Students and faculty members will find the third edition of *Advanced Practice Nursing*, a valuable text as it contains the key information necessary

for the role aspect of advanced practice. Many courses are devoted to the clinical focus of practice. This text places the clinical content within the realities of the practice arena. All will find it an easy-to-use and helpful text.

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PREFACE

The dynamics of health care systems provide both challenges and opportunities for advanced practice nurses (APNs). Today, more than ever, health care is influenced by politics, legislation, regulatory bodies, insurance companies, and global events. Nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists have worked diligently over the decades to ensure their roles in the health delivery system. Although positive patient outcomes have been linked with care provided by advanced practice nurses, APNs need to be ever vigilant in advocating legislation that continues to promote advanced practice nursing.

This text is written for graduate students enrolled in advanced nursing programs. The content presented is not setting or role specific, but rather addresses the competencies identified by organizations representing advanced nursing practice including the American Association of Colleges of Nursing (AACN), the National Organization of Nurse Practitioner Faculties (NONPF), the National Association of Clinical Nurse Specialists, the American Association of Nurse Anesthetists (AANA), and the American College of Nurse Midwives (ACNM).

A brief overview of each of the four advanced nursing roles and the historical context within which they developed provides the reader with an understanding of the richness of advanced practice nursing. Contributors to this text bring perspectives from a wide variety of practice backgrounds and settings. Their current, active involvement in the delivery of care ensures that the content presented is critical for students as they embark on new careers as APNs.

This third edition of *Advanced Practice Nursing* reflects the changing arena in which APNs practice. Previous editions have emphasized specific subroles of the advanced practice nurse. This edition integrates the roles as a dynamic component of advanced practice nursing. The text is organized in three units: Foundations of Advanced Practice Nursing, Implementation of the APN Role, and Transitions to the Advanced Practice Role.

The editors wish to acknowledge the work of past contributors and, in particular, the past editor, Dr. Mariah Snyder. Dr. Snyder's high standards

and vision for advanced practice nursing were instrumental in establishing the quality of the first two editions of this text. We hope that her retirement is as fruitful as her professional career, and we thank her for all her guidance and assistance.

Michaelene P. Mirr Jansen
Mary Zwygart-Stauffacher

UNIT I

FOUNDATIONS OF ADVANCED PRACTICE NURSING

Chapter 1

OVERVIEW OF ADVANCED PRACTICE NURSING

Linda Lindeke, Mary Zwygart-Stauffacher, Melissa Avery, and Kathleen Fagerlund

Advanced practice nurses (APNs) are taking their place in the forefront of the rapidly changing health care system. APNs are developing a myriad of roles in organizations that aim to provide cost-effective, quality care. APNs can be found working in community health, governmental positions, hospitals, nursing homes, clinics, and internationally. They serve the most economically disadvantaged as well as the elite. APNs function as deans and educators, as consultants and researchers, as policy experts, and, of course, as outstanding clinicians.

Advanced practice nursing is an exciting career choice with many opportunities and challenges. Some of the challenges are related to prospective payment systems, decreased hospital stays, and spiraling costs. Evolving technology is producing amazing diagnostic and treatment results; genetic research is unraveling complex pathophysiology; and sophisticated information technology is changing the way information is gathered, stored, and shared. Home health care programs and complementary care clinics are now commonplace. These and other trends have resulted in a rapidly changing health care system, ripe to be influenced by APNs.

Graduate education prepares APNs to be key players in these complex systems. Nursing theories provide APNs with a strong conceptual base for practice. Nursing research uncovers scientific evidence for best practice, and research utilization skills enable APNs to bring fresh ideas and proven interventions to health care consumers. Complex, evolving reimbursement mechanisms require that APN education also encompass content in financial management and health policy issues. Whereas APNs were traditionally

educated to provide advanced nursing care within a specific system or setting such as a hospital unit or clinic, it is now typical that APNs navigate within the multifaceted care delivery arena.

Advanced specialization of nurses beyond their formal entry-level education has a long history in nursing. Nurse anesthetists and nurse midwives were the first to develop programs, professional organizations, and certification, beginning nearly a century ago (Hanson & Hamric, 2003). However, only recently has the preparation, certification, and licensing of these advanced nurses become more standardized (American Nurses Association, 2004a). The term "advanced practice nurse," sometimes also called "advanced practice registered nurse" (APRN) denotes nurses with formal post-baccalaureate preparation in one of four roles: nurse midwives, nurse anesthetists, nurse practitioners, and clinical nurse specialists (ANA, 2004a).

A number of factors led nursing leaders to delineate these four roles in advanced practice nursing. A critical factor was the legal status that enabled APNs to obtain direct reimbursement for their nursing services, a gradual process first achieved by nurse midwives 25 years ago and expanded to the other three roles over time. Reimbursement law and regulations require that nursing be able to specify the preparation of these reimbursable APNs and led to increased standardization of titling and education. The term APN became the common name used to designate these four roles. Public protection was another factor that led to APN delineation. State boards of nursing are mandated by state legislatures to safeguard the public from unsafe practice, and over time, all states have implemented laws and regulations to ensure that nurses who have APN preparation have certain expertise and skills. In some states, this is done by a second-level licensure process; in other states it is through laws such as title protection and specific designation of scope of practice (National Council of State Boards of Nursing, 2002). A final factor impacting standardization has been work done by nursing organizations such as the American Association of Colleges of Nursing (AACN, 1996), ANA (2004a, 2004b), the National Organization of Nurse Practitioner Faculties (HRSA, 2002; NONPF, 1995) and numerous specialty organizations to define advanced practice nursing curricular guidelines and program standards.

APNs are best understood by examining each of the four groups that comprise advanced practice nursing: their evolution, their commonalities, and issues related to titling, licensing, and certification.

ADVANCED PRACTICE NURSING

There are numerous definitions of advanced practice nursing. *Nursing's Scope and Standards of Practice* (ANA, 2004b) defines APNs as having advanced specialized clinical knowledge and skills through master's or doctoral education that prepares them for specialization, expansion, and advancement of practice. Specialization is concentrating or delimiting one's focus to part of the whole field of nursing. Expansion refers to the acquisition of new practice knowledge and skills, including knowledge and skills legitimizing role autonomy within areas of practice that overlap traditional boundaries of medical practice. Advancement involves both specialization and expansion and is characterized by the integration of theoretical, research-based, and practical knowledge that occurs as part of graduate education in nursing. APN is an umbrella term for the four roles mentioned earlier—clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM) and nurse practitioner (NP). Each role is distinguishable from the others but in some respects they overlap. This APN definition encompasses nurses engaged in clinical practice; it does not include nurses with advanced preparation for administration, education, or research (ANA, 2004b).

Only recently has there arisen the expectation that APNs receive their education within master's or doctoral nursing programs. Although CNSs have always had master's degrees in nursing, the educational preparation for many nurse midwives, nurse anesthetists, and nurse practitioners did not necessarily occur in graduate nursing programs. Now, however, NPs must receive their education in graduate master's programs in nursing; CRNAs receive preparation in graduate programs, although the master's degree does not necessarily have to be in nursing. The majority of CNMs are prepared in graduate nursing programs. Moving education of APNs within master's degree nursing programs has resulted in more uniformity in CNM, CRNA, NP, and CNS education, regulation and credentialing.

The four groups included within the definition of APN have each evolved along different paths over different time frames. Because of their historical underpinnings, each APN category has developed a strong sense of history, with members having strong allegiance to their title and their group. At times this allegiance has been a barrier to the development of consistent language regarding APN roles since each group has developed its own education, history, and title. However significant progress continues to be made in identifying commonalities (Hanson & Hamric, 2003).

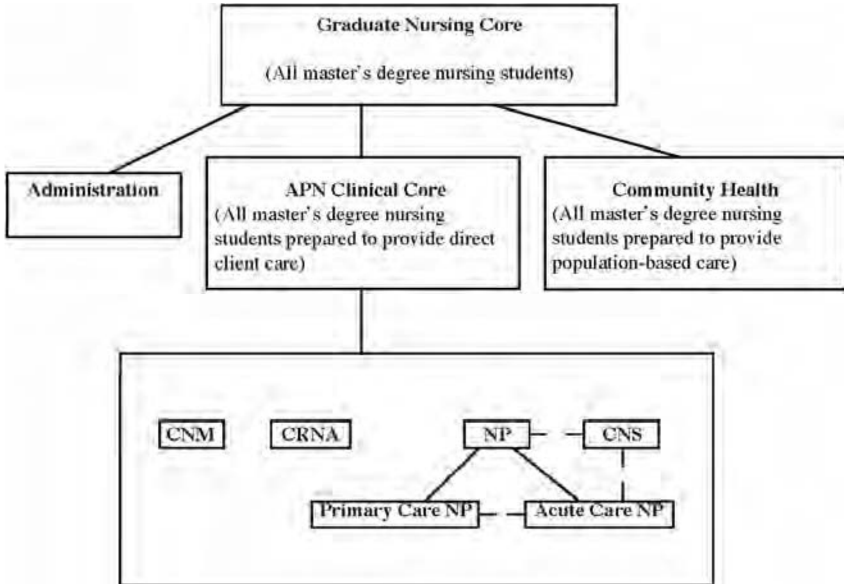

FIGURE 1.1 The AACN conceptulization of graduate nursing education.

Note: From *The essentials of master's education for advanced practice nursing,* American Association of Colleges of Nursing, 1997, p. 5. Copyright © 1997 by the author. Reprinted with permission of the author.

Traditionally, four functions have been identified as characteristic of APN practice: patient care, educator, consultant, and researcher (Hamric, Spross, & Hanson, 2004). Although the four functions have been most strongly associated with CNSs, these functions are appropriate for all four types of APN. NONPF (1995) specified that these four functions were part of the professional role of an NP. Research-based practice is one characteristic that has overwhelmingly been acknowledged as a key characteristic of APNs. Each of these functions will be addressed in subsequent chapters.

The AACN, through a consensus building process, formulated curricular elements for graduate advanced practice nursing education in 1996. Figure 1.1 depicts the AACN conceptualization of graduate nursing education. Table 1.1 presents the content to be included in the graduate core curriculum and the advanced practice nursing core curriculum.

TABLE 1.1 Essential Elements of Curriculum for Advanced Practice Nursing by AACN

Graduate Core Curriculum
- Research
- Policy, Organization, and Financing of Health Care
  - Health care policy
  - Organization of the health care delivery system
  - Health care financing
- Ethics
- Professional Role Development
- Theoretical Foundations of Nursing Practice
- Human Diversity and Social Issues

Advanced Practice Core Elements
- Advanced Health/Physical Assessment
- Advanced Physiology and Pathology
- Advanced Pharmacology

Note: From *The essentials of master's education for advanced practice nursing,* American Association of Colleges of Nursing, 1997, p. 5. Reprinted with the permission of the author.

The core clinical content focuses on advanced health/physical assessment, advanced physiology and pathology, and advanced pharmacology. The AACN (1996) noted that this content is of a general nature and that specifics are needed for students in the various specialty areas. For example, midwifery students need additional content on assessment of pregnant women and newborn infants, nurse anesthetist students require content on anesthetic agents, while psychiatric/mental health students need additional content on antipsychotic medications. One area not specified in the AACN core content was nursing therapeutics. With society's increasing use of complementary therapies, it is imperative that APN students receive content about complementary therapies. Many of these therapies have a long history of use in nursing, so APNs should incorporate these therapies into their practice. NONPF (1995) noted that although APN curricula are crowded, there is increasing social pressure to include content on complementary therapies.

Although the curriculum and competencies proposed by NONPF in 1995 and updated in 2002 (HRSA, 2002) were developed specifically for NP education, they have much relevance to the content included in the graduate nursing core. Components of the graduate nursing core, advanced nursing specialty core, and NP specialty core are found in Table 1.2. Many

TABLE 1.2 Nurse Practitioner Curiculum Guidelines and Program Standards from NONPF

Graduate Nursing Core
Research
Health Policy
Nursing and Health-Related Theory
Organizational Theory
Ethics
Cultural Diversity
Community-Based Care
Health Care Economics
Health Care Delivery System
Managed Care
Advanced Nursing Practice Core
Health Assessment
Pharmacology
Pathophysiology
Clinical Decision Making
Health Promotion/Disease Prevention
Community-Based Practice
Role
Family Theory
Nurse Practitioner Specialty
Specialty Management
Clinical Practice
Specialty Role

Adapted from *Advanced nursing practice: Curriculum guidelines and program standards for nurse practitioner education,* National Organization for Nurse Practitioner Faculties, 1995, p. 44.

commonalities are found between the AACN curriculum (1996) and the NONPF guidelines and standards (NONPF, 1995; HRSA, 2002). For example, both see the need for content on research, theory, ethics, health care systems, and cultural diversity. The APN core of NONPF is more detailed than the AACN document and specifies the need for content on clinical decision-making and family theory.

In addition to the content to be included in graduate APN programs, NONPF (1995) also proposed domains and competencies for NPs. These six domains are: 1) management of client health/illness status, 2) nurse-client relationship, 3) teaching-coaching function, 4) professional role, 5) managing and negotiating health care delivery systems, and 6) monitoring

and ensuring the quality of health care practice. These are based on work by Brykczynski (1989), Benner (1984), and Fenton (1985). Specific competencies are described for each domain. These domains are detailed and encompassing, indicating that APN practice requires a broad range of knowledge and expertise.

The American Nurses Association (ANA 2004a, 2004b) has developed many types of practice standards, some of which are broadly inclusive, and others that are specialty-focused, such as the *Scope and Standards of Pediatric Nursing Practice* (ANA, 2003). These documents differentiate scope of practice for APNs as well as for non-APN-prepared nurses (ANA, 2004 a).

Health promotion and health maintenance are emphasized in all of the nursing standards. Nurses have traditionally emphasized health promotion activities as being a key characteristic of the professional practice of nursing. Health promotion, whether it be for persons who have no specific illness or for persons who have chronic health problems, is critical in our current society. Implementation of care that focuses on health promotion also has been shown to be cost effective (Safriet, 1998). Horrocks, Anderson and Salisbury (2002) noted that NPs offered more advice on self-care and management than did physicians, and they seemed to identify physical abnormalities more frequently; they showed no difference in patient health outcomes between the NP and physician-managed patient groups.

Ethics is another area where there are professional standard for APNs. In addition to issues related confidentiality and relationships, APNs must provide support to patients and families in making ethical decisions related to treatment options (Bartter, 2001). Although ethical issues appear to be more prominent in tertiary care settings, issues such as abuse and neglect are present in all settings. APNs are frequently called upon to assist staff in resolving ethical dilemmas.

The increasing complexity of care and the provision of care in multiple settings require that APNs collaborate with other health professionals. Collaboration is an ANA standard of care and is also referenced in state and federal law. Functioning on interdisciplinary teams or working in collaboration with other health professionals requires APNs to be able to identify the contributions of nursing to patient outcomes. APNs also collaborate with patients and their families in planning care and making decisions about the most acceptable treatments.

The above description of content in APN education and professional standards demonstrates the complexity and depth of the APN preparation and practice. It has been questioned whether APNs can be fully prepared for

their scope of practice in 2–year master's programs. This has prompted discussion about whether it would be more appropriate to have APNs prepared at the doctoral level (Edwardson, 2004). Some examples of doctoral APN education exist, such as the program at Rush University, which had awarded a Nursing Doctorate (ND) degree to students completing NP programs and is now moving to a DNP. A new initiative being advocated by the AACN and explored by NONPF is the Doctor of Nursing Practice (DNP). These two organizations held a joint conference in December 2003 and developed a consensus statement regarding the DNP role that is currently under discussion by educators and APNS nationwide (AACN & NONPF, 2003). In October 2004, the AACN passed a resolution to move APN education to a practice doctorate level by 2015. There are many pros and cons to the DNP. The increased in time and money for students is balanced by the increase in knowledge, skill, and prestige that this doctoral degree would confer. The trends in pharmacy, audiology and physical therapy as well as psychology to have doctoral education as the entry to practice have also had some influence on the DNP initiative. Whether the practice community will embrace the DNP and whether employers will compensate DNP graduates at a level commensurate to their education are just two of the issues under discussion at the present time.

NURSE MIDWIVES

Nurse midwives are unique among those APNs because they are educated in two different professions. Midwifery is a profession in its own right; nursing is not a prerequisite to midwifery in many countries around the world. The American College of Nurse-Midwives (ACNM) defines certified nurse midwives (CNMs) as individuals educated in the two disciplines of nursing and midwifery and who possess evidence of certification according to the requirements of the ACNM (ACNM, 2004). According to the ACNM, midwifery practice

> is the independent management of women's health care, focusing particularly on common primary care issues, family planning and gynecologic needs of women, pregnancy, childbirth, the postpartum period and the care of the newborn. The certified nurse midwife and certified midwife practice within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. Certified nurse midwives and certified midwives practice in

accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM, 2004, p. 1).

Although the focus of midwifery care has historically been prenatal care and managing labor and births, nurse midwives are also primary care providers for essentially healthy women. Nurse midwives strongly believe in supporting natural life processes and not utilizing medical interventions unless there is a clear indication. This belief and others are reflected in the 2004 ACNM philosophy statement that states that midwives believe that

> Every person has a right to:
> — equitable, ethical, accessible quality health care that promotes healing and health
> — health care that respects human dignity, individuality and diversity among groups
> — complete and accurate information to make informed health care decisions
> — self-determination and active participation in health care decisions
> — involvement of a woman's designated family members, to the extent desired, in all health care experiences (ACNM, 2004b).
>
> Midwives also believe in:
> — watchful waiting and nonintervention in normal processes
> — appropriate use of interventions and technology for current or potential health problems
> — consultation, collaboration and referral with other members of the health care team as needed to provide optimal health care (ACNM, 2004b)

Midwifery is a very old profession and, in fact, is mentioned in the Bible. The practice of midwifery as it was known declined in the 18th and 19th centuries, and obstetrics developed as a medical specialty. In 1925, Mary Breckenridge established the Frontier Nursing Service (FNS) in Kentucky and was the first nurse to practice as a nurse midwife in the United States. She received her midwifery education in England and returned to the US with other British nurse midwives to set up a system of care similar to that which she had observed in Scotland. The FNS was begun to care for individuals who were without adequate health care. The nurse midwives of the FNS provided maternal and infant care and effectively demonstrated quality care and significantly improved outcomes. The first U.S. nurse midwifery education program was started at the Maternity Center

Association, Lobenstein Clinic, in New York City in 1932. The American College of Nurse-Midwives was incorporated in 1955. Nurse midwifery practice grew slowly until the late 1960s and early 1970s when nurse midwifery experienced increased acceptance as a profession and an increase in consumer demand for nurse midwives and the kind of care they provided (Varney, 2003). There are over 7,000 CNMs/CMs in the U.S., and in 2002 they attended over 300,000 births, or 7.6% of all births and over 10% of vaginal births in the U.S. (Martin, Hamilton, Sutton, Ventura, Menacker, & Munson, 2003). Nurse midwives have direct third-party reimbursement and prescriptive authority in nearly all states.

In the 1970s, national accreditation of nurse midwifery education programs and national certification of nurse midwives was begun by ACNM. The accreditation process is recognized by the United States Department of Education and the certification process now conducted by the ACNM Certification Corporation, is recognized by the National Commission of Health Certifying Agencies (Varney, 2003). The ACNM document, Core Competencies for Basic Midwifery Practice (ACNM, 2002), describes the skills and knowledge that are fundamental to the practice of a new graduate of an ACNM Division of Accreditation (DOA) accredited education program. These competencies guide curricular development in midwifery programs and are utilized in the nationally recognized accreditation process. Categories of competencies described in the document include professional responsibilities; the midwifery management process; primary health care of women including health promotion and disease prevention, preconception care, family planning and gynecologic care, peri- and postmenopausal care and management of common health problems; the childbearing family, including prenatal, intrapartum and postpartum care of the childbearing woman pre, as well as care of the newborn. Hallmarks of midwifery practice are also delineated (ACNM, 2002).

Nurse midwifery education began with certificate programs and has progressed primarily, but not entirely, to graduate education. There are presently 45 ACNM DOA accredited programs in the United States. All but four are master's programs; a majority of the certificate programs have an affiliation with a graduate program. The majority of master's programs are in schools of nursing; one is in a school of public health. A direct entry (nonnursing) route to midwifery education, utilizing the same nationally recognized accreditation and certification standards, began in 1997 at the State University of New York (Downstate campus), and a second accredited program added a direct entry option for physician assistants in 2001. Cer-

tified midwife (CM) students are required to complete certain prerequisite health sciences courses such as chemistry, biology, nutrition, and psychology, prior to beginning midwifery education. In addition, certain knowledge and skills, common in nursing practice, are required before beginning the midwifery courses in the program (ACNM DOA, 2000). CMs are currently licensed to practice under the title of certified midwife in three states. Certified Professional Midwives (CPMs), another type of direct entry midwife who attend out of hospital births are increasingly recognized by some states, and are often confused with the ACNM DOA educated midwives.

Nurse midwives in the U.S. have consistently demonstrated that their care results in excellent outcomes and client satisfaction. These outcomes include those of the large proportion of underserved, uninsured, low-income, minority and otherwise vulnerable women for whom CNMs provide care. Researchers have demonstrated lower caesarean section rates and outcomes comparable to a private obstetrics practice in a nurse midwifery practice caring for underserved women (Blanchette, 1995), and fewer medical interventions, a lower caesarean section rate for nurse midwifery clients compared with similar low-risk women cared for by family physicians and obstetricians (Rosenblatt, et al., 1997). A study at the National Center for Health Statistics demonstrated significantly lower risks of neonatal mortality, low birth weight, infant mortality and a significantly higher mean birth weight in births attended by nurse midwives compared with those attended by physicians. These comparisons controlled for medical and sociodemographic risks (MacDorman & Singh, 1998). Births attended by CNMs and CMs occur primarily in hospitals; 99% of births in the U.S. occurred in hospitals in 2002 (Martin, et al., 2003).

Over the nearly 80–year history of nurse midwifery and midwifery in the United States, a strong base of support, documented by research, has been developed. The number of educational programs and practitioners has grown substantially. As health care dollars continue to be carefully allocated and specific outcomes are measured more closely, certified nurse midwives and certified midwives should continue to play an important role in providing quality primary health care to women.

CERTIFIED REGISTERED NURSE ANESTHETISTS

Modern nurse anesthesia traces its roots to the last two decades of the 1800s where records indicate that nurses were often asked to administer

anesthesia. In fact, the practice was so common that in her 1893 textbook entitled *Nursing: Its Principles and Practices for Hospital and Private Use,* Isabel Adams Hampton Robb included a chapter on the administration of anesthesia. By 1912 a formal course in anesthesia had been developed in Springfield, Illinois, by Mother Magdalene Weidlocher of the Third Order of the Hospital Sisters of St. Francis. The Sisters of St. Francis went on to establish St. Mary's Hospital in Rochester, Minnesota, where nurse anesthetists became well-known for their expertise in the administration of anesthesia (Bankert, 1989). Alice McGaw, one of the early nurse anesthetists for the Drs. Mayo at St. Mary's Hospital, published several papers in the early 1900s reporting on the thousands of anesthetics administered with ether and/or chloroform—all "without a death attributable to the anesthesia" (Bankert, 1989, p. 31).

A Certified Registered Nurse Anesthetist (CRNA) is a registered nurse who is educationally prepared to provide anesthesia and anesthesia-related services in collaboration with other health care professionals. The practice of nurse anesthesia is a specialty within the profession of nursing, and CRNAs are recognized by state licensing or regulatory agencies in all 50 states, primarily boards of nursing (Jordan, 1994).

According to the American Association of Nurse Anesthetists (AANA), the CRNA scope of practice includes, but is not limited to:

1. Performing and documenting a preanesthetic assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering, and administering preanesthetic medications and fluids; and obtaining informed consent for anesthesia.
2. Developing and implementing an anesthetic plan.
3. Initiating the anesthetic technique, which may include: general, regional, local, and sedation.
4. Selecting, applying, and inserting appropriate noninvasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
5. Selecting, obtaining, and administering the anesthetics, adjuvant and accessory drugs, and fluids necessary to manage the anesthetic.
6. Managing a patient's airway and pulmonary status using current practice modalities.
7. Facilitating emergence and recovery from anesthesia by selecting, obtaining, ordering and administering medications, fluids, and ventilator support.

8. Discharging the patient from a postanesthesia care area and providing postanesthesia follow-up evaluation and care.
9. Implementing acute and chronic pain management modalities.
10. Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life-support techniques (AANA, 2002).

Nurse anesthesia educational programs are a minimum of 24 months in length and are conducted in a master's degree framework. In 2004, approximately 55% of nurse anesthesia educational programs were housed within or affiliated with university schools of nursing. The other nurse anesthesia programs offer a variety of master's degrees, including majors such as nurse anesthesiology (not housed in a school of nursing), biology, health science, or anesthesiology education. The Council on Accreditation (COA) accredits all programs for nurse anesthesia educational programs. In turn, the COA is recognized by the U.S. Department of Education and the Commission on Recognition of Postsecondary Accreditation. This formal accreditation program was begun in 1952. While many programs exceed the requirements, all nurse anesthesia programs regardless of the master's degree offered, provide a minimum curriculum as well as pharmacology of anesthetic agents and adjuvant drugs including concepts in chemistry and biochemistry (105 hours); anatomy, physiology, and pathophysiology (135 hours); professional aspects of nurse anesthesia practice (45 hours); basic and advanced principles of anesthesia practice including physics, equipment, technology and pain management (105 hours); research (30 hours); and clinical correlation conferences (45 hours). In addition to completing the classroom hours, nurse anesthesia students are required to administer a minimum of 550 anesthetics during their education (COA, 2004).

To become a Certified Registered Nurse Anesthetist (CRNA), a nurse anesthesia graduate must successfully complete the Certification Examination administered by the Council on Certification of Nurse Anesthetists (CCNA). Because CRNAs must graduate from a COA-accredited educational program and pass the certification examination to practice, the public can be assured that a CRNA has "met objective, predetermined qualifications for providing nurse anesthesia services" (CCNA, 2003, p. 3). In spite of this standardization, clinical practice opportunities vary considerably for CRNAs. According to the 2003 AANA membership survey, approximately 75% of CRNAs practiced in anesthesia care teams with MD anesthesiologists, and the other 25% practiced independently as sole

anesthesia providers primarily in rural hospitals (often designated as critical access hospitals), providing the entire range of anesthesia options for their clients (S. Tunajek, AANA Director of Practice, personal communication, July 14, 2004). CRNAs practicing in anesthesia care teams may find their clinical privileges limited to certain anesthesia modalities (e.g., general and intravenous anesthesia, but not regional anesthesia).

The Omnibus Budget Reconciliation Act of 1986 granted CRNAs the right to be directly reimbursed for their services to Medicare recipients, giving CRNAs new practice options. Because CRNAs function as sole anesthesia providers in approximately two thirds of rural hospitals, the AANA has made it a priority to assure that health care plans cannot exclude providers based solely on their license or credentials (AANA, 2004).

NURSE PRACTITIONERS

Nurse practitioners (NPs) have been defined by the ANA (2004a) as follows:

> Nurse practitioners (NPs) are registered nurses who have graduate level nursing preparation as a nurse practitioner at the master's or doctoral level. NPs perform comprehensive assessments and promote health and the prevention of illness and injury. These advanced practice registered nurses diagnose; develop differential diagnoses; order, conduct, supervise, and interpret diagnostic and laboratory tests; and prescribe pharmacologic and nonpharmacologic treatments in the direct management of acute and chronic illness and disease. Nurse practitioners provide health and medical care in primary, acute, and long-term care settings. NPs may specialize in areas such as family, geriatric, pediatric, primary, or acute care. Nurse practitioners practice autonomously and in collaboration with other health care professionals to treat and manage patients' health programs, and serve in various settings as researchers, consultants, and patient advocates for individuals, families, groups and communities. (p. 16)

Nurse practitioners have traditionally been defined as primary care providers. However, NPs are now functioning in many settings, including tertiary care.

The nurse practitioner movement began at the University of Colorado; Loretta Ford, PhD, RN and Henry Silver, MD, both full professors, collaborated to launch a post-baccalaureate program to prepare nurses for ex-

panded roles in care of children. Professors Ford and Silver (Ford, 1979) recognized that nurses had the ability to assess children's health status and define appropriate nursing actions. The purpose of the first nurse practitioner demonstration project was to implement new roles to improve the safety, efficacy, and quality of health care for children and families (Ford, 1979). Although the project's initial focus was on children and families, Ford noted that she was confident that nurses could be educated to meet the health needs of community-dwelling persons across the life span. Nurses in the Colorado program received 4 months of intensive didactic education in which assessment skills and growth and development were emphasized. The nurses then completed a 20–month precepted clinical rotation in a community-based setting.

Following Colorado's lead, many schools initiated educational programs admitting nurses with varying levels of educational preparation. The growth of the nurse practitioner movement was facilitated by many studies through the years, such as those summarized in a meta-analysis by Brown and Grimes (1995). Over the years, NPs have demonstrated that they safely provide high quality health care, and the NP role has expanded into many new practice areas (Martin, 2000; Mundinger, Kane, Lenz, Totten, Tsai, et al., 2000). Although initially, Dr. Ford's goal was to prepare nurse practitioners within master's programs, societal demand for nurse practitioners led to a proliferation of post-baccalaureate continuing education programs rather than graduate education (Ford, 1979. Ford, 2005). Federal funding for nurse practitioner programs also prompted the initiation of numerous post-baccalaureate and graduate nurse practitioner programs. The length of these early NP programs varied from a few weeks to 2 years, with many certificate programs being 9 to12 months in length.

The proliferation of post-baccalaureate programs rather than graduate programs for the education of NPs was partially due to the resistance of graduate nursing programs to recognize NPs as being a legitimate part of nursing. A number of nursing leaders termed NPs as "physician extenders" and did not view NP practice as being "nursing." This lack of enthusiasm for NP education exhibited by numerous nursing leaders in the 1960s and 1970s may also have been fostered by the fact that the NP movement grew out of a collaborative nurse-physician effort rather than being solely initiated by nurses. The early NP curricula were viewed as based on the medical model rather than a nursing framework, although that was not the focus of Dr. Ford's original NP curriculum that emphasized child development and health promotion (Ford, 1979).

There were over 100,000 NPs in the U.S. as of March 2000, of which 15,000 were dually prepared as NP/CNSs (HRSA, 2001). They represented the majority of graduates from master's nursing programs; 88% of master's graduates were NPs (Berlin & Bednash, 2000). NPs are prepared in a multitude of specialties including acute care, adult health, family health, gerontology, pediatrics, psychiatry, neonatal, and women's health. Specific competencies have been developed for five NP specialty areas (HRSA, 2002), and others are currently under development for other types of NP practice (i.e., acute care, psychiatric mental health, etc). After completing graduate education, NPs are eligible to sit for national certification examinations in their specialty areas. Certification is a mechanism for the nursing profession to attest to the entry-to-practice knowledge of NPs. The certification requirement has been adopted by third-party payers such as the Center for Medicare and Medicaid Services (CMS) and by some state boards of nursing as a standard that assists in protecting the public from unsafe providers (Pearson, 2005). Certification examinations are offered by a variety of bodies: the American Nurses Credentialing Center (ANCC), the American Academy of Nurse Practitioners (AANP), the Pediatric Nursing Certification Board (PNCB), the American Association of Critical Care Nurses, and the National Certification Corporation (NCC) for the obstetric, gynecologic, and neonatal specialties. Typically, certification must be renewed every 5 years. Certification maintenance requires documentation of activities such as continuing education specific to the NP specialty and professional presentations/publications. Ongoing clinical practice in the specialty is required by some certification boards in order to maintain NP certification.

Changes in reimbursement laws, regulations and policies that allow for direct reimbursement of NPs, the rapid increase in managed care as a mechanism to control health care costs, and the growing recognition of the significant contributions of NPs to positive patient outcomes have resulted in a rapid increase in the number of NP programs. Currently, there are 330 schools of nursing that prepare nurse practitioners (Berlin, Stennett & Bednash, 2003). Although there are some concerns about overproduction, APNs who are savvy about ascertaining the gaps in health care and designing roles for themselves that are not merely physician-replacement roles are likely to be very successful in obtaining satisfactory employment (Hanson & Hamric, 2003; Lindeke, 2004).

Relative to CNMs and CRNAs, NPs have a relatively short history in the health care delivery system. However, in this short period of time they have gained the respect of many health professionals and of their patients.

Recently, television and lay publications have featured NPs and the significant contributions that they are making to improve health. New successful roles are being developed, such as the acute care NP role (Rosenfeld, McEvoy, & Glassman, 2003; Wyatt, 2001). In many instances, NPs have succeeded in caring for persons in rural areas, inner city, and other vulnerable groups (Lindeke, 2005). NPs have established themselves as an integral part of the health care system.

CLINICAL NURSE SPECIALISTS

The ANA (1996) defined clinical nurse specialists (CNSs) as follows:

> The clinical nurse specialist is a clinical expert who provides direct patient care services including health assessment, diagnosis, health promotion and preventive interventions and management of health problems in a specialized area of nursing practice. The clinical nurse specialist promotes the improvement of nursing care through education, consultation, research, and in the role of change agent in the health care system (p. 3).
>
> CNSs are registered professional nurses with graduate preparation earned at the master's or doctoral level. There is also the option to be prepared in a postmaster's program that prepares graduates to practice as CNSs for specific specialty areas (Lyon & Minarik, 2001; Lyon, 2004). Currently, 183 schools offer CNS master's programs, an increase from 147 programs in 1997 (Dayhoff & Lyon, 2001). In addition to the curriculum proposed for graduate clinical education by the American Association of Colleges of Nursing (AACN, 1996), the National Association of Clinical Nurse Specialists has made developed CNS curriculum recommendations for CNS education.(NACNS, 2004) CNSs have traditionally worked in hospitals, but they now practice in many settings such as nursing homes, schools, home care, and hospice.

The CNS is one of four categories of advanced practices nurses, each with distinctively different practice characteristics (NACNS, 2004). The CNS has had a long history within the U.S. The Clinical Nurse Specialist role was developed following World War II. Prior to that time, specialization for nurses was in the functional areas of administration and education. Recognizing the need to have highly qualified nurses directly involved in patient care, the concept of clinical nurse specialists emerged. Reiter has

been credited with first using the term "nurse clinician" in 1943 to designate a specialist in nursing practice (Reiter, 1966). The first master's program in a clinical nursing specialty was developed in 1954 by Hildegarde Peplau at Rutgers University to prepare psychiatric clinical nurse specialists. That program launched the CNS role that has been an important player in the nursing profession and health care arena ever since. The CNS role has not though been without controversy. Health care restructuring and cost-cutting initiatives in the 1980s and 1990s resulted in a loss of CNS positions in the U.S. However, CNSs were hired back a few years later in many systems. The later 1990s brought increasingly frequent reports of adverse events in hospital settings (Institute of Medicine, 1999 & 2001), and it became apparent that CNSs were critical to obtaining quality patient outcomes (Clark, 2001).

As with the NP movement, the availability of federal funds for graduate nursing education programs and the Professional Traineeship Program that provided stipends for students has played a role in the development of numerous graduate programs offering CNS areas of study.

The development and use of complex health care technology in the management of hospital patients in hospitals and intricate surgical procedures has resulted in increasing acuity and complexity of patient care. Thus, there is a need for nurses with advanced knowledge and expertise to be integrally involved in working with staff to assess, plan, implement, and evaluate care for these patients. Many hospitals have placed CNSs in care coordinator or case manager roles to coordinate the care of patients with acute or chronic illnesses during their hospital stay and to prepare them for discharge to their homes or to other care facilities (Wells, Erickson, & Spinella, 1996). CNSs have also been utilized as discharge planners to work with staff to plan post-hospital care for patients who have complex health problems (Naylor, et al., 1994; Neidlinger, Scroggins, & Kennedy, 1987). Their importance in care coordination over the care continuum is only now being lauded, as exemplified by the work of Naylor and colleagues reporting that use of gerontological CNSs as discharge planners resulted in fewer readmissions of elderly cardiac patients.

Since its inception, the CNS role has suffered from role ambiguity (Rasch & Frauman, 1996; Redekopp, 1997). While the initial vision for CNSs was for them to be integrally involved in patient care for a specific patient population, CNSs have assumed many other roles, such as staff and patient educator, consultant, supervisor, project director, and more recently, case manager. Redekopp noted that it is difficult for CNSs to precisely describe

their role to others, since their roles are continually changing to meet the health needs of a changing patient population within an ever-changing health care system. Role ambiguity has made it difficult to measure the impact that CNSs have on patient outcomes. Thus, when budgetary crises occur within hospitals, CNSs have frequently had to advocate strongly to maintain their positions since outcome data to support the positive impact of their practice has in the past either not been readily available, or simply did not exist.

There are numerous CNS specialties and subspecialties: psychiatric/mental health nursing, adult health, gerontology, oncology, pediatrics, cardiovascular, neuroscience, rehabilitation, pulmonary, renal, diabetes, palliative care, to name a few. Numerous organizations offer certification examinations for CNSs. However, some organizations do not specify that master's degrees are required for certificaqtion in the speciality, and that has caused confusion regarding the regulation and title of clinical nurse specialist. Because in the past many CNSs have not sought third-party reimbursement, they have not taken specialty CNS certification examinations. With changes in state nursing practice acts and the increase in third-party payment and prescriptive privileges for advanced practice nurses, however, the number of certified CNSs is now increasing. Controversy regarding CNS certification continues, however, since there are no examinations available in the many specialties that CNSs perform. Exemptions from state laws and regulations for CNSs have been provided by some states because of this.

In the late 1980s and early 1990s, many discussions and debates took place around the merging of the CNS and NP roles (Page & Arena, 1994). Several studies were conducted comparing the knowledge and skills of these two advanced practice roles (Elder & Bullough, 1990; Fenton & Brykczynski, 1993; Forbes, Rafson, Spross, & Kozlowski, 1990. Lindeke, 1996). Findings indicated many similarities in the educational preparation of these two groups of APNs. Many CNSs viewed the proposed merger as the demise of the CNS role. NPs were concerned that they would need to abandon the title of NP, a title that had become familiar to many patients and health professionals. A new organization, the National Association of Clinical Nurse Specialists, was formed to assist CNSs and to provide a vehicle to publicize the many contributions that CNSs have made and continue to make in providing quality patient care. The CNS role today is a dynamic and needed advanced practice nursing role and one that is anticipated by many in nursing to continue for years to come.

INTERNATIONAL

Although the content in this chapter has focused on APNs in the United States, it is encouraging to see the continuing development of these roles in other countries. Clinical specialization in nursing has existed in many countries for a very long time. For example, in the United Kingdom the NP role developed dramatically during the 1990s once the National Health Services recognized its legitimacy (Reverly, Walsh, & Crumbie, 2001). However, in other countries, APNs are only beginning to develop programs and practices (Wang, Yen, & Snyder, 1995). Beginning in 1993, international APN conferences have been held to bring together nurses from around the world to examine issues of common concern. The third of these conferences was held in The Netherlands in July 2004, and had the stated aim of sharing knowledge and expertise among APNs to change the distribution of health care throughout the world (ICN International Nurse Practitioner/Advanced Practice Nursing Network Conference, 2004). Nurses can do much by sharing their experiences, providing support to each other in the cause of advancing the status of nursing worldwide, and overall, by keeping alive the ideal of nursing's quest to provide quality care for all persons.

CONCLUSION

Advanced practice nurses have made significant contributions to quality health care, particularly for vulnerable populations. If all Americans are to receive quality, cost-effective health care, it is critical that greater use be made of APNs (Hooker, & Berlin, 2002). A bright future awaits nursing and APNs in the new millennium. Their advanced knowledge and skills, both in nursing and related fields, provide APNs with the capabilities to make valuable contributions to the current and future health care system. As America becomes more diverse, APNs can play key roles in ensuring that culturally competent care is delivered. APNs are poised to assume leadership in developing new practice sites and innovative systems of care to enhance health care outcomes.

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Chapter 2

ADVANCED PRACTICE WITHIN A NURSING PARADIGM

Michaelene P. Mirr Jansen

The most important word in the title of Advanced Practice Nursing (APN) is the last one: nursing. Advanced education enables nurses to expand their knowledge base and expertise in nursing so that their practice differs not only from that of nurses with an associate's or bachelor's degree, but also from that of other health professionals, particularly physicians. Nurses often underestimate the profound positive effect that their care can have on improving patient outcomes (Lang & Marek, 1992). Florence Nightingale, in *Notes on Nursing* (1859/1992) noted that people in her day often thought of nursing as signifying "little more than the administration of medicines and the application of poultices" (p. 6). Efforts are still necessary to convey the full scope of nursing practice to other professionals and to the public so that nurses'contributions to positive health outcomes are understood, valued, and reimbursed. So often the media has focused on the physical assessment skills and prospective privileges rather than on the distinctive skills and expertise that characterize APN practice.

WHAT IS NURSING?

Definitions of Nursing

For many years the nursing profession has sought to define what constitutes nursing and to identify its scope of practice. It is critical for APNs and

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those aspiring to this role to have a clear understanding of what constitutes nursing so that in interdisciplinary and other interactions they are able to provide a clear understanding of nursing's unique contributions to health care outcomes. Therefore, we will examine several of the numerous definitions of nursing that have been put forth over the years.

Florence Nightingale (1859/1992) formulated one of the earliest definitions of nursing as "having charge of the personal health of a person." The aim of nursing care, according to Nightingale, is to put the patient in the best possible condition so that nature can act upon the person. *Notes on Nursing,* although written almost 150 years ago, speaks to the substantive basis of nursing. Not only does Nightingale elaborate on interventions nurses can employ, but she also underscores the necessity of thorough assessments before planning nursing care. Reading *Notes on Nursing* should, therefore, be a part of every APN curriculum.

In Virginia Henderson's (1966) definition of nursing, emphasis is placed on the nurse collaborating with the patient to enhance the patient's health status. Henderson defined nursing as:

> Assisting the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as soon as possible. (p. 15)

Henderson's definition contains many elements that constitute the substantive nature of nursing. Health promotion is a key component of her definition. In addition, the caring aspects of nursing are emphasized. Not all patients will recover from their diseases or injuries. It is the nurse's role to assist patients to achieve the goals the patient has established. Myss (1996), in her well-known work on healing, *Anatomy of the Spirit,* noted that in curing modalities, the patient is passive, but she argues that the patient must take an active role to be healed. APNs can play a key role in assisting patients in their healing process. APNs are able to bring additional expertise to interactions with patients and to perform holistic health assessments. Henderson stresses helping the patient gain independence. Independence is truly a Western belief and may not be a value in all cultures. Thus, it is important for the nurse to ascertain the personal values of each patient and realize that independence may not be one of his/her preferences.

Nojima (1989), a Japanese nursing theorist, defined nursing practice as "a human activity carried out by nurses to help individuals organize their

health conditions so that they are able to live optimally and realize their potential" (p. 6–7). In her definition, the focus is on a person's quality of life. The partnership between the nurse and the patient is evident in Nojima's definition of nursing.

The American Nurses Association (ANA) has defined nursing as follows:

> Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations. (ANA, 2003)

Previously, the definition of nursing focused on persons and their responses to health problems, rather than specific illnesses. The current definition also emphasizes health promotion and optimal health. This focus serves to differentiate nursing from medicine. Despite the frequent reference to the ANA definition of nursing, many APNs have encountered difficulty in working from a nursing model. They have been forced to launch their practice within the medical model. Although it is important to know the cause of a person's pain or stress, much of nursing care remains the same, despite the etiology. It has been encouraging to see the Agency for Healthcare Research and Quality (AHRQ) consider problems or responses, rather than disease entities, as the focus of practice guidelines. The AHRQ web site (www.ahcpr.gov) is an excellent resource for evidence-based practice and current clinical practices.

Scope of Practice

Gaining more knowledge about the substantive basis of nursing is an essential component of APN education. Numerous initiatives have undertaken to identify, describe, and classify the phenomena of concern to nurses. The findings from these explorations have helped nurses gain an understanding of the scope of nursing practice. A number of initiatives have been carried out to delineate the substantive basis of nursing. Next we will discuss two of these initiatives: nursing diagnoses and human responses.

Nursing Diagnoses

The use of nursing diagnoses is one of the strategies nurses have used to describe phenomena for which nurses provide care. Since the First Nursing

Diagnosis Conference in 1973, nurses within the North American Nursing Diagnosis Association (NANDA) have worked to identify, describe, and validate patient problems and concerns that fall within the domain of nursing. Currently, 167 nursing diagnoses have been approved, and it is projected that eventually there will be over 300 diagnoses (NANDA, 2003). Continued efforts are necessary to identify and validate new diagnoses and to revise existing diagnoses. APNs have and can continue to provide leadership in the nursing diagnosis movement.

NANDA diagnoses are grouped under nine functional patterns: exchanging, communicating, relating, valuing, choosing, moving, perceiving, knowing, and feeling. According to Newman (1984), it is important for nurses to determine changes in a patient's patterns. In approaching assessment in this manner, the focus is the whole rather than specific diagnoses.

Nursing diagnoses have been widely accepted not only in the United States, but also internationally (NANDA, 2003). Nursing diagnoses are the first effort to develop a common language for nursing phenomena. Despite numerous criticisms of nursing diagnoses, their use has assisted nurses in focusing on those aspects of care for which nursing interventions can be identified and nurse-sensitive outcomes can be determined. APNs, therefore, need to be familiar with both nursing and medical diagnoses.

In addition to establishing a common language for nursing diagnoses, the International Council of Nurses is working on identifying and classifying nursing interventions and outcomes (International Council of Nursing Project, 1997). In the United States, a number of projects to identify and classify nursing interventions have been initiated. The National Intervention Classification (NIC) has identified and classified over 433 interventions (McCloskey, Dochterman, & Bulechek, 2003). Likewise, a project identifying nursing outcomes classification (NOC) occurred at the University of Iowa. Linkages between nursing diagnoses, nursing outcomes, and interventions are now available for use in nursing practice (Johnson, Bulechek, McCloskey Dochterman, Maas & Moorhead, 2001).

Human Responses

The American Nurses Association has delineated phenomena of concern to nursing (ANA, 2003). The identified phenomena were not meant to be exhaustive, but rather exemplars of the types of concerns that fall within the purview of nursing. Human experiences and responses identified by ANA are found in Table 2.1.

Table 2.1 Human Experiences and Responses That Are the Focus for Nursing Intervention

Promotion of health and safety
Care and self-care processes
Physical, emotional, and spiritual comfort, discomfort, and pain
Adaptation to physiologic and pathophysiologic processes
Emotions related to experiences of birth, growth and development, health, illness, disease, and death
Meanings ascribed to health and illness
Decision making and ability to make choices
Relationships, role performance, and change processes within relationships
Social policies and their effects on the health of individuals, families, and communities
Health care systems and their relationships with access to and quality of health care
Environment and prevention of disease

Note: From *Nursing's social policy statement* (p. 7), by the American Nurses Association, 2003, Washington, DC: American Nurses Publishing. Copyright © 2003 by the Association. Reprinted with permission.

As with nursing diagnoses, these identified human responses assist APNs to focus on the health concerns for which nursing care is primary in producing positive patient outcomes. Therapeutics for managing the responses or assisting the person to manage transcends medical entities. For example, despite various etiologies for sleep problems, nursing interventions, such as massage and music therapy, can be used to manage sleep problems. Viewing nursing from the perspective of human responses helps nurses to organize content from a nursing prospective.

THE ART AND SCIENCE OF NURSING

The Art of Nursing

The art of nursing is integrally tied to the caring aspect of nursing. Moore (1992), a clinical psychologist, stated that care is what a nurse does. For many years, nursing was defined as being an art and a science. As nursing began to give more attention to establishing a scientific basis for practice and become accepted within the scientific community, the art or caring aspect of nursing received less attention. In practice settings, nurses gave increasing attention to the high technology used in the care of patients

with complex health problems. Currently, the public has indicated that they value caring interventions such as massage, touch, and aromatherapy. A number of reasons for which people seek complementary therapies have been proposed: 1) they wish to be treated as a whole by health professionals; 2) they wish to be active participants in their care; 3) they desire that the treatment not be worse than the disease; and 4) they feel that Western health care does not meet all of their needs. Therefore, it is important that APNs consider how they can integrate the art of nursing, which includes traditional nursing interventions into their practice.

Caring is a critical element of nursing practice. Leininger (1990), Watson (1988), and Gadow (1980) have each put forth definitions of caring. Watson defined the art of caring as:

> A human activity consisting of the following: a nurse consciously, by means of certain signs, passes on to others feelings he or she has lived through, realized, or learned; others are united to these feelings and also experience them. (p. 68)

Newman, Sime, and Corcoran-Perry (1991) noted that the focus of nursing is "caring in the human health experience" (p. 3). The National Organization of Nurse Practitioner Faculties (NONPF) has identified caring as a characteristic of APNs.

Caring requires that a nurse be competent in assessing and intervening. Benner (1998) noted that a caring attitude was not sufficient to make an action a caring practice. The practice must be implemented in an excellent manner in order to be viewed as caring. Caring and the art of nursing convey very similar meanings. Caring nurses seek the scientific basis for their practice and continue to update their expertise and knowledge. APNs possess the knowledge and ability to critique research about specific therapies and determine their applicability to specific patient populations.

The Science of Nursing

Nursing is characterized by both art and science (ANA, 2004). Significant progress has been made in developing the knowledge base that underlies nursing practice. Nursing is guided by standards of practice based on clinical evidence and research. (ANA, 2004) However, much additional research is needed before APNs will have a sound scientific basis that will assist them in choosing specific interventions for a patient or population.

The clinical guidelines developed by professional and governmental agencies that are available through the National Guideline Clearinghouse are an example of work that has and continues to be done in identifying "best practices" based on research findings. APNs have a key role in assisting nurses to review research and develop clinical guidelines that incorporate the existing knowledge base.

THEORETICAL AND CONCEPTUAL MODELS

During the past 50 years, nursing has given considerable attention to theoretical and conceptual models. This attention has served to differentiate nursing from other disciplines (Engebretson, 1997). Nursing theories are not, however, new in nursing. Nightingale (1859/1992) elaborated the relationship of the environment to health and well-being. Numerous theoretical and conceptual models exist.

What relevance do nursing theories have to practice? Can't nurses merely practice nursing? Meleis (2004) noted that a theory articulates and communicates a mental image of a certain order that exists in the world. This image includes components and all nurses have a model or relationship(s) among those components. All nurses have a model or perspective that guides their practice. This model may be identical to one of the publicized nursing theories, or it may be based on a theoretical perspective from another discipline. In some instances, eclectic models are used in which nurses combine elements from established nursing theories or theories from other disciplines. New nursing theories continue to be developed. Of particular importance is the delineation of nursing theories that incorporate various cultural perspectives since, to date, the Western philosophical perspective has pervaded many of the existing theories.

Discussion has ensued on whether one grand nursing theory is needed. Would the existence of a grand or metatheory be advantageous to the progression of the profession and discipline? Riehl-Sisca (1989) stated that nursing has benefited from having a multiplicity of theories. The wide range of perspectives elaborated in these theories has assisted nurses to more clearly define the nature of the discipline and profession, to evaluate various approaches that can be employed in practice, and to respect diversity as a positive element. Marriner-Tomey & Alligood (1998) identified seven theorists who have developed grand theories or conceptual frameworks for nursing: Johnson (1980), King (1971), Levine (1967), Neuman (1974), Orem (1980), Rogers 1970), and Roy (1984). Numerous other nurses have

developed midrange theories or conceptual frameworks that have served as a basis for research and practice.

More recently, nurses have turned on their attention to midrange theories. Midrange theories, according to Olson and Hanchett (1997), focus on a limited number of variables. Midrange theories also are more amenable to empirical testing than are grand theories, as they are more concrete and limited in scope. Examples of midrange theories include empathy (Olson & Hanchett, 1997), uncertainty in illness (Mishel, 1990), resilience (Polk, 1997), mastery (Younger, 1991), self-transcendence (Reed, 1991), caring (Swanson, 1991), and illness trajectory (Wiener & Dodd, 1993).

Many nurses give little thought to the tenets that guide their practice; however, these philosophical underpinnings have profound impact on the nature and scope of their practice. Nurses have an ethical responsibility to practice nursing with a consciously defined approach to care. The theoretical or conceptual model used by a nurse provides the basis for making the complex decisions that are crucial in the delivery of good nursing care. In this regard, Smith (1995) stated:

> The core of advanced practice nursing lies within nursing's disciplinary perspective on human-environment and caring interrelationships that facilitate health and healing. This core is delineated specifically in the philosophic and theoretic foundations of nursing. (p. 3)

Thus, nursing theory is an important component of APN education.

Nursing is a practice discipline, and theories achieve importance in relation to their impact on nursing care. Only recently have attempts been made to relate nursing theories to practice, and to begin to test these theories. However, only minimal testing of these theories in practice settings has occurred. The numerous theoretical nursing studies, particularly studies examining the efficacy of nursing interventions, is an indication of the apparent separation of theories and practice that has characterized much of nursing practice.

The theoretical or conceptual framework that an APN selects and uses has a major impact on the patient assessments that are made and the nature of interventions that are chosen to achieve patient outcomes. Gordon (1987) and Johnson (1989) have noted the profound impact a nurse's theoretical perspective can have on a nursing practice. Gordon (1987) stated:

> One's conceptual perspective on clients and on nursing's goals strongly determines what kinds of things one assesses. Everyone has a perspective, whether

> in conscious awareness or not. Problems can arise if the perspective "in the head" is inconsistent with the actions taken during assessment. Information collection has to be logically related to one's view of nursing. (p. 69)

A conceptual model provides the practitioner with a general perspective or a mind-set of what is important to observe and which, in turn, provides the basis for making nursing diagnoses and selecting nursing interventions.

INCORPORATING NURSING INTO ADVANCED PRACTICE NURSING

APNs provide health care to many populations and in many settings. Opportunities exist for APNs to make major contributions to the advancement of the substantive basis of nursing. APNs, by focusing on the nursing elements of health care, have the opportunity to demonstrate to the public and to policymaking bodies the unique and significant contributions that nursing has to health outcomes. Using the nursing rather than the medical model as the focus of practice results in advanced practice nursing presenting the public with a distinct and adjunctive model of care rather than a substitutive model (i.e., replacing physicians). Activities that have traditionally been a part of medicine may be carried out by APNs, but the performance of these activities by an APN needs to be translated into the realm of nursing.

Guaranteeing that APNs view the provision of health care from a nursing perspective has implications for graduate curricula. Huch (1995) proposed weaving content on nursing theories throughout the APN curriculum. The American Association of Colleges of Nursing includes nursing theory as an essential component of graduate education for advanced practice nursing education. Not only is content needed, but students also need assistance in utilizing this theoretical content in their practice. Faculty and preceptors who model the application of theory in practice are critical for helping APN students integrate theory into their practice.

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Chapter 3

MULTIFACETED ROLES OF THE APN

Deborah R. Monicken and Mary Zwygart-Stauffacher

The public often views the role of the advanced practice nurse as one directly involved in patient care. Although this may be a dominant or primary role for many APNs, it is not the only role. The APN incorporates a variety of roles, including case management, educator, researcher and advocate, just to name a few. How each of these roles is operationalized depends on the individual advanced practice nurse and the employer. Direct patient care is certainly an expected role in APN practice, particularly for the novice. It should, in fact, remain a constant to the APN practice assuring a strong foundation and laboratory for the development of patient care and APN expertise. However, over time, the issues and circumstances presented in one-to-one patient care become more predictable, and the complexity of the systems of care delivery more evident. To address these issues, the APN must be equipped to utilize other APN roles to more dramatically influence these broader issues and enhance APN practice. These roles are the tools that may be initiated within the context of current practice or evolve to become a dominant part of the APN position. Traditionally, roles of the APN included care provider, educator, researcher, consultant and manager. The National Association of Clinical Nurse Specialists (NACNS) has conceptualized these various roles into spheres of practice. These spheres include the patient/client sphere, the nurses and nursing practice sphere, and the organization/system sphere (NACNS, 2004). Table 3.1 compares traditional and contemporary practice roles.

As the APN assumes more leadership in health care, the roles of patient advocacy, education, change agency, case management, and consultation

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TABLE 3.1 Role of Clinical Nurse Specialist

Traditional	Contemporary
Direct Care Provider	Patient/Client Sphere
Educator	Nursing & Nursing Practice Sphere
Researcher	Organization/System Sphere
Consultant	
Manager	

Note: Adapted from NACNS (2004), *Statement on clinical nurse specialist practice and education.*

become more essential to the APN's development, the evolution of nursing, and the management of complex health care issues and systems. Though management may argue that there is a loss of revenue with the APN functioning outside of direct care, the APN must continue to market the cost savings of improved outcomes or changes in care delivery that can be generated when the APN embraces other roles. In frustration, many APNs have pursued supervision outside of nursing to assure more flexibility in their practice. This can be a loss not only to the profession of nursing but also to the APN. Though the APN should continue to market the importance of contributions to be gained through these other roles, so, too, must nursing management work to expand its knowledge and competence to better utilize the APN expertise and to more accurately represent and advocate for the APN. For example, during the 1990s, many CNS positions were eliminated due to downsizing and inability to directly reimburse their activities. Recently there has been a resurgence of CNS positions with (hospital) systems validating their value to the organization.

APN ROLES

Basic nursing education has provided a strong foundation to guide the APN in practice using the systematic approach of the nursing process. So, too, graduate nursing education provides foundations for beginning APN practice with each program having varied preparation and emphasis on these other roles utilized by the APN. The APN needs to respect the wealth of knowledge that is unique to each of these roles and become well grounded in that knowledge in order to ensure success when operationalizing them in their practice. This chapter will examine the various spheres or roles focusing on incorporating them into the whole.

Advocacy in APN Practice

Advocacy for patients must remain fundamental to the practice of nursing. It is the underpinning of the nurse/patient relationship. Advocacy is defined as a way of being in a relationship in which the nurse sees the patient as a whole human being in their experience with health and promotes the uniqueness of the client (Nelson, 1998). Nelson (1999) notes further that advocacy has progressed to being a guardian of the patient's rights and freedom of choice. While several other elements may be attributed to the essence of advocacy, respect for the individual is what guides a nurse's advocacy.

Advocacy can be viewed from a variety of perspectives. Nelson (1998) lists seven types of advocacy: legal advocacy, moral-ethical advocacy, substitutive advocacy, political advocacy, spiritual advocacy, advocacy for nursing, and advocacy for community health (Table 3.2). In legal advocacy, the nurse is supportive of the patient's legal rights such as informed consent or the right to refuse treatment. This may include assuring that all patients have a copy of the institution's bill of rights. Moral-ethical advocacy requires that the nurse respect the patient's values and support decisions which are consistent with those values, such as decisions regarding abortion. In substitutive advocacy, if the patient is unable to express his/her opinion, the nurse should continue to respect the rights of the client/surrogate and support the prior wishes of the patient that may have been expressed. Political advocacy includes work to change laws and policies to assure equities for all patients, groups, and society. APNs participate on committees and boards to help determine policy that benefits patients. In spiritual advocacy, the APN assures that the patient has access to spiritual support such as clergy, and the plan of care includes spiritual aspects of care. Advocacy for nursing directs the nurse to be supportive of other nurses in their professional growth and supportive of the evolution/contribution of the nursing profession. Nelson feels this is an opportunity for APNs to facilitate and empower other nurses through leadership, education, and modeling standards

TABLE 3.2 Types of Advocacy

Types of Advocacy
Legal advocacy
Moral ethical advocacy
Substitutive advocacy
Political advocacy
Spiritual advocacy
Advocacy for nursing
Advocacy for community health

Note: From Nelson, M. (1998). In M. Snyder & R. Lundquist (Eds.), *Complementary/alternative therapies in nursing* (3rd ed.). New York: Springer Publishing.

for practice. To advocate for a community's health, nursing must advocate for the assessment of health needs in a community, consider priorities for care and resources, and determine health and environmental trends that may impact a community.

Advocacy should occur for any client. On occasion, issues of competency arise in areas such as substitutive advocacy and moral-ethical advocacy. APNs should advocate for all clients to complete living wills and advanced directives to assure that health care issues are well documented and patient wishes are respected. When competency is a concern, the APN needs to be familiar with laws governing competence. APNs need to be knowledgeable regarding the criteria for the assessment of competence and be instrumental in the establishment of policies to direct action when a patient is judged incompetent. When a patient is determined to be incompetent, the APN needs to communicate the patient's expectations, if known, to the surrogate and/or family to support any requests/decisions to be made based on the patient's past recommendations. There can be confusion and conflict among family, friends, surrogates, and even health care professionals during these times. The APN should have no reservations about convening family/client conferences and ethics committee evaluations if questions or controversies arise.

Advocacy carries with it a significant ethical dimension in that the principles of ethics can serve as tools to evaluate a nurse's effectiveness in advocacy (Nelson, 1998). Pinch (1996) points out that some ethical principles can be in conflict. The principle of autonomy (self-determination) could conflict with distributive justice (fair, equitable distribution of goods or services) if the patient's decisions were to impact the community's greater need/safety. For instance, if a patient requested no treatment and is discharged with a dangerous communicable disease that may infect the community, or if a patient demanded resources that jeopardized the financial or medical resources of a community, the patient's autonomy may be at risk of being overshadowed by what is best for the majority. In maintaining advocacy, the APN would need to be sure that this indeed reflected a conflict in distributive justice and not a prejudice toward an individual or group.

There is currently great concern regarding the ability of a nurse to be an advocate given the current health care system (managed care, critical pathways) and cost containment measures (Nelson, 1998; Watson, 1989). Is the APN in a position to maintain advocacy despite the demands of the system? Nelson (1998) contends that the APN can rise above these constraints. It is believed that the APN is in the unique position of influence through interaction with other team members, assuring advocacy through policy formulation that directs patient care and through legislative involve-

ment. Additionally, it is critical that the APN be well-versed in the areas of evidence-based practice, standards of care, ethics policies, accreditation criteria, nursing licensure regulations, and professional association standards which can help to support an APN's advocacy position.

Education

The APN is in a unique position to use the role of educator with patients, students, and staff. The APN maintains a base in the reality of patient care. This affords the APN a workshop of experiences for developing protocols and standards for practice, strategies for utilization of equipment and procedures, assessment of patient issues and concerns, and evaluations of nursing staff capabilities and limitations. With advanced practice education, the APN also is a resource for current knowledge in content areas, supportive resources, and research findings. When providing education to students and staff, the APN can provide sound clinical examples that enhance the application of content. APNs may find it helpful to seek assistance from their colleagues in academic settings when initially developing educational content. There is considerable knowledge and skill attached to developing a sound teaching-learning plan.

Whether the APN is teaching students, colleagues or patients, an assessment of the person's current knowledge base is essential. A thorough assessment should include their capabilities (e.g., able to utilize the computer), limitations (e.g., unable to read), disabilities (e.g., difficulty hearing), and availability of resources, to name a few. A patient's readiness to learn is also a factor. To plan for the best teaching strategies, the APN needs to know the learner. Knowles & Associates (1984) developed a list of assumptions about adult learners that will assist the APN in educational planning: 1) the learner is self-directed, needing a sense of involvement and control; 2) experience is a rich resource for learning; 3) readiness to learn occurs with a perceived need to know or do something; 4) orientation to learning is problem-centered or task-centered; and 5) internal motivation is more potent than external motivators.

Though isolated teaching events can be provided, to assure learner outcomes and competencies, a planned content series is most effective. First, when planning for the patient, student or staff, an assessment needs to be completed to determine what knowledge is needed in order to focus the content. This may be guided through planned curriculum, observed problems in patient care, standards or protocols for practice, or common client questions, to name a few. This identifies what type of learner outcomes

(competencies) are to be achieved. Once this is complete, the APN needs to develop content objectives to achieve these outcomes. Guidelines for the development of objectives were established by Bloom (1956) dividing objectives into three domains of learning: cognitive, affective, and psychomotor. Objectives are developed with action verbs like *identify* or *demonstrate* with these action verbs dictating a certain level of complexity. For instance, the expectations of the learner would be very different if they were required to *identify* the steps to doing CPR as opposed to actually *demonstrating* CPR. The action verb also guides the educator in selecting teaching strategies. To have the learner *identify,* lecture may be adequate. However, to have the learner *demonstrate* requires some guided lab activity. This also is consistent with the evaluation that learning has occurred (outcomes/competencies). Identification could be done with a written test where a demonstration would require a lab to have the learner show that skill. Support content such as handouts or videotapes may also need to be developed. These, too, should reflect the level of learning being addressed. With staff, the APN has the unique opportunity of continuing to work alongside other staff members. In this way, the staff members can continue to pursue clarification and assistance and the APN can evaluate for their grasp of the information.

Sparks (1999) offers these principles when teaching: 1) proceed from the simple to the complex; 2) build on what is known to learn the unknown; 3) use terminology that is familiar to the learner; 4) set short-term and long-term goals; 5) plan a sequence of incremental learning activities; 6) apply content to enhance learning; 7) use learner objectives to direct content and learning experiences; 8) use positive reinforcement; and 9) evaluate outcomes of the learning process.

Patients and students alike are using the Internet as a primary source of information. Some sources have information that is directed to health care professionals and is more likely a reliable source. Other sources may be inaccurate (Sparks, 1999). Information is generated from a wide variety of sources like chat rooms on the Internet, advertisements, brochures, newspapers, television, health kiosks, nontraditional care providers, or family/friends. This information can be skewed, inaccurate, or incomplete. The APN needs to take the time to access and review these sources to know what type of information is being provided. Patients can come with fears or preconceived ideas of care. They may be very knowledgeable or considerably uninformed. Just as you might ask a student for content references, the APN should ask the patient for their information sources. The APN needs

to make a point of screening related health information being distributed in their facility. Most printed educational content should be written at a fifth- to eighth-grade reading level. Background, color, and print format are all considerations. Many patients are overwhelmed just with a diagnosis, much less the medication, treatment course, or plan of care. Printed information can be given to a patient to reinforce information.

For students, the opportunity to learn from an APN can complement their education by providing a strong emphasis in nursing practice. Murphy (2000) described a collaboration that brought together a nurse educator/researcher and a practitioner. The practitioner in this study was an RN. However, certainly the use of an APN in both undergraduate and graduate curriculums could afford the student the same clinical opportunities. This collaboration would also benefit the development of the APN through the opportunities to share with nursing educators/researchers in academia. Driver and Campbell (2000) also described the role of having a lecturer/practitioner in a 50/50 clinical and academic position. Though there was no significant difference in learning outcomes, the students appreciated opportunities to work with a practitioner and subjectively described a sense of better preparation for practice.

Case Manager

Case management has become a more common dimension of the APN role, coinciding with the expansion of managed care programs. Coffman (2001) describes case management as a collaborative process promoting quality care and cost-effective outcomes to specific patients and groups. The key features of the case manager role as outlined by Benoit (1996) include: 1) standardized resources for a length of stay for selected patient care, caregiver, and system outcome; 2) collaborative team practice among disciplines; 3) coordinated care over the course of an illness; and 4) job enrichment for the caregiver, patient and physician satisfaction with the care, and minimized costs to the institution. Taylor (1999) initially described the two primary types of case management as: 1) the patient-focused model, which supports the patient throughout the continuum of care helping them access health care, and 2) the system-focused model, which involves the service environment and is structured for cost containment of a specific group of patients and using critical pathways for cost effective outcomes. However, Taylor advanced her model of comprehensive

case management that incorporates elements of cultural competency, consumer empowerment, clinical framework, and multidisciplinary practice in addition to other activities of assessment, service, planning, plan implementation, coordination and monitoring, advocacy, and termination. The focus in health care now is on patient empowerment and quality service based on process improvement, outcome measurements, and performance-based expectations. Though in the past, case management was associated with the utilization of clinical pathways to drive the plan of care—therefore focusing on process—the focus most recently has been on outcome measures. This new model Taylor purports is optimal in that it incorporates components of both patient and system models to ensure that the patient receives needed services.

Ethical concerns have persisted on how nursing and case management can remain as an advocate for patients in a managed care environment (Donagrandi & Eddy, 2000). Nursing is bound by ethics, however, and with recent capitation legislation and JCAHO's emphasis on outcomes management and patient empowerment, the focus is changing. Taylor (1999) notes that the success of managed care now rests on ensuring that access and utilization are appropriate with managed care serving to control high costs and reduce the use of ineffective treatment modalities. Taylor contends that the case manager is the person who makes managed care work well.

The use of APNs as case managers has been advocated by multiple authors (Donagrandi & Eddy, 2000; Taylor, 1999). APNs exhibit qualities of enhanced capabilities in interdisciplinary coordination, advanced clinical decision making, autonomy, synthesis, and critical thinking. Taylor (1999) states that the primary case manager must be an APN with a registered nurse doing case management in specialty areas under the guidance of an APN. In this time of economic constraints, it may be a concern to have an APN managing day-to-day coordination of patient services. It would seem practical to utilize the APN in supervision of patient care providers with a focus on direct involvement on more complex patient cases. The APN expertise would also be valuable in the development of outcome standards, communication/coordination between disciplines, and analysis of patient care trends. In addition, a focus on complex patient populations requiring extended lengths of stay or resources are viewed as appropriate to APN management. APN case management is felt to be best focused in health and disease prevention (Taylor, 1999).

Change Agent

In any organization, and particularly in the unpredictable market of health care, an organization will need to identify needs and make changes in order to survive. The change agent is the individual who identifies, plans and implements that change. Freed (1998) states that what distinguishes the change agent is the ability to move from analysis to synthesis and show results.

Barker (1990) notes that the change agent must have resilience, flexibility, creativity, and responsiveness. Recognizing the need for change is critical. For the best change, Price Waterhouse (1995) suggests that the change be: 1) integral to and focused on the strategy of the organization; 2) leading to high performance, significantly improved results with measurable differences; 3) helped by the energy and creative ideas of people in the organization; 4) supported by empowered and motivated employees; 5) driven by specific customer needs; 6) guided by a limited number of balanced performance measures; 7) able to build revenue; and 8) institutionalized in a culture that values continuous improvement.

Three models of organizational change are described by Kaluzny and Hernandez (1988): 1) rational, which focuses on internal needs of the organization; 2) resource dependent, which is focused on the relationship/interdependence between the organization and the environment; and 3) organizational ecology, which emphasizes the concept of an evolutional natural process. Wheatly (1992) describes a fourth model, chaos, where the organization is in a necessary disequilibrium, making change continuous. Change occurs due to internal or external elements that motivate change. Hansen (1999) advocates that the ecology model and the chaos model may be the more useful in understanding the health care organization today.

Anderson & Ackerman Anderson (2001) now indicate that the organization has three types of change: 1) developmental, which primarily deals with improvement in things like skill, methods, or performance standards, and is, therefore, the simplest of changes; 2) transitional, which does more than improve on what is, it replaces the current situation with something new; and 3) transformational, which is the most complex type of change, moving from one state of being to another by changing culture, behavior, and mind-set. Developmental change is usually accomplished through sharing of information and process improvement. The threat in this change is

low. Transitional change is needed when a problem exists, an opportunity for something is not being pursued, or something needs to change or be created to serve current or future demands. This change requires a dismantling of the old and pursuit of a new state; it also requires a comprehensive plan, which includes building the case for change and involving employees in the design and implementation. Transformational change is required when leadership is aware of two things: 1) the current process must be changed to reach the objectives, and 2) the scope of this change is so significant that it requires a fundamental shift in people's culture, mind-set, and behavior in order to be successful. In transformational change, leadership must first be transformed for the change to occur.

Hansen (1999) describes both internal and environmental forces for change. Internal pressures come from behavioral and process sources such as a need for increased efficiency, improved staff competence, or a need for analysis and reassessment of the work process. Environmental forces are elements outside of the organization that occur which require the organization to change, such as new technology, client dissatisfaction, or legislation. Anderson & Ackerman Anderson (2001) define the drivers of change as being environment, marketplace, business imperatives, organizational imperatives, cultural imperatives, leader and employee behavior, and leader and employee mind-set. This is viewed as a progression, with the initial event (environment) triggering the next event and progressing through each until it finally reaches leader and employee mind-set.

A discussion of change would not be grounded in the literature if the work of Lewin (1951) were not included. Lewin describes the change process as consisting of three phases unfreezing (realizing the need for change), moving (forces for change are identified and altered) and refreezing (establishing a new equilibrium). Hansen (1999) recommends these principles for effecting change: 1) selecting and focusing on the change opportunity/benefit; 2) building and maintaining relationships which will help in the change effort; 3) planning and guiding the change; and 4) continuously monitoring, getting and receiving feedback, and making adjustments. Price Waterhouse (1995) has now developed a change readiness assessment to evaluate the change for success, scoring each factor on a scale of 1 to 5. If the assessment score is between 15–34, the change agent should *watch out.* If the score is between 35–55, it needs to be closely watched, and if the score is between 56–75, it is likely to succeed. The use of this assessment may help the change agent identify areas of weakness and areas of strength to improve the change plan or realize its worth or neces-

sity. Failed change can leave the individuals less inclined to embrace another change.

In order to achieve a positive change, the change agent must be prepared to work through or avoid some specific issues. One potential for failure surrounds the fact that there is no sense of dissatisfaction with a current situation (Oates, 1997). If a change is introduced in this environment, resistance will occur. McPhail (1997) notes that individuals will be reluctant to leave what is considered a secure situation. Also, employees may not share the same vision with that of the change. It is critical that participants be aware of the plan and participate in its construction. Early in the planning, the change agent should identify the people who will be actively involved in the change, and of these people, determine who will be supportive and who will be resistive to the change and the rationales. Many times resistance can be as simple as feeling left out or uninformed. Price Waterhouse (1995) suggests that planning for a change must consider all the areas that may be affected and each of these areas should be addressed to assure that the plan will be effective in addressing each issue, whether to redesign jobs or modify procedures. Likewise, the change should avoid pitting people against each other, which can be very disruptive and a source of considerable wasted energy. Price Waterhouse identified 11 issues that may create problems for the change project:

1. Failure to deliver early, tangible results—if the change process goes beyond 6 months, you can anticipate your support to decrease by half and your barriers to double;
2. Talk about breakthroughs, but don't drown in the detail—focus on the outcomes, not the process;
3. Pick the most important priorities, always refining this as the project progresses;
4. Use performance measures appropriate to the plan—avoid the old, long-established measures; however, do measure because what gets measured, gets done;
5. Assure that competing projects support the other and are not divisive or competitive—show how all the changes are connected;
6. Listen and involve your consumer;
7. Involve your employees in the project—this can build commitment;
8. Assure that management is well informed, have a stake in the plan, and endorse that same plan;
9. Explain how the change will improve a situation, making it tangible for employees;

10. Assure everyone that the change is based on that organization's facts and is tailored to that organization's needs; avoid just implementing something that has worked elsewhere;
11. Engage another set of employees, not just those who have always been involved; this can lead to new ideas to promote the change rather than maintain the status quo.

The APN as change agent needs to use strategies that will help to ensure a positive change and experience of that change. Freed (1998) provides several suggestions: 1) you should not wait for organizational readiness, as it is unlikely that it will ever happen; and 2) you must plan to avoid the consequences of not changing and adapting soon enough. Also, the right change agent must be selected. A person internal to the organization, even if the person is well-known, is not always viewed as most credible, this credibility often being reserved for outside consultants. In another strategy, even small, successful change can build credibility and that a successful long-term change has many short-term milestones. Freed notes that any meaningful change will disenfranchise someone. When change occurs, one must plan and be prepared to step in with the new order, to prevent the slow return of the status quo. Freed indicates that the change agent should not expect that it is reasonable to expect infinite inclusion, consensus, and popularity. For some changes, it is simply necessary to help people realize the lack of good alternatives. So, while it may be comfortable to stay where one is, it is also the reality that they will eventually have to change. Freed also reminds the reader that some people just have to be *kidnapped* and moved to the new environment so that they don't have to contemplate the change for too long. It probably will not be helpful to ask people who created the current system to help change it. Change will not be orderly and Freed indicates that this helps to signal the advent of a new change and the need to refine a new model. Lastly, an important message is that having too many options can paralyze the change and sometimes it is best to proceed with what you have available.

Price Waterhouse (1995) lists these principles for implementing change:

1) confront reality;
2) focus on strategic contexts;
3) summon strong mandates (i.e., top management);
4) set a reasonable amount of change;
5) build a case for the change and work for consensus;

6) get the consumer involved to help make the change;
7) know who the powerful individuals or groups are who can help with the change;
8) communicate;
9) reshape your performance measures;
10) use anything that will help to effect the change—rewards, technology, etc.;
11) encourage and generate big and creative ideas;
12) encourage the use of diverse populations of staff who may be able to see the issues differently;
13) build skills;
14) assure that the plan addresses all the major issues;
15) balance creative initiatives with focused strategies.

The advanced practice nurse has the knowledge, competence and motivation to plan change and complete the change (Oates, 1997). The APN is also in a position to notice opportunities to improve structure, process, or outcome (Hansen, 1999). APNs are often in positions that Hansen refers to as *boundary spanning,* and are able to communicate to a variety of people. Change, best suited for the APN, will occur at the case level having an effect on patient outcomes, cost, and quality of care. APNs should be encouraged to position themselves to make changes in delivery of care to the chronically ill, underserved, and vulnerable populations. APNs must perfect the skills of organizational politics, interpersonal influence, group leadership/decision making, collaboration/conflict management, systems thinking, quality improvement, and program planning/management. To assure APNs have the knowledge and skill set necessary to influence change, graduate nursing curriculums need to address the areas that will prepare the APN as a change agent in areas such as systems analysis, budgeting, and business management.

Consultation

The activities of the APN in the area of consultation are well documented in the literature (Badger, 1988; Barron, 1989; Noll, 1987). An APN may be an internal consultant (person inside the organization) or external consultant (person outside the organization). Generally an internal consultant has been hired to manage ongoing issues (i.e., specific client populations)

that have a high prevalence and/or require long-term management. Edlund, Hodges, and Poteet (1987) describe several advantages/disadvantages to each type of consultant. Advantages of the internal consultant include: 1) being less likely to be viewed by staff as an agent of management; 2) knowing the system's issues better; and 3) functioning better in a client or consultee consultation because of availability and follow-up. In contrast to this position, Lippitt and Lippitt (1978) believe that an internal consultant is viewed as being on a more subordinate level to management and is therefore viewed by staff as their agent. Edlund, Hodges and Poteet (1987) do note that the internal consultant is more likely to be perceived as having less ability, credibility, and power (i.e., not viewed as expert in the backyard). In practice, the day-to-day presence of an internal consultant can reinforce certain practices, ensure the consultant's availability to manage changes, and provide immediate alternatives. In terms of the perceived limitations in authority and ability of the internal consultant, these issues may be based more on the person than the position.

An external consultant is often perceived as having greater administrative sanction, more knowledge, easier access to information sources, and fewer preconceived ideas about a situation. The external consultant can often be an impetus for change and, having no long-term investment, can be the *scapegoat* for staff anxieties about the change, which shields management from the rancor (Harris, 1995). However, limitations are that the consultant has to gain the trust of staff, spend substantial time acquiring knowledge about the system, and may still have diminished long-term effects, especially in a client or consultee consultation (Edlund, Hodges, & Poteet, 1987). Additionally, it is difficult involving an external consultant in direct client care in that there is not the same level of staff interface or day-to-day follow-up. If an APN provides external consultation on client care, such as at a workshop, it may be practical to contract for an assessment opportunity to review the clinical setting and a posteducation practicum with staff to model care expectations.

As possibly the best of all alternatives, Ulschak and Snowantel (1990) suggest that internal and external consultants work together. To use this approach, the external consultant should provide the internal consultant with increased opportunities to participate in the planning, implementation, and educational process. The external consultant should work to enhance the organization's perception of the internal consultant's expertise and authority. This approach certainly enhances the probability of long-term impact.

Certainly, consultation could be considered a primary vehicle for the dissemination of an APN's expertise. Caplan (1970) notes that consultation can be described by the type of client served, the type of activities requested in the consultation, the method of consultation (formal or informal), and the relationship of the consultant to the organization (internal or external). Consultation is categorized in four ways: 1) client-centered case consultation; 2) consultee-centered case consultation; 3) program-centered administrative consultation; and 4) consultee-centered administrative consultation.

Consultation requires much planning prior to the actual consultation meeting. Lippitt and Lippitt (1978) provide a six-phase guide to consultation which has been used in a variety of consultation situations: 1) contact and entry; 2) formulating a contract and establishing a helping relationship; 3) problem identification and diagnostic analysis; 4) goal-setting and planning; 5) taking action and cycling feedback; and 6) contract completion, continuity, support, and termination. In APN practice, Caplan's client-centered consultation is often accomplished using an informal approach in phases 1 and 2 because of the casual nature and frequency of this type of consult in a nurse to APN interaction. Though this informal approach can have the advantages of being time saving and educational, Manian and Janssen (1996) warn that the consultant (and client's care) can be vulnerable to incomplete information and examination especially if the consultation is of a complex nature. In any consultation, it is important to establish areas of responsibility for the consultant and consultee. The APN who elects to function as a consultant must respect the confines of a consultant's practice and the authority it assigns to others.

Consultation is a function into which the individual APN must evolve. It is based on the APN's knowledge, experience, and confidence. The beginner APN will generally first serve in the area of direct practice and client-centered consultations. Holt (1984) describes an evolution of development, with many of the areas of consultation occurring much later in the professional development of the APN. Certainly, the beginning APN will need time in the application of newly acquired skills to be recognized as competent by others and will need to have the personal confidence to provide expert consultation.

How the APN consultant evolves is dependent on the definition and parameters of the client group, the framework of the consultant's practice, and the inherent rewards for maintaining consultation as a function of the APN practice. Over time, consultation should demonstrate growth, diversity, and mentorship as the practice is refined.

In the early years of practice, the APN may remain in a consultation area where the parameters are ones of a defined client group with specific known problems. The APN should always retain this client-oriented consultation in that it serves as a laboratory for the development of new knowledge. However, as the consultant's practice evolves, the definition of "client" should change to represent groups of patients, staff, or organizations. This is both economical and growth producing. The consultant should ask these questions:

1. What is needed?
2. Why is it needed, i.e., what has happened or changed that created the need?
3. What has been tried?
4. What outcome is desired?
5. What outcome is reasonable?
6. What is the time frame?
7. What are the obstacles/resources to achieving the outcome?
8. What areas/options of change are comfortable/uncomfortable?
9. Who is important to the process?
10. What are the limits/boundaries of the consultation?

Also, in this preparation, the APN should do the following:

1. *Become familiar with the client, organization and environment.* This can be accomplished by reading the philosophy statements, procedures, and models of care of the organization, and by getting descriptions of the locale and other demographics. In client care, one might explore a client's finances, environment, etc., to assure a realistic plan of care that the client is likely to accomplish (Larson, Risor, & Putnam, 1997).
2. *Identify a primary contact in the organization* and ensure that the individual has the ability to access needed information and has the authority to carry out the recommendations. If there are other parties who will be involved, they should be identified. There are no greater obstacles to a plan than those that have been left out of the process.
3. *Be honest about the consultant role and the expectations about what is to be accomplished.* Know whether recommendations are to be treated as suggestions or mandates. State your limitations as a consultant where these are due to expertise, conflict of interest, or administrative re-

strictions. Stay within the confines of what has been requested. If other issues are identified, these can be noted if they impact the area of the consultation, but they should not be acted on unless acceptable to the consultee.

4. *Allow adequate time to accomplish the work required for the consultation.* In client-based consultation, allow at least 1–2 hours for the initial visit. Subsequent follow-up can be shortened to 5–15 minutes. Consultation to an organization will vary in time depending on the size and complexity of the organization and its issues. Time should be allotted for the preparation and evaluation components, as well as the actual visit.
5. *Know why the consultation was requested and whether it is related to a need for change.* Continue to keep the client focused on a defined area.
6. *Respect the client and consultee.* Their knowledge of the problem and their ideas for the practical solutions are essential for the accomplishment of the recommendations.
7. *Know when to leave.* There are two reasons for leaving: completion of the consultation, and disregard for the recommendations. If recommendations are not followed and if a comfortable compromise is not reached, the consultant can be of no value and the consultant should terminate the contract. On the other hand, in many cases the clients have embraced the recommendations and are functioning well with them. The best consultation outcomes occur when consultants hear their own recommendations being verbalized by the client who expresses a sense of ownership. This is the best of all changes that can be made by a consultant and is evidence of completion.

Depending on the type of consultation, the consultant can assume a variety of behaviors. Lippitt and Lippitt (1978) describe a continuum of consultant behaviors that require the consultant to be either more directive or less directive. The consultant assumes a greater leadership role where more directive behavior is needed. Lippitt and Lippitt's eight consultant behaviors are: 1) objective observer/reflector; 2) process counselor; 3) fact finder; 4) alternative identifier; 5) linker, joint problem solver; 6) trainer/educator; 7) information expert; and 8) advocator. The amount of the consultant's directive behavior increases as one move toward the latter behaviors.

The use of the Intervention Model developed by McEvoy and Egan (1979) is a very effective framework for developing the consultant's practice.

This model helps the consultant identify commonalities of a population and test interventions to promote reliable outcomes. In doing this, a consultant can move from the client/consultee-specific practice to a more group-related model of practice as seen in program development and administration-centered consultation. The intervention model provides a systematic way for the consultant to collect and analyze information while looking for characteristics and trends about the population.

Meyer and colleagues (1996) reviewed the use of consultation expertise when applied to a computerized program which would ask the nurse questions regarding a clinical issue. In this system (the urological nursing information system-UNIS) the program was placed in a nursing facility and compared with the actual consultant practitioner. On initial evaluation, the UNIS asked more questions and had more recommendations than the actual practitioner. However, on retrospective analysis, there were clear limitations with UNIS. Therefore, an analyst followed an APN during consultation in an effort to understand the consultation process and eventually modify the program. It was discovered that the problem was verbosity with UNIS having to ask many more questions and nurses being its only data source. This differed from the APN consultant who used multiple sources. Also, the use of rule changing for interfacing and the inability to interface with the patient record limited the UNIS. It was felt that eventually these issues could be corrected. However, one needs to ask if information procured through multiple levels of nursing staff and no direct examination of the patient, can accurately replace the assessment, diagnosis, and intervention planning of the APN consultant. The APN needs to be vigilant about the development of these types of systems. Questions of accountability and the impact on nursing practice without having a licensed practitioner need to be explored to assure integrity of the nursing profession, reliable content, and patient safety.

Because of the APN's unique role, knowledge, and position of influence, APNs have many issues of ethical boundaries and power for which they must be responsible and cognizant. Lippitt and Lippitt (1978) provide a code of ethics for the professional consultant which requires that the consultant have objectivity and integrity, competence to do the work, moral and legal standards, avoidance of misrepresentation, confidentiality, primary concern for the client's welfare, adherence to professional rather that economic standards, integrity in interpersonal relationships, fair remuneration, respect for the rights and reputation of the organization, and accurate promotional activities.

The issue of power, which is available to the consultant, is also a concern. Van Bree Sneed (1991) states that the consultant's power is legitimate (power of the position held), referent (based on personality), and expert (based on the possession of special knowledge and skills). With this power comes responsibility, and the APN should consider these issues carefully:

1. Respecting the fact that power places the consultant and the client in an unequal relationship;
2. Understanding that the consultant's knowledge has a limited scope;
3. Resisting the practice of withholding information with the intention of creating dependency;
4. Being honest in the presentation of one's abilities and limitations;
5. Expecting the aura of influence generated by consultants and avoiding its misuse; and
6. Working to assure a balance with regard to the client's perception of that power by providing positive reinforcement to the client.

There are also other areas where the consultant must remain vigilant. When in consultation, one should not push one's own personal opinions, beliefs, values, or biases upon a client. Also, when working in an organization, the consultant should be careful not to stress ideas that may conflict with the mission or capabilities of that organization. Likewise, the parameters of professional/personal conduct should be stressed. Where there are potential differences between client and consultant, resolution or clarification should be sought before proceeding. The APN must let go of that which has been shared in the consultation. There can be a tendency to want to cling to certain turf. Always clarify reasons for retaining certain professional responsibilities and removing or limiting others.

STRATEGIES FOR IMPLEMENTATION OF APN ROLES

It is critical that APNs be familiar with any organization with which they interact. Ulschak and Snowantel (1990) describe a CPR+F Model representing the organization's purpose, roles, feedback in communication, and commitment with the organization's environment (trends, regulatory bodies, licensing groups, vendors, and professional groups), which encompass the entire model. Using this model, the APN can look at the culture of the organization. This will help the APN better understand the elements of the

organization. The APN needs to be familiar with policy, procedure, resources, affiliations, and structure in order to market an advanced practice.

The APN also should prepare a written statement of APN capabilities along with fiscal and patient outcome potentials that could be realized through these advanced roles. This can help management realize the expanded potential of the APN beyond direct care. In that management may not be familiar with the capacities of the APN, the APN will have to continue to provide regular updates that extend beyond direct patient care. This should be something the APN uses when interviewing for a position or in regular updates to immediate supervisors. Maintaining patient outcome statistics is important and will help management advocate and support the APN position. APNs must become more visible on community boards and organizational committees, and in legislative activities to promote the ideas of disease prevention and health care through APN practice. Opportunities for collaboration with academic institutions can promote a more expansive role.

SUMMARY

For APNs to fully participate in their roles, management needs to be educated to the many aspects to their position and to the benefits to patient care and the institution in supporting that practice. APNs will need to initially market these capabilities to many groups of people, from management to legislators. While the opportunities for providing direct patient care are valuable and rewarding, the APN can still continue to evolve and actually have greater impact in patient care, community/social health, and the development of nursing by pursuing advanced APN roles. Whether as part of a practice or as a separate position, the opportunities provided by these advanced roles will provide the APN with new changes while enhancing the care of patients and the knowledge of nursing.

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Chapter 4

LEADERSHIP SKILLS AND EXPERTISE: KEYS TO APN SUCCESS IN HEALTH CARE SYSTEMS

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The complexity of health care systems today is creating a paradox for advanced practice nurses (APNs), presenting both unprecedented challenges as well as opportunities. At a time when revolutionary advances are being made in information systems, diagnostic abilities, technology, and treatment, the Institute of Medicine (IOM) has uncovered sobering unintended consequences of a complex, highly regulated, and yet fragmented system gone awry (IOM, 1999, 2004). At a time when cloning of a human is possible, millions of dollars are being spent to ensure the basics, such as accurate patient identification, to prevent sentinel events that cause up to 95,000 unnecessary deaths per year in our health care systems (IOM, 1999). In the United States over 40 million people are uninsured, and clear disparities exist for minority populations. Health care costs have skyrocketed, reimbursements have dropped, and health care providers are scrambling to protect their compensation (IOM, 2004).

What does this all mean for the APN working clinical in a variety of settings? In order to be successful in today's complex and political health care system, APNs can no longer afford to rely solely on expertise in practice, nor naïve optimism about collaboration and cooperation. APNs must develop leadership skills and political savvy, or their unique contribution will not be maximized, nor potentially even recognized. Never was advanced practice nursing expertise more needed for vulnerable humans seeking health care. Although great strides have been made in licensure,

recognition, and reimbursement (Pearson, 2004), patients are at risk for losing the best of what APNs offer. APNs must develop skills, knowledge, and competencies not only in clinical practice, but in systems thinking, negotiation, change agency, and health care system trends and politics in order to be a successful contributor to the health care team.

This chapter will outline the importance of mastering the context of the health care system where APNs exercise their role, and the necessity for APNs to develop a different skill set to match the complexity of the health care system. Senge (1990) has articulated that the systematic structure of any organization (e.g., the incentives, interdependencies, policies, group norms) provides the context in which all behavior, relationships, and outcomes result. Understanding and mastering this context is as important, or more important for APNs than for any other clinical competency they might develop. Currently, this competency is at best not effectively nurtured in either education or practice settings and, at worst, it is undermined. Historical influences will be presented, along with four areas (i.e., comparison of policy agendas for organized medicine and organized nursing; variations in licensure and reimbursement decisions and practices; impact of organizational alignment and reporting relationships; and consequences of credentialing and privileging processes with organizations) that need to be addressed by APNs in order to protect and maximize their contribution. Unfortunately, these four areas greatly influence the leverage of the APN, but are often invisible to the APN's practice, because they are handled administratively, often outside of the APN's awareness. We will therefore articulate leadership skills that are necessary to address these concerns.

INFLUENCE OF HISTORY

In order to progress successfully into the future, it is imperative to understand the historical context, which has influenced the present state of nursing and APN practice. Nursing history has resulted in both a light and shadow side of nursing (Ashley, 1979; Roberts, 1983, 1997; Nightingale, 1946). Two powerful influences of the profession will be highlighted here. The first is the place nurses traditionally occupied within organizational structures of health care systems; the second is the way the profession articulated and practiced its philosophy and values, specifically as contrasted with the philosophy and values of medicine.

Historically, the predominant thinking and design within other industries influenced the organizational design of hospitals and health care. In the 20th century, the assembly line design was prominent. Most of these industries resembled what Mintzberg would call a "machine bureaucracy," where roles were clearly delineated with the strategic apex (e.g., the thinkers) of the organization creating the decisions and standardized processes that those in the operating core (e.g., the doers) carried out. The place of nursing was clearly in the operating core, whereas physicians straddled both spheres, practicing medicine in the operating core, but influencing decisions in the strategic apex (Mintzberg, 1983). It is important to recognize that the historical differences in gender in these two professions, nursing being predominantly female and medicine male, also influenced the alignment within the hospital structure. Weber poignantly observed that once a hierarchical system is in place, it is easier to annihilate it completely than to make any incremental changes in its structure that are long lasting, since those holding power have no incentive to relinquish it, and those without the power do not have the leverage to obtain it easily (Weber, 1987/1946).

In addition, nurses have always been steadfast in grounding their values, philosophy, and vision in a framework of care (Gordon, Benner & Noddings, 1996; Reverby, 1987, 2001). Reverby, a philosopher who studied the nursing profession, articulated that in contrast to medicine, nurses focused on the *duty to care* rather than the *right to care,* whereas medicine understood that in order to fulfill the *duty to care* they needed to focus on the *right to care,* which necessitated placing a priority on protecting economic viability. The differences in philosophy influenced the two different groups' place in hierarchical structures. It is important to note that the hierarchical positions were influenced, not by differences in inherent contributions, but by philosophical and political positioning.

APNS AND THE CONCEPT OF POWER

Given nurses' history, philosophy, and values, the concept of power creates ambivalence for most nurses, even APNs. In a graduate course on systems taught by one of the authors, an imagery exercise is conducted on the concept of power. Images of power experienced in this exercise often include negative militaristic and hierarchical images. APNs are sometimes ambivalent about the concept of power, given how they may have experienced or witnessed power in many systems. The imagery exercise includes

a question: "Who wants to be powerful?" Many are tentative about raising their hands, and those that do, admit that they were hesitant about raising their hand as the desire for power seemed to be in conflict with the prototype of an expert nurse committed to patient care. Although, in response to the next question, "Who wants to avoid being powerless," everyone raises their hand. This is a dilemma; APNs resent powerlessness and yet are ambivalent about wanting to be powerful. Although many arguments could be made related to the word *power* and its meaning, it is not coincidental that this ambivalence exists, given our history and our values, in contrast with a health care system that is clearly traditional and hierarchical. On the contrary, when this imagery exercise is held with a predominantly male audience, almost all participants raise their hand in response to the question, "Who wants to be powerful."

Many APNs either do not desire, or have not been adequately socialized or educated with regard to understanding and using bases of power. Although APNs usually believe in and align themselves with Benner's (2001/1984) transformational "power with," they may be uncomfortable making a concerted effort at enhancing the traditional bases of power as articulated by French and Raven (1950). Nurses tend to rely heavily on their expert power base. Although expert power is crucial, APNs will do well to develop other bases of power in order to advocate more successfully for their patients.

Nurses by nature strive toward collaboration, often using accommodation as a primary approach to negotiation. Accommodation as a conduit to collaboration is often a learned approach for women, and nurses use it, often believing it may be the only way to assure that high-quality care is delivered to patients, at least in the short term. Unwittingly, they may be creating the very thing they are wishing to avoid, a continual experience of being at what Kritek (2002) calls the "uneven table." The systematic structure in most health care settings does not, unfortunately, reward the essence of nursing (Fagin, 1993, 1994, 2000), but rather the actions and outcomes that facilitate the traditional medical model. This creates a fine line between collaboration and competition, especially between APNs and physicians (Stewart-Amidei, 2003). Consequently, nurses must develop the leadership, negotiation, and system skills needed in order to influence the systems that are not designed to naturally accommodate their unique contribution.

Current State Influences on APN Practice in Health Care Systems

To demonstrate the urgency and necessity of developing a different skill set for APNs, we will analyze four areas that influence APN success in health

care systems. The four areas include: 1) comparison of policy agendas for organized medicine and organized nursing; 2) variations in licensure and reimbursement decisions and practices; 3) the impact of organizational alignment and reporting relationships; and 4) the consequences of credentialing and privileging processes within organizations.

Organized Medicine and Organized Nursing: Different Policy Agendas

Although there are many successful individual nurse-physician collaborative relationships, nurses would be naïve to believe that organized medicine supports independent nursing practice. Most formal statements from the American Medical Association (AMA) support the role of the APN, as long as the physician remains the leader of the health care team who delegates authority. Many of the formal positions and policy statements articulated on the AMA web site are adversarial in tone and intent. For example, one statement in the AMA Scope of Practice asserts the following:

> For the past several years, physicians have squared off against allied health professionals who seek to expand their statutory scopes of practice . . . through legislative, regulatory, and administrative processes. These (sic) groups have been increasingly adamant in their efforts to expand their scopes of practice to include the authority to prescribe certain types of medications, conduct certain types of procedures and monitor certain types of chronic diseases. The AMA continues to aid physicians . . . by strongly opposing the inappropriate expansion of the scope of practice. (AMA, 2004b, paragraphs 1–2)

Another document entitled “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by APNs” states the following:

> Physicians must retain authority for patient care in any team arrangements . . . medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team, and exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (AMA, 2004c, paragraphs 1–2)
>
> In a further policy statement, “Independent Nursing Practice Models,” the AMA clearly continues its attempt to control APN practice. The statement delineates the AMA’s intent to monitor federal and state legis-

> lation for direct reimbursement of nonphysicians, so that statutory guidelines for physician supervision as a qualification for reimbursement may be maintained. In addition, the statement asserts that the AMA will take all appropriate action to achieve a reversal of the CMS policy that allows payment for physician services rendered by nurse practitioners and certified nurse specialists that are performed without physician supervision (AMA, 2004d, paragraph 6).

The AMA continues to define selected APN roles only in terms of an extension of medicine, under the supervision of medicine, failing to recognize the profession and its scope in its own terms. Efforts were made in the early 1990s through a task force to craft a common definition of nurse-physician collaboration. This combined ANA/AMA task force arrived at a definition that was formally adopted by the ANA. The AMA failed to adopt this statement and there have been no further discussions published by the AMA on this statement (ANA, 1998). The joint task force definition is as follows:

> Collaboration is the process whereby physicians and nurses plan and practice together as colleagues, working interdependently within the boundaries of their scopes of practice with shared values and mutual acknowledgement and respect for each other's contribution to care for individuals, their families, and their communities. (*ANA, 1998)*

Although little agreement has been reached between the AMA and the ANA on collaboration, two specialty groups have made some progress. In 1992, the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG) issued a Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives (ACNM, 2004). This statement was revised in October 2001, and was approved by both professional organizations. In this statement, the need for collaboration is recognized and valued. The statement is published on the ACNM web site, but interestingly, is not found on the ACOG web site.

Over the past several years, the American Association of Nurse Anesthetists (AANA) and the American Society of Anesthesiology (ASA) have collaborated to jointly influence the Medicare anesthesia payment system. A draft procedural agreement between the two groups is anticipated, and it is hoped it will be the basis for a continuing, mutually respectful professional relationship (see the AANA and ASA web sites). In this case news releases were located on both web sites (AANA, 2004; ASA, 2004).

Other organizations would be well served by using the experience of these two successes in crafting their own political policy agendas. For change to continue to occur and progress to be made toward issues related to practice, independence and collaboration must be addressed at the local, state, and national levels. Assuring APNs are at the policy tables at all levels is critically important. This means APNs must be willing to take and spend time engaging in this work. The outcomes of these policy discussions and decisions have a direct impact on the scope and implementation of APN practice at the system level. Ignorance about the political forces at play in the issues of power and finance in health care diminishes the ability of the nursing profession, specifically APNs, to assure that everyone has access to the best of what nursing has to offer, and that their fundamental right to receive health care is protected.

LICENSURE AND REIMBURSEMENT

Federal, state, and private insurance decisions influence the ability of APNs to be reimbursed for services provided, a prerequisite for APNs' success in today's health care systems. Progress has been made state by state, and managed care organization by managed care organization, in gaining the ability to both prescribe medications and receive reimbursement for services rendered. Today the language and resulting authority for APNs varies by state, making it more difficult and complex than necessary for the rules to be understood at the local system level or for individual APNs. The reality of complex differences between Medicare, Medicaid, managed care organizations, and indemnity insurance companies within any given state leads to confusion and ambiguity. APNs and the organizations employing them need to keep current on rules and regulations to assure the most effective reimbursement for services. Differing interpretations of the rules and regulations can also leave APNs vulnerable. Maximizing APN reimbursement logically increases leverage for APNs.

State regulations vary for different APN roles, although they often require some type of collaborative arrangement with physicians in order for APNs to have prescribing authority (AANP, 2002; Pearson, 2004). The longer APNs prescribe with no demonstrated change in the quality of prescribing, the more difficult it becomes for organized medicine to reverse this practice within the health care system. Unfortunately, at least some of organized medicine plans to do just that, returning to the traditional practice

of physician control (see American Medical Association, 2004a, H-160.950, Guidelines for Integrated Practice of Physicians and Nurse Practitioner).

Receiving reimbursement for services has the benefit of making APN practice visible within the health care system. But even when APNs are included on provider panels within MCOs, they are often not visible by name and title on printed materials as providers, nor included in the organization's communications regarding changes in reimbursement. When APN services are billed under a physician's name and provider number to maximize reimbursement to the practice, the APNs contribution is difficult to capture, including tracking productivity and outcomes. While tracking is certainly possible, it cannot be done using existing systems. Unless this problem is remedied, which is often difficult as changes are incremental and slow, APNs contribution to the system is difficult to articulate, track, and quantify. This difficulty in identifying APNs' contributions could leave them vulnerable when important decisions are made about resources.

The exclusion of nursing nomenclature in payment systems is another difficult issue in full reimbursement for services. Current reimbursement is received through the use of the Common Procedural Terminology (CPT) codes (a standard reimbursement mechanism) and International Classification of Diseases (ICD-9) codes, (a diagnostic taxomony) and neither specifically describes nursing practice. The default option is to use existing reimbursement codes, while attempting to add nursing to the CPT coding system. Nurses need continued involvement at both the national and system level to ensure that nursing language is included in the newly emerging electronic systems. While SNOMED, the terminology system adopted by the federal government includes many nursing classification systems; SNOMED terminology is not the current basis for reimbursement. It is critically important that organized nursing move forward in a united fashion around this issue because the failure to do so will dilute the overall potential for inclusion. Unfortunately, APNs are not always involved in these discussions and decisions, nor are they even always aware that these discussions are taking place or of the impact they will have on their practice.

The Impact of Organizational Alignment on APN Practice

While there are a variety of opinions about what constitutes the best alignment in terms of reporting relationships for APNs in health care organiza-

tions, most APNs agree that reporting relationships influence leverage in systems and, ultimately, quality of care. Most APNs would agree that reporting lines must include respect and support for clinical work, continuing knowledge and skill development, and the APN scope of practice, as well as fair and equitable compensation for services.

As employees, the reporting relationships of APNs are varied, with some APNs reporting to an administrator or manager, who may or may not have nursing background, and others reporting to one or more physicians. Where and to whom APNs report in a system makes a difference in the support and visibility of the role. Standards for educational preparation of APNs have been set, with all certifying bodies now requiring master's level education. This is not the case for administrators and managers (ANCC, 2004). Reporting lines often reveal perceptions about the power and influence of a given role. For example, Clinical Nurse Specialists reporting to a unit manager, whose highest education may be a BSN, clearly have less visibility in a system than those reporting to a director or vice president for nursing or patient care services who holds a master's or doctoral degree.

In ambulatory practices, APNs may be hired by the practice and report both to a business manager, often with no clinical background, and to the physician-owners of the practice. When ambulatory practices exist within health care systems, the same model of reporting often exists with APNs reporting to a nonclinical business manager, while physicians have a formal Medical Section for decision making and a process for peer control of the practice. This lack of parallel structure for APNs can weaken APNs' leverage in the system.

Advocating for effective reporting lines is essential if systems/practices are to maximize APN services. Attention to the need for ongoing support in the form of coaching and development offered by a nursing leader who is knowledgeable and qualified is always important, but becomes even more important if APNs are not reporting to a nurse leader at the executive level (Etheridge, 2004).

One of the authors of this volume is currently in a unique position, having created a Department of Advanced Practice Nursing that provides infrastructure support to close to 90 APNs who have different employers but all practice within the same health system. In her role as director of the department she works to provide ongoing education, mentoring, coaching, and support, and to create the appropriate communication lines, structures, committees, and policies to help foster effective practice. With her APN colleagues she plans and works to provide continual awareness throughout

the system of the contribution of APNs, as well as education regarding their roles.

Job descriptions and percentages of time allotted to various dimensions of the role ideally include all dimensions of advanced practice nursing, not just the medical-model aspects of the role. When APNs are scheduled to provide (and bill for) 40 or more hours per week of direct care, there is not sufficient time to read, develop educational materials, conduct quality monitoring, implement practice changes, or determine effective ways to implement evidence- based practice. When APNs engage in these necessary professional activities in order to continue high-quality, evidence-based practice, they are often doing so without legitimized support or financial compensation, which results in dissatisfaction with the role and potential burnout. An assessment of the intended and unintended consequences of any given alignment is useful to those in organizations who wish to fully capitalize on the expertise and benefits APNs offer to the health and improve the well-being of care recipients.

SUPERVISION, COLLABORATION, AND PRIVILEGING

A related but different process that can affect an APN's leverage in the system relates to credentialing. While credentialing is a requirement in health care organizations, it is primarily an administrative process that will be discussed in depth in another chapter. The issue to be addressed here is the process for establishing the policies and procedures for privileging in health care systems and subsequent consequences for the role implementation of the APN.

Privileges to practice are granted based on the individual state's Nursing Practice Act, collaborating relationships, and the health care organization's regulations. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has expanded the need for credentialing and privileging to include not only those APNs affiliating with an organization but to those employed by the organization as well (JCAHO, 2004). The arena of privileging is ripe for conflict and power issues to erupt. A prime example is the fact that admitting privileges to a hospital are traditionally governed by medical staff bylaws. In a recent informal telephone survey completed by one of the authors in a local metropolitan area, including four large health care systems and one free-standing specialty hospital, it was discovered that only one hospital allowed APNs to have admitting privileges, and those were only Certified Nurse Midwives (CNMs).

JCAHO requirements include language indicating that privileging, an administrative and peer process, must be completed using the existing process for physicians, or an equivalent process. Knowledge of the consequences of the formal role, or lack thereof, of nursing in this process is necessary. Many, possibly most, organizations use the privileging process established by the medical and dental staff for credentialing and privileging. In determining privileges a decision must be made whether the APN can perform independently, collaboratively, or under supervision. This is a key issue, because the voting members on the credentialing committees are, by and large, not nurses, but physicians—who are, therefore, applying their own interpretations of APN practice.

There is also confusion about the term *supervision,* including where and when there is need for supervision, and what exactly is meant by supervision. The mix of reasons that might be provided as a rationale for APNs needing to be supervised includes billing issues, current laws, JCAHO guidelines, and medical staff bylaws. In systems with both nurse practitioners and physician assistants, there is often confusion about the differences in state statutes for the two different professional groups. Add to this the variability among state requirements for practice relationships, billing, and prescribing and the result is even more confusion and potential political posturing to protect individual interests.

If the medical staff credentialing committee is used for privileging APNs, it is essential that APNs be voting members of standing committees. Another option available to systems is to design an equivalent process, deemed acceptable to JCAHO, wherein a separate APN credentialing and privileging committee with APN leadership and membership makes recommendations for privileges to the board of the hospital, or its equivalent in other health care entities.

The need for supervision upholds the physician as "captain of the ship," leader of the health care team. This works against the possibility for real change or interdisciplinary exchange, and against the option of patients fully benefiting from the services provided by a multidisciplinary team. This unfortunately mirrors the reality of nursing within many systems and, indeed, throughout the ages. The ability to articulately speak about nursing practice and the array of diagnoses an APN is qualified and competent to treat is diminished by the reality of rounds and case reviews framed in the traditional medical model. In traditional rounds and case reviews the focus is often the medical diagnosis, obscuring nursing phenomena that are crucial to good patient outcomes. Physicians then remain ignorant, often in-

nocently, of the contribution of APNs beyond their role as physician extenders. While the care provided by APNs may be appreciated, unless it is clearly articulated and becomes part of the culture of a practice and/or organization, it will not be understood. It seems clear that all nurses, regardless of education or role, must become articulate about their practice and knowledgeable about system functioning if patients are to be assured access to APN care.

EVIDENCE-BASED LEADERSHIP INTERVENTIONS

Understanding the historical context and the areas of leverage for APNs is necessary, but not sufficient, to ensure that patients have access to the best APNs have to offer. In order to advocate for patient care, APNs need knowledge and skills in systems and leadership. The responsibility to enhance the evidence-based leadership skills of the APN lies with graduate education, professional organizations, and the individual APN. All three entities need to identify as a priority the development of the APN as leader. These leadership and system skills are as important to the success of APNs in health care organizations as their clinical skills.

Although the ability to assume leadership in a measurable way remains elusive, there is now a growing body of literature that has correlated outcomes with leadership, even when measured or articulated in different ways. Buckingham and Coffman (1999), leaders in the research conducted by Gallup on managers and outcomes, have found that strong leadership is correlated with retention, productivity, profitability, and satisfaction. The research on magnet hospitals has supported a need for strong leadership. The AACN has now identified a need for stronger leadership presence in the health care system in order to enhance the quality of care (Long, 2003). The Institute of Medicine (IOM) reports clearly indicate that mastering and coordinating the context of care is an important variable for quality (IOM, 1999, 2001, 2004). APNs not only need to practice evidence-based practice for clinical phenomena but also for system phenomena. The National Association for Clinical Nurse Specialists (NACNS) clearly recognizes that one dimension of the scope of practice for APNs is leadership within the organization or system (NACNS, 2004).

Applying leadership principles to the four areas we have identified, may help APNs see how they can use leadership not only in the day-to-day communication with patients and other providers and leaders in the health

care system, but also in engaging in long-term solutions to enhance the future impact of APNs. Whether APNs are hired in acute care settings or in ambulatory settings, there are three main areas in which they need to gain competencies in order to maintain the visibility of their contribution and have the leverage to advocate and care adequately for their patients.

First, APNs must enhance their leadership skills. These skills include self-awareness, systems thinking, communication, negotiation, change agency, and conflict resolution. These are the skills that are needed for successful leadership (Argyris, 1991; Buckingham & Coffman, 1999; Farkas & Wetlaufer, 1996; Goleman, Boyatzis & McKee, 2002; Kouzes & Posner, 1995; Kritek, 2002; Mintzberg, 1987 Porter-O'Grady & Malloch, 2003; Rogers, 2004). APNs may acquire these skills in a variety of ways—by reading, attending workshops and training, taking courses, and working with a mentor. How they acquire these competencies is not nearly as important as a focused, systematic effort to enhance their competencies. Hopefully in the future all graduate programs will include a more intense focus on systems and leadership. Today, most organizations are investing heavily in leadership development for those in administrative positions because they know the impact strong leaders can have on an organization. APNs need to inquire about participating in these development opportunities.

Second, APNs need to understand the system and system politics. APNs need to be socialized in their graduate education as well as in their professional organizations to study the systems where they are or will be employed. All APNs should understand the organizational chart, formal and informal (Mintzberg, 1983), to examine where they are placed within the hierarchy, and the place and role of the person to whom they report. APNs need to inquire about where the decisions that affect their practice, credentialing, and privileges are made and who makes them. Understanding reimbursement issues that affect the APN role and the system in which they are employed is key to leverage in the system. APNs should carefully review their job descriptions and ascertain how words such as *supervision* and *collaboration* are defined. In essence, how APNs are described, where they are in the organization scheme, and over what decisions they have influence are as important as their clinical expertise in terms of affecting outcomes of care.

Finally, and quite simply, APNs need to *show up* at the table. APNs are often so immersed in practice that they may make the mistake of being unintentionally absent from, or even intentionally avoiding important system decision-making bodies (formal and informal) because they don't want to

engage in "politics." APNs need to network with their colleagues to ensure adequate representation themselves or through other strong nursing leaders when discussions or decisions are being carried out that affect their role. APNs must take every opportunity to be present, particularly when invited to the table. In a recent discussion with APNs who were invited to the annual business meeting of a large group practice, but chose not to attend, they indicated that they believed such a meeting was not relevant to them, or that they were too busy with patients. Missing these opportunities unfortunately signals disinterest, and lack of professional involvement.

In summary, demonstrating leadership competencies and understanding the interplay between political forces, reimbursement mechanisms, legal definitions, and organizational alignment, as they define the context for APN practice, are critically important to ensure effective, high-quality APN practice in systems. Being knowledgeable about the current state of affairs and understanding when and how to choose high-leverage targets for change is essential for APNs to raise their practice to a level of respect in the system where they are universally accessible, receive appropriate compensation for services rendered, and sit at the appropriate decision-making tables.

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UNIT II

IMPLEMENTATION OF THE APN ROLE

Chapter 5

CLINICAL DECISION MAKING IN ADVANCED PRACTICE NURSING

Sheila K. Smith

Clinical decision making in advanced practice nursing occurs as a continuous, purposeful, theory- and knowledge-based process of assessment, analysis, strategic planning, and intentional follow-up. Because the role of the advanced practice nurse (APN) is multifaceted, the scope of APN decision making is similarly complex. It incorporates health promotion, disease prevention, risk reduction, management of functional health needs, subjective concerns, program planning, and for some, biomedical diagnostics and disease management. Large amounts of data are elicited, sorted, and organized into meaningful patterns. Conducted within the context of nurse-patient relationships, APN clinical decision making is frequently characterized by changing health circumstances and complex social variables. The nursing and biomedical decision making involved may be straightforward, of moderate complexity, or of high complexity. The level of patient health risk may range from very low to very high. The amount and quality of evidenced-based health information available may demonstrate a wide degree of variability. From a societal perspective, recipients of health care and health policy makers are demanding ever greater transparency in the decisions made by health care professionals and greater accountability for the outcomes. As stated by Thompson and Dowding (2002), "the development of a solid and transparent rationale for [health care] decisions will not be an optional extra" (p. 6). Advanced practice clinical decision making thus necessitates careful and conscientious attention to a wide range of cognitive skills, with an eye toward deliberately applying and continuously improving the critical thinking and knowledge base required for practice.

PROCESSES, FOCUS, AND FRAMEWORKS

In examining clinical decision making, we are exploring the confluence of clinical knowledge and action in advanced practice at the point of care. To understand clinical decision making at the APN level it is necessary to examine at least three interrelated aspects of practice: decision-making processes; the focus of APN practice; and APN frameworks for practice. Each of these components contributes essential elements to the process of clinical decision making in advanced practice nursing, resulting in a unique and valuable clinical practice role. Both research and knowledge from practice have made important contributions to understanding these components.

Decision-Making Processes: Research in Clinical Reasoning

Research in clinical judgment and decision making has been an important area of study for over 50 years. Much of the decision making and problem solving research began in the cognitive sciences (Newell & Simon, 1972; Tversky & Kahneman, 1974), with early application to diagnostic reasoning and clinical problem solving in nursing and medicine (Elstein, 1976; Elstein, Shulman & Sprafka, 1978; Hammond, 1964; Hammond, Kelly & Castellan, 1966). Strong interest in this field of study has continued such that much clearer distinctions between clinical problem solving in nursing and medicine can now be discerned. Nursing problem solving, for example, frequently focuses on expert judgment about changes in a patient's overall status; anticipating and preventing potential problems; ensuring safe passage through uncertain health-illness trajectories; addressing the functional needs and capacities and quality-of-life issues for the whole person; understanding and responding to complex human responses; and protecting individuals and groups in their health-illness vulnerabilities (Benner, Hooper-Kyriakidis & Stannard, 1999; Carnevali & Thomas, 1993; Tanner, Benner, Chesla, & Gordon, 1993). Medical reasoning, in contrast, focuses more specifically on the management of illness, pathology and disease, biomedical hypothesis generation with probability determination, and medical treatment decisions (Elstein & Schwartz, 2000). In medicine, a very different set of problem solving skills and knowledge bases are required: pathophysiologic causal reasoning, use and interpretation of diagnostic tests, prognostic determination, and disease-oriented therapeutic decision making (Kassirer & Kopelman, 1991). Because advanced practice nursing can

involve a complex blending of both nursing and medical decision making, it is important to be able to synthesize decision-making skills from both fields. To that end, we will identify several overall generalizations from the research in clinical decision making.

Commonalities in Clinical Reasoning Across Health Disciplines

Several common or core features of clinical reasoning across health disciplines have been identified in the research (Higgs & Jones, 2000). First, clinical reasoning and clinical knowledge are now accepted as being strongly interdependent. At one time, particularly in medicine, it was hypothesized that clinical reasoning and clinical knowledge could be learned independently (Patel & Kaufman, 2000). Many educational programs attempted to deal with the rapidly escalating volume of biomedical information by emphasizing the development of problem-solving skills and devoting less time to content. Research has shown, however, that the development of expertise in clinical reasoning requires considerable depth and organization of domain-specific clinical knowledge (Boshuizen & Schmidt, 1992). Growth in clinical expertise is accompanied by increasing depth and complexity of knowledge structures (Higgs & Jones, 2000).

Another core feature of clinical reasoning across health disciplines is that an array of higher-order cognitive skills and processes is necessary for effective clinical reasoning. Various theorists identify these higher order cognitive skills differently, but some that have been emphasized in the literature are propositional knowledge (Titchen & Higgs, 2000), clinical appraisal (Brookfield, 2000) and categorization (Hayes & Adams, 2000). Propositional knowledge incorporates hypothesis generation and the development of plausible and probabilistic relationships between events. Clinical appraisal involves judging the accuracy and validity of multiple information sources, selectively attending, discarding and reframing the information to achieve the best fit between data sources. Categorization is both a way of learning complex content and using salient features and pattern recognition clinically to relate novel instances to known categories. When clinicians make prospective predictions about the likely course of a condition based on clinical signs and symptoms, they are engaging in a combination of categorization and probabilistic reasoning.

The third feature associated with clinical reasoning is that it is highly context-dependent. The context within which clinical reasoning occurs is

determined by the client's health concern(s); the specific health setting; the care provider's disciplinary background and level of experience; the client's unique personal context; and elements of the wider health care environment (Higgs & Jones, 2000). Research attending to context-specific factors (e.g., Benner, Hooper-Kyriakidis, & Stannard, 1999) demonstrates that expert clinical reasoning is complex, interpretive and personalized: "A good clinician is always interpreting the present clinical situation in terms of the immediate past condition of the patient" (p. 10). The expert clinician attends to the direction of change in the client's condition and interprets ambiguous and unfolding client information as it becomes available.

Clinical Reasoning in Nursing

Multiple approaches have been used to study clinical reasoning in nursing, including information processing theory (Corcoran, 1986a), analytical decision-making (Corcoran, 1986b), skill acquisition or hermeneutic processes (Benner, 1984), cognitive continuum theory (Lauri & Salatera, 2002), and the use of heuristics (Cioffi & Markham, 1997). Information processing derives primarily from the cognitive sciences. It focuses on memory capacity, the "chunking" or clustering of complex information into recognizable patterns, weighing alternative options, and searching for pathways to solutions (Elstein, 1976; Newell & Simon, 1972). Information is accessed from long-term memory and cue assessment, then transformed into units that can be cognitively manipulated in short-term memory. Research using this model was originally directed toward understanding the hypothetico-deductive process used in deriving medical diagnoses (Elstein, Shulman & Sprafka, 1978), a process of generating hypotheses to explain data, then searching for additional data to support the hypotheses. In nursing, information processing has been used with verbal or "thinking aloud," protocols to study cognitive processes used in clinical decision making (Corcoran, 1986a; Simmons, 2002). More recently, the tendency of information-processing models to be overly linear and mechanistic has been addressed through the addition of heuristics, contextual variables, varying degrees of task complexity, and varying levels of uncertainty (Higgs & Jones, 1995; Narayan & Corcoran-Perry, 1997; Tanner, Padrick, Westfall & Putzier, 1987). This recent development provides a better theoretical match for the dynamic environments and ambiguity of decisions in clinical practice. In clinical practice, information-processing models are regarded as

consisting of the following analytic components: cue acquisition (data gathering), hypothesis generation, cue interpretation, further cue acquisition, deciding the problem, formulation of possible solutions, repeat cue interpretation, and evaluation of each hypothesis (Elstein, Shulman & Sprafka, 1978).

Analytical decision making relies on a more structured process of identifying options and possible outcomes, assigning values to the outcomes, and determining probability relationships between the options and anticipated outcomes. Formal (mathematically based) or informal (conceptually based) models are used to systematize decision making using grids or decision flow diagrams (Corcoran, 1986b; Narayan, Corcoran-Perry, Drew & Lewis, 2003). Decision analysis has been reported as useful for evaluating medical treatment options, cost analysis, quality improvement decisions, and policy decisions (Narayan, Corcoran-Perry, Drew & Lewis, 2003). These same sources note, however, that assigning value to various options in health care decision making can be immensely difficult and frequently cannot account for all considerations or points of view.

Skill acquisition theory, also referred to as the hermeneutic model, has been used by Benner (1984), Benner and Wrubel (1989), and Benner, Tanner and Chesla (1996) to study expertise in clinical nursing practice. Benner and colleagues, argue that experienced nurses frequently use the nurse-patient relationship and their intimate knowledge of a patient's response patterns to make clinical judgments about patient care. From their contributions, definitions of clinical judgment, particularly at the level of expert practice, have been expanded to include both deliberate analytic thinking and nonconscious holistic discrimination of a patient's clinical status. In the hermeneutic model, expert judgment includes ethical decision making on what is good and right, a repertoire of extensive knowledge from practice, emotional engagement with patients and with one's practice, and a deep understanding of specific contexts for care (Benner, Tanner & Chesla, 1996). Components of the hermeneutic model have been identified as pattern recognition, similarity recognition, common-sense understanding, skilled know-how, sense of salience, and deliberative rationality (Dreyfus & Dreyfus, 1986).

As language has evolved in nursing to name and examine the cognitive processes and activities of expert clinical decision making, reference is frequently made to the use of "intuition" to guide expert practice in nursing (Benner, 1984; Pyles & Stern, 1983; Smith, 1987; Rew, 1988). "Intuition" refers to the capacity of the expert clinician to nearly instantaneously pro-

cess large amounts of complex data, simultaneously discern patterns, and act on hypotheses without necessarily being able to consciously name all of the factors involved in their decision making. The term "intuition" is invoked in an attempt to capture episodes when the complexity of expert knowledge combines with the artistry of expert practice, resulting in a "flow" of engaged practice that seems beyond the capacity of available language to describe. Using Heideggerian and other phenomenologic methodologies, the goal of such inquiries is not necessarily a reductive analysis of linear thought, but an in-depth understanding of the complex experiential knowledge embedded in practice. Intuition is the understanding of a phenomenological gestalt of nurse-client interaction, characterized by intense involvement in an evolving health scenario and the ability of the expert clinician to apply heuristics, attribute meanings, and enact effective care.

Cognitive continuum theory (Hamm, 1988; Lauri & Salantera, 2002) posits a range of analytical thinking approaches with varying combinations of intuitive and analytical thinking. In this theory of decision making, features of the task to be accomplished are thought to determine the degree of intuition and/or analysis used by the decision maker. Three features of the task are viewed as particularly salient: the complexity of task structure (number and redundancy of cues, form of an accurate organizing principle); the ambiguity of task content (availability of organizing principles, familiarity with the task, possibility of high accuracy); and the form of task presentation (task decomposition, cue definition, and response time). In this model, greater analytical thinking is assumed to be related to fewer cues, less redundancy of cues, and more complex procedures for combining evidence to result in correct answers. The availability of organizing principles, greater task familiarity, and the possibility for high accuracy also contribute to greater use of formal reasoning. Hamm (1988) identifies a relationship between the thinking process used and the depth of the clinician's knowledge base, with greater knowledge enabling greater analytical thinking.

The use of heuristics was proposed by Tversky and Kahneman (1974) as a method for reducing the complexity of judgment tasks by cognitively estimating probabilities, typically based on prior experience. Heuristics identified by Tversky and Kahneman were representativeness, availability, and anchoring-adjustment. *Representativeness* can be used to compare signs and symptoms in a new clinical situation to previously encountered clinical conditions. The *availability* heuristic is the ease with which particular in-

stances or cases of a condition can be brought to mind. *Anchoring-adjustment* is used to determine a baseline set of indicators for a condition, then shifting that baseline to account for the clinical factors present in a specific situation. Cioffi and Markham (1997) examined relationships between the use of heuristics and task complexity in midwifery. In simulated clinical decision making situations, heuristic processes were used more frequently in situations of greater clinical risk and complexity, less predictability, and when less clinical information was available. Heuristic techniques were used effectively (i.e., high rate of accurate diagnoses) and more frequently as task complexity increased. Cioffi (1997) has proposed that heuristic strategies are an important component of nurses' decision making in ambiguous clinical situations and in deriving intuitive judgments.

A small number of studies have focused specifically on the clinical reasoning of advanced practice nurses. White, Nativio, Kobert, and Engberg (1992) used an information-processing model to study diagnostic reasoning among nurse practitioners. They concluded that the nurse practitioners in their study used a decision-making model reflective of hypothetic-deductive models proposed in the information processing literature. Experienced nurse practitioners demonstrated greater expertise in making hypothesis-driven choices about what data was necessary for making accurate diagnoses. Nurse practitioners with less expertise in a clinical area tended to sample the data widely rather than focusing assessments on the basis of diagnostic hypotheses. Participants also went beyond the hypothetic-deductive reasoning model to include what the authors identified as "comprehensive care," i.e., they gathered subjective and objective data that "increased their understanding of the patient and her health status but that was not required to diagnose the cause of the patient's presenting complaint" (p. 156). The content of this additional data collection was frequently related to health promotion or risk reduction aspects of nurse practitioner care. In addition, not all participants had the content expertise needed to correctly interpret the significance of findings or to make correct management decisions. Given that clinical reasoning and clinical knowledge are interdependent, it can be concluded from this study that both the process of clinical decision making and the nurse practitioner's content expertise were necessary for effective client care.

In a study of 70 entry-level nurse practitioners, Sands (2001) found that 76% of the participants were able to develop differential diagnoses, acquire relevant data, refine their hypotheses and make an accurate diagnosis with a common health concern (pregnancy). Characteristics of novice practice

were demonstrated in the tendency of participants to acquire a great deal of data, "seemingly in an effort 'not to miss something'" (p. 137). Entry-level nurse practitioners with at least 5 years of RN experience demonstrated stronger scores on the test of diagnostic reasoning. Participants with less than 2 years of RN experience were at increased risk for incorrectly or inadequately reasoning through the clinical problem. Ritter (2003) examined the diagnostic reasoning of ten expert nurse practitioners using both information-processing and hermeneutic models. Specific steps of either information processing or hermeneutics accounted for 99% of participants' think-aloud responses. Within information processing, gathering information accounted for 32% of the responses. Within hermeneutics, skilled know-how accounted for 25% of the responses. Information processing was found to begin the process. Hermeneutics were then used for cue acquisition, thereby bringing structure to the clinical problem and determining what information was salient.

APN Phenomena of Concern

One factor that can be used to distinguish clinical decision making in advanced practice nursing from other autonomous health care providers is the focus of APN practice, or the phenomena of concern. Smith (1995) identified the core of advanced practice nursing as lying within nursing's disciplinary perspectives on health, healing, person-environment interactions, and nurse-client relationships. Huch (1995) echoes this in identifying the need to use nursing theory as the basis for advanced nursing practice. Many authors argue that the inclusion of nursing theory and nursing's disciplinary perspectives is an area that needs to be strengthened in advanced practice nursing. There seems to be agreement in the literature, however, that at a minimum this would include nursing's perspectives on health, holism, person-environment interactions, and nurse-client relationships (Dunphy & Winland-Brown, 2001; Hamric, Spross & Hanson, 2000; Robinson & Kish, 2001).

Clinically focused advanced practice nurses focus their clinical decision making on health promotion, health protection, disease prevention, and the management of health concerns (NONPF, 2002; NACNS, 2004). As outlined by nurse practitioner and clinical nurse specialist organizations, health promotion activities include lifestyle concerns, principles of lifestyle change, and behavioral change. Health protection includes knowledge of

health risks, use of epidemiologic principles, and community/population level measures to protect health. Disease prevention includes primary and secondary prevention measures addressing major chronic illness, disability, and communicable disease. Management of health concerns focuses on assessing, diagnosing, monitoring, and coordinating the care of individuals and populations (NONPF, 1995; NACNS, 2004). Depending on the APN's role and specialty preparation, phenomena of concern include both disease- and nondisease-based etiologies that affect health, wellness, and quality of life. For nurse practitioners, the focus is generally on providing direct patient care. For clinical nurse specialists, the focus tends to be on influencing the outcomes of care more widely within an area of specialization, at individual patient, population, and health system levels. Human responses to health and illness, evidence-based nursing interventions, and expertise in the health care needs of a specialty population are frequently emphasized by the CNS.

APN Practice Frameworks

Advanced practice nursing has been consistently characterized as based in holistic perspectives, the formation of partnerships with patients or populations, the use of research and theory to guide practice, and the use of diverse approaches in health and illness management (Brown, 2000; Davies & Hughes, 2002). These characteristics are now built into nationally recommended educational guidelines for advanced practice educational programs (AACN, 1996; NONPF, 2002; NACNS, 2004). For example, the National Organization of Nurse Practitioner Faculties (NONPF) (1995, 2002) core competencies for nurse practitioner clinical decision making incorporate the following expectations for practice:

- Purposeful use of scholarship and evidence-based knowledge for practice
- Integrating nursing models of health, wellness, and person-centered care
- Considering theoretical perspectives on specific populations, health problems, or the phenomena of care
- Using ethical frameworks to guide healthcare decision making
- Facilitating the development of health-promoting environments for practice

Explicit frameworks for APN practice have been developed in the form of consensus statements on master's education (AACN, 1996), nurse practitioner education (NONPF, 1995), and clinical nurse specialist education (NACNS, 2004). These statements have been developed from multiple sources, including studies on expert practice in nursing (Benner, 1984). Role delineation studies (Brykczynski, 1989; Fenton, 1985) and studies on the effects of advanced practice nursing (NACNS, 2004) have contributed to these statements as well. Benner's (1984) work examining expert practice was foundational to the development of the consensus statements. As part of her research, Benner identified seven domains of expert practice: the helping role; the teaching-coaching function; the diagnostic and patient-monitoring function; effective management of rapidly changing situations; administering and monitoring therapeutic interventions and regimens; monitoring and ensuring the quality of health care practices; and organizational and work-role competencies. Each of these domains was identified from groupings of practice competencies captured in descriptions and observations of clinical situations with expert nurses.

Fenton (1983) extended Benner's work to master's prepared nurses by using the domains of expert practice to identify areas of skilled performance among these nurses in a large acute-care setting. In addition to verifying the domains identified by Benner, two domains were expanded for master's prepared nurses: monitoring and ensuring the quality of health care practices; and organizational and work-role competencies. A new domain was also described: the consulting role of the nurse. Brykcyznski (1989) used Benner's (1984) methodology and taxonomy of practice domains to describe domains of nurse practitioner practice. An important revision to the domains for nurse practitioners was the addition of management of patient health/illness in ambulatory care settings. Five competencies within this domain were identified as assessing, monitoring, coordinating and managing the patient's health status; detecting acute and chronic diseases; providing anticipatory guidance; closely monitoring patients in uncertain situations; and selecting appropriate diagnostic and therapeutic interventions. Refinements of these studies have resulted in statements on domains and competencies for nurse practitioners and clinical nurse specialists (NACNS, 2004; NONPF, 1995, 2002).

Research examining the contributions of advanced practice nursing to quality patient outcomes has shown significant positive effects from APN care (Fulton & Baldwin, 2004; Girouard, 2000). An important feature of clinical decision making in advanced practice nursing is that the above

TABLE 5.1 Approaches for Incorporating Core Nursing Perspectives Into APN Care

Make an effort to understand meanings that patients attribute to their health situation.
Learn about the patient's lived social world, support systems, and role responsibilities.
Work with the patient to identify personal and social health obstacles or facilitators.
Determine the patient's preference for and ability to participate in health care decision making and self-health management.
Jointly determine appropriate health care goals and priorities.
Work with patients as they struggle through personal crises, losses, or transitions.
Learn about the patient's spiritual point of view and how they view the relationship between their health status and spirituality.

characteristics and phenomena of concern continue to be evidenced in daily practice. This can be done, for example, by making an effort to understand the meanings that patients attribute to their health situation; by learning about the patient's lived social world, support systems, and role responsibilities; and by working with the patient to identify personal and social health obstacles or facilitators. Several additional approaches for incorporating basic nursing perspectives into APN care are listed in Table 5.1.

In addition to the specialty knowledge required for health and illness management, these patient-centered, holistic dimensions of clinical decision making are necessary to maintain the quality of APN care and the ability to distinguish advanced practice nursing from other forms of autonomous health practice.

CLINICAL DECISION MAKING AS UNDERSTOOD FROM PRACTICE

In addition to influences from nursing research, theory, and professional organizations, much has been learned about APN clinical decision making directly from clinical practice and from the research and practice experiences of other disciplines. Since understandings of clinical problem solving are still incomplete, principles to guide the development of APN decision making are similarly incomplete. Nonetheless, a process of clinical thinking can be outlined that has been found to be helpful in APN practice. Skilled

communication and interaction are essential components of clinical decision making at all levels, whether the APN is posing wide-field or focused inquiries, clarifying diverse perspectives, providing guidance for lifestyle health behaviors, or evaluating a client's responses to treatment. As Chase (2001) points out, clinical decision making is not a process that occurs with the APN in isolation. It occurs as dialogue and interaction between the patient and provider, with experiences of satisfaction significantly influenced by the quality of communication and engagement with the clinical situation (Benner, Stannard, & Hooper, 1996).

Most descriptions of APN clinical decision making begin with something that is similar to an expanded nursing process model, integrating elements of hypothetic-deductive reasoning. Carnevali and Thomas (1993) describe the diagnostic reasoning process in nursing as reviewing pre-encounter data, entry into the assessment situation, collecting the database, coalescing cues into working clusters, selecting pivotal cues or cue clusters, determining possible diagnostic explanations, further comparison of the clinical situation with diagnostic categories, and assigning the diagnosis. White, Nativio, Kobert, and Engberg (1992) outlined a clinical decision making framework for advanced practice nurses that adds elements from hypothetic-deductive reasoning. First identified as the way physicians use clinical information under conditions of uncertainty, hypothetic-deductive reasoning focuses strongly on hypothesis formation and verification. Hypothesis formation and verification includes forming hypotheses about the underlying causes of a patient's health problems, searching for confirmatory or disconfirmatory data, and reaching diagnostic conclusions based on an evaluation of relevant data. The hypotheses formed are used to guide the process of inquiry, i.e., decisions about how to focus the history, exam, and diagnostic testing. The process outlined by White, Nativio, Kobert, and Engberg adds many of these elements to nursing clinical decision making: reviewing preencounter data, early hypothesis generation, engaging in clinical inquiry, determining working hypotheses, conducting diagnostic testing, testing the final hypothesis, specifying the diagnosis, determining client management, and evaluating the total clinical situation. Chase (2004) configures this process even more specifically for nurse practitioner practice. She lists the phases of clinical judgment as: an early wide-field search for the primary concerns; early hypothesis generation on probable causes of the concerns; focused data acquisition related to supporting the active hypotheses and ruling out other serious conditions; evaluating various hypotheses by clustering and analyzing the data for the appropriate fit with diagnostic

TABLE 5.2 Comparison of Nursing and APN Clinical Decision Making Frameworks

Carnevali & Thomas (1993), Diagnostic Reasoning in Nursing	White, Nativio, Kobert & Engberg (1992), APN Clinical Decision Making	Chase (2004), Process of Clinical Judgment for Nurse Practitioners
• Collecting pre-encounter data	• Reviewing preencounter data	• Wide-field data search
• Entry into the assessment situation	• Early hypothesis generation	• Hypothesis generation
• Collecting the database	• Clinical inquiry	• Data acquisition
• Coalescing cues	• Determining working hypotheses	• Hypothesis evaluation
• Selecting pivotal cues	• Diagnostic testing	• Naming priority problems
• Determining diagnostic explanations	• Final hypothesis testing	• Determining therapeutic goals
• Comparison with diagnostic categories	• Specifying the diagnosis	• Determining management plan
• Assigning the diagnosis	• Determining client management	• Evaluating effectiveness
	• Evaluation	• Confirming or revising

categories; naming the priority problems; determining appropriate therapeutic goals; determining an appropriate management plan; evaluating the effectiveness of the clinical process; and confirming or revising the diagnoses and plans. Table 5.2 provides a comparison of these three approaches.

In advanced practice nursing, each of these approaches might be appropriate for differing clinical scenarios or problems. The decision-making processes can be used with both disease- and nondisease-based concerns, as well as with medical or nursing diagnoses. Clinical nurse specialists might place less relative emphasis on the biomedical diagnostic content attendant to hypothetic-deductive reasoning tending more often to work collaboratively with medical care providers for these decision-making components. Nurse practitioners emphasize greater autonomy in medical diagnostic and treatment elements, but place less overall emphasis on specialty nursing care and system-level thinking. With either role, however, keys to the processes are clinician characteristics of perception and engagement, discipline-specific knowledge, commitment to quality practice, and knowing how to

"think clinically" under differing clinical role expectations. Skilled clinical decision making occurs as an intentional process of problem solving, critical thinking, and reflection in action (Benner, Stannard, & Hooper, 1996). It is guided by content expertise and deliberate decisions about how to proceed through the current clinical encounter as well as reasoning through the anticipated trajectory of the health concern.

Relationship Between Critical Thinking and Clinical Decision Making

Critical thinking skills can assist with sorting out the above complexities. In a 1990 consensus statement on critical thinking, Facione defines critical thinking as a tool of inquiry characterized by "purposeful, self-regulatory judgment" resulting in "interpretation, analysis, evaluation and inference" (Facione, 1990, p. 3). It is not "rote, mechanical, unreflective" (p. 8) or disconnected from other thought activities. Critical thinkers are able to examine and evaluate their own reasoning processes and apply critical thinking skills in a variety of contexts. The consensus components of critical thinking are provided in Table 5.3.

TABLE 5.3 Consensus Components of Critical Thinking

Critical Thinking Skill	Identified Components of the Skill
Interpretation	Categorizing Clarifying meanings
Evaluation	Assessing claims and arguments
Inference	Examining evidence Drawing conclusions Proposing alternatives
Explanation	Stating results Presenting arguments Justifying procedures
Self-Regulation	Self-examination Self-correction
Dispositional Skills	Inquisitiveness Eagerness for reliable information

Scheffer and Rubenfeld (2000) used a Delphi method to develop a consensus statement on critical thinking in nursing, describing both its affective and cognitive components. In addition to the components described by Facione (1990), the nursing study identified creativity and intuition as two additional affective components.

While critical thinking is defined by educators as a broad set of cognitive skills and habits of mind, applying these skills in clinical practice requires large amounts of discipline-specific knowledge. Research-based understandings of relationships between critical thinking and clinical decision making are not yet well developed. It can be seen, however, that the skills of interpretation, analysis, evaluation, and inference are highly necessary in advanced clinical practice, where both nursing and medical knowledge needs to be distinguished and applied. Thus it seems reasonable to propose that well developed critical thinking skills and habits of mind are an important foundation for the discipline-specific processes of clinical thinking in advanced practice nursing.

Thinking Clinically

As suggested above, what "thinking clinically" means will vary widely from one advanced practice nursing clinical setting and role to another. General elements can be described, however. From these elements it becomes incumbent upon nurses in advanced practice who are pursuing future research agendas to discern the particulars for their practice areas.

Organizing Clinical Knowledge for Practice

Carnevali and Thomas (1993) describe the individual practitioner's task of cognitively organizing diagnostic-treatment concepts for clinical practice as work that each clinician must do for her/himself. They recommend using a systematic approach, based on specific diagnostic/prognostic/treatment concepts and exemplars from practice. For knowledge from nursing, such cognitive categories could be built around human response categories, broad nursing diagnostic categories, functional health patterns, or population health needs. As the depth of knowledge increases with various phenomena, increasing expertise is developed relating to manifestations, underlying mechanisms, risk factors and complications, prognostic variables and anticipated trajectories, and the efficacy of treatment options. Increasing depth of medical

knowledge, on the other hand, relates to the complexity of pathophysiologic explanations and relationships, variations in disease attributes and manifestations, use and interpretation of diagnostic tests, increasingly precise probabilistic and prognostic thinking, and increasingly sophisticated risk/benefit analyses. Building the medical and nursing knowledge structures for advanced clinical practice is an ongoing process of study and accumulating personal exemplars for practice.

Clinical Decision Making Within Human Responses to Health/Illness

In the realm of advanced nursing knowledge and human responses, clinical decision making relating to health and illness concerns is characterized more by differences in the depth and complexity of skills and knowledge employed than by differences from professional nursing in the decision making processes themselves. Relationships between and among human responses to health/illness concerns are more deeply understood, and purposeful engagement with the human responses becomes a larger focus of practice. Benner, Tanner, and Chesla (1996), for example, describe one focus of expert nursing practice as attending to human concerns such as easing suffering, protecting from vulnerability, and preserving dignity. At the advanced practice level, these attributes of expert practice might be the primary focus of a nurse-client interaction enacted from expert knowledge derived through the study of nursing research and theory on suffering or vulnerability within a specific population or disease process. One approach to modeling nondisease-based problems is to seek an understanding of the mechanisms or dynamics most fundamental to the clinical issue that needs to be addressed. For example, inadequate self-health management might be a common nursing diagnosis among individuals with poorly controlled chronic illness. Dynamics underlying such a diagnosis, however, may range from lack of knowledge, to situational depression, specific skill deficits, or inadequate social support. Once some of the situation-specific dynamics are understood, realistic decisions about where and how to intervene can be made much more effectively.

Clinical Decision Making in Health/Illness Management

In the realm of biomedical knowledge, diagnosis and management of health/illness concerns places much greater emphasis on probabilistic thinking and inferential or inductive reasoning, with much greater attention to the spec-

ificity of the data and the precision of decisions. Rational justification, confirmation and elimination strategies, as well as judging value are critical reasoning skills within this domain. As outlined by Kassirer and Kopelman (1991), the first step in the diagnostic process is hypothesis activation, or the identification of diagnostic possibilities. Hypothesis activation is based on preliminary information such as the patient's age, medical history, clinical appearance, and presenting concerns. The next step is information gathering and interpretation. This step is strongly influenced by probabilistic thinking and inductive reasoning. The likelihood of various diagnostic hypotheses is carefully considered, with new data used to assist with confirming, eliminating, or discriminating between diagnoses. The working diagnosis is then selected based on causal attribution, i.e., whether all physiologic features are consistent with the favored diagnosis and underlying cause. The working diagnosis becomes the basis for therapeutic action, prognostic assessment, or further diagnostic testing. Final verification of the diagnostic hypothesis is determined through tests of adequacy and coherence. Adequacy ascertains whether the suspected disease process encompasses all of the patient's findings. Coherence determines whether all of the patient's illness manifestations are appropriate for the suspected health concern. The final diagnostic hypothesis then becomes the basis for treatment decisions, in combination with patient-specific cost/benefit analyses for each of the treatment options. Experience and mentoring are clearly necessary to learn biomedical decision making. Kassirer and Kopelman (1991) also advise parsimony in medical reasoning, i.e., seeking a simple, direct, and clear explanation for the patient's health/illness findings whenever possible.

Heuristics in Advanced Practice Nursing

Heuristics are specific cognitive techniques used by skilled clinicians to make reasoning more efficient by reducing complex tasks to simpler and more automatic processes (Tversky & Kahneman, 1974). Heuristics are domain-specific (i.e., medical-surgical nursing, critical care nursing, mental health nursing) and are thought to operate strongly in what has been understood as the "intuitive" knowing of clinical experts.

Simmons (2002) identified eleven heuristics used by experienced nurses to reason about assessment findings: recognizing patterns, enumerating lists, forming relationships, searching for information, setting priorities, providing explanations, judging value, stating practice rules, stating propositions,

drawing conclusions, and summing up. Other heuristics used by expert nurses have been identified by Benner and colleagues. These include clinical grasp (making qualitative distinctions, clinical puzzle solving, recognizing changing clinical relevance, and developing population-specific clinical knowledge) and clinical forethought (future think, clinical forethought about specific diagnoses or conditions, anticipating crises, risks and vulnerabilities, and seeing the unexpected) (Benner, Hooper-Kyriakidis, & Stannard, l999). Central to clinical grasp are understanding and recognizing clinical patterns, and attending very closely to the clinical situation. It is essential to get an accurate story, then to observe carefully for patient responses and trends. Clinical forethought involves thinking ahead to common eventualities and using this knowledge to be prepared for or, when possible, to prevent the unfolding of detrimental scenarios. Expertise in clinical forethought requires not only expert textbook knowledge but an array of personal case experiences, providing firsthand experience from which to generate understandings of the clinical terrain, timing issues, and practical knowledge on how to read and interpret clinical cues. Chase (2004) and Dains, Baumann, and Scheibel (2003) describe multiple heuristics specific to nurse practitioner judgment and decision making. The heuristics described are too numerous to elaborate here, but these and other clinical reasoning texts provide very valuable compendiums of practice knowledge central to nurse practitioner decision making.

Errors in Clinical Reasoning

Several types of clinical practice errors are described in the literature, broadly grouped as skill-based errors, knowledge-based errors, and errors caused by psychoemotional factors. Skill- and knowledge-based errors in this context are not the same as not possessing the necessary skills or knowledge. Rather, the assumption is made that the necessary skills and knowledge are present, but errors are made in their application. Skill-based failures include lack of attention at crucial moments, distraction or preoccupation resulting in missed crucial events, failure to carry out specific activities or intentions, and errors resulting from mixing up behaviors or activities. Knowledge-based failures include errors due to the use of heuristics. Despite the value of heuristics, overuse has the potential to increase errors in clinical judgment. Because heuristics shortcut formal reasoning, care must be taken to maintain a reflective balance between formal reasoning and the use of

knowledge from practice. Overconfidence about the correctness of one's knowledge (overconfidence bias), using personal case experience alone as the basis for a decision (hindsight bias), and neglecting the underlying base rate of a health condition when diagnosing or treating (base rate neglect), are three common types of errors in the application of practice knowledge (Thompson, 2002). Conservativism is the failure to revise diagnostic probabilities as new data are presented. Pseudodiagnosticity, or confirmation bias, is the tendency to seek information that confirms a diagnosis, but failing to efficiently test competing hypotheses (Elstein & Schwartz, 2000). A psychoemotional error occurs (value-induced bias) when the clinician exaggerates the probability of a diagnosis when one possible outcome is perceived as exceedingly unfavorable compared with others (Buckingham, 2002; Kassirer & Kopelman, 1991).

Errors in the information processing components of practice are also categorized using terminology from hypothesis testing. Type I errors, claiming a significant difference when there is none (analogous to rejecting a true null hypothesis), occurs in clinical decision making through naming a problem when there is none. In this situation the disease model employed by the clinician may be too broad, perhaps causing the clinician to overestimate the allowable range of variation for findings in a given diagnosis and not recognizing that the actual findings are at odds with the favored diagnosis. Type II errors, claiming no significant difference when there is one (analogous to accepting a false null hypothesis), occurs with failing to name a problem when there is one. This may occur through missing significant clinical indicators of a health problem, or failing to realize the significance of specific signs or symptoms. A correct diagnosis may have been eliminated even though the findings are consistent with the diagnosis. Type III errors, solving the wrong problem, involves phrasing a problem incorrectly, setting the boundaries/scope of the problem too narrowly, or failing to think systematically (Kassirer & Kopelman, 1991).

Based on the above information, habits of practice that promote sound reasoning can be cultivated by the advanced practice nurse. These are summarized in Table 5.4 (revised from Chase, 2004).

Ethical Considerations

The ethics of caring, responsive, and relationship-based practice, and a commitment to good and appropriate actions in health care are additional

TABLE 5.4 Habits That Promote Sound Clinical Reasoning in Advanced Practice Nursing

Phase of Clinical Reasoning	Habits That Promote Sound Reasoning
Data Acquisition	Use a systematic and comprehensive approach. Use nursing and medical hypotheses in combination with a systems approach to focus the data collection. Integrate new findings into the emerging model. Search for and attend to both confirming and disconfirming data. Critically evaluate the significance and reliability of findings. Attend to variations in clinical attributes and manifestations.
Hypothesis Generation	Formulate preliminary hypotheses early in the encounter. Develop reasonable competing hypotheses. Remain vigilant for serious or life-threatening conditions. Use the hypotheses as models against which to seek and compare findings. Adjust the hypotheses as new data emerge. Carefully compare the hypotheses to reliable information on manifestations, prevalence, and probability. Eliminate hypotheses that fail to remain tenable.
Diagnostic Testing	Consider test results as further probability information. Decide if a test result could alter the probability of disease enough to alter management. Use highly sensitive tests (low rate of false negatives) to exclude serious disease. Use highly specific tests (low rate of false positives) to confirm a diagnosis.
Hypothesis Evaluation	Determine the "working hypothesis." If competing hypotheses remain, determine a strategy for discriminating between them. Test the hypothesis for coherence, adequacy, and parsimony. Avoid premature closure. Continue testing the working hypothesis against test results, clinical course, and response to therapy.
Comprehensive Care	Include disease- and nondisease-based perspectives. Incorporate nursing theory, human responses, personhood. Identify the most fundamental problems/concerns. Include health promotion, disease prevention, risk reduction. Engage the patient as a partner in care.
Establishing Goals	Include the patient in establishing goals. Determine management priorities and plan care accordingly. Identify specific and realistic goals for treatment. Incorporate clinical standards in goal setting.

(continued)

TABLE 5.4 ***(continued)***

Phase of Clinical Reasoning	Habits That Promote Sound Reasoning
Determining Management Plans	Employ intervention modalities from both nursing and medical perspectives.
	Initiate effective care for emergency or life-threatening conditions.
	Consult with appropriate colleagues in complex care situations.
	Consider patient's social context, preferences, abilities, lifestyle, individual needs.
	Anticipate and discuss possible conflicts in values, priorities, beliefs.
	Use evidence-based therapies appropriately.
	Consider treatment efficacy as compared to risks, costs, and desired outcomes.
Evaluation	Evaluate each component of the client's care against the context of care.
	Follow up with the client to evaluate the response to treatment.
	Use the response to treatment as an opportunity to revisit the working hypothesis and management approach.
	Use evaluation as an opportunity to build health care relationships and assess client satisfaction.
	Document and report individual and aggregate treatment effectiveness.

Note: Adapted from Chase (2004).

essential components of skilled decision making. Dreyfus, Dreyfus, and Benner (1996) refer to "skilled ethical comportment" in nursing as the skills of interaction, involvement, and recognizing and protecting vulnerabilities. Jean Watson (1979) maintains that core aspects of nursing, i.e., the aspects that produce therapeutic results in the person being served, are based on humanistic values and altruistic behaviors toward others. "The nurse must first view the other person as a separate thinking and feeling human being" (p. 25), with the appropriate orientation being one of understanding the individual's personal meanings, rather than as an object of care to be "treated" or manipulated. Swanson (1995) summarizes this as the need for nurses to have "a clear articulation on what it means to be a person, and to accord that status of personhood to each client" (p. 319). Patients must first and foremost be humanized in order to practice in ways that preserve dignity and enhance well-being. Practicing from person-centered values that emphasize the meaning of human health-illness experiences,

nurse-patient relationships and partnerships, individual self-determination, and a willingness to provide interpersonal interventions, can provide a framework for ethical reasoning as an essential component of clinical decision making. The complex considerations of contemporary health care can very easily develop into ethical issues of what "should" be done to promote the client's best interests. In addition to basing one's practice on humanistic values, Brown (2000) advocates the use of "preventive ethics" in APN practice. Preventive ethics emphasizes "shaping the process of clinical care so that possible value conflicts are anticipated and discussed prior to outright conflict" (p. 154). Early communication, critical reflection, and working to preserve trust and understanding are necessary components of this approach.

Tools To Support and Enhance Clinical Decision Making in Advanced Clinical Practice

A final aspect of APN decision making is the increasingly important role of a variety of tools that can be used to support and enhance clinical decision making. A listing of these tools is provided in Table 5.5.

Multiple nursing standards of practice have been developed by the American Nurses Association and by specialty nursing organizations. These are organized both by specialty practice areas and by practice-related frameworks such as the nursing code of ethics and the nursing social policy statement. They continue to serve as basic frameworks for nursing practice and are especially important documents for clinical nurse specialists. The NANDA/NIC/NOC taxonomies, though not necessarily complete and not

TABLE 5.5 Tools To Support and Enhance Clinical Decision Making in Advanced Clinical Practice

Nursing Standards of Practice
NANDA/NIC/NOC
Mid-Level Theories
Evidence-Based Practice
Clinical Practice Guidelines
Web-Based Information Systems

universally used, help to organize ways of naming nursing diagnoses and begin the process of building common expectancies for interventions and outcomes. Mid-level theories help to guide practice by addressing the needs or experiences of specific populations, typically relative to one or more human responses or areas of concern. Incorporating information or concepts from mid-level theories is an excellent way to begin addressing the holistic care considerations of health care populations and build depth at an advanced practice level.

Evidence-based practice has been described as basing clinical decisions and practice on the best available evidence (Higgs, Burn, & Jones, 2001). Not all elements of practice are based on empirical evidence, however. Many areas of practice do not have adequate bodies of evidence. In addition, context-specific problems sometimes warrant decisions not addressed by the research literature. Thus it is imperative that critical thinking, research appraisal and clinical decision-making skills be used in combination with one another. Typically evidence-based practice is assumed to refer to external, population-based evidence derived through systematic research. Many authors caution against the application of external evidence without careful consideration of its appropriateness to a specific individual's needs and circumstances. There is a growing expectation, however, that advanced practice nurses will seek the available evidence and use this evidence to inform their decision making.

Clinical practice guidelines can be formalized by specific managed care organizations with the expectation that the guidelines are used to direct practice, or they may simply refer to concise informational outlines and algorithms intended to assist clinicians with the massive amounts of diagnostic and management information available. In either case, they are tremendously useful, but they can also constrain and oversimplify practice. Brown (2002) notes that a limitation of clinical guidelines is the tendency to focus on more common problems. If overly relied upon, clinical guidelines can result in failing to attend to the individual needs and nuanced presentations of a patient's condition. Many web-based information systems have been developed and are now viewed as part of the standard support tools for practice. These include intra- and internet systems, as well as online journals, databases, and governmental and organizational web sites. A commonly expected advanced practice competency is the ability to access, search, and critically evaluate the appropriateness of clinical guidelines and electronic resources for practice.

CONCLUSIONS

Expertise in clinical decision making is vital for clinical competency. At the advanced practice level this is a complex undertaking for both the individual provider and for the profession. Keeping the core of nursing theory and perspectives central and visible, while gaining competency in the knowledge base and probabilistic thinking of medicine, requires continuous attention to practice-based cognitive skills and processes. It is recommended that advanced practice clinical decision making be approached as a continuous and deliberate process of knowledge expansion and reflective practice, maintaining the personhood and holistic needs of the patient and the importance of the nurse-patient relationship central to practice.

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Chapter 6

PROFESSIONAL ISSUES: LICENSURE, CERTIFICATION, PRESCRIPTIVE PRIVILEGES, CREDENTIALING, AND LEGAL ISSUES

Michaelene P. Mirr Jansen

Advanced practice nurses (APNs) encounter a variety of professional issues in their practices. Most questions focus on what APNs can or cannot do within the scope of nursing practice. Most of the primary and preventive care traditionally performed by physicians could be performed by advanced practice nurses if legislative barriers did not exist (Larkin, 2003; Pearson, 2004). The wide variety of settings in which APNs practice has provided new opportunities for nurses in advanced practice. With these opportunities, new issues related to advanced practice have emerged. The focus of this chapter will be issues related to licensure, certification, prescriptive authority, clinical privileges, and legal issues. Inherent in these questions is the need for legislative awareness and action on the part of all nurses in advanced practice. Recently, many states have broadened or expanded legal or prescriptive authority for APNs, thus illustrating the importance of APNs taking an active role in the legislative process (Pearson, 2004).

LICENSURE

Licensure is defined as the "process by which an agency of government grants permission to persons to engage in a given profession or occupation

by certifying that those licensed have attained a minimum degree of competency necessary to ensure that the public health, safety and welfare be reasonably protected" (Mirr, 1981, p. 10). Entry-level professional nurses are governed by nurse practice acts passed in each state. As the roles of nurses expanded during the 1970s, many state nurse practice acts were revised to include the added responsibilities nurses assumed. State legislatures chose several methods to provide jurisdiction of advanced practice nurses under the nurse practice acts overseen by state boards of nursing. As of 2004, 45 boards of nursing have sole authority to regulate advanced nursing practice.

Licensure, particularly second licensure, is a controversial issue in nursing. In the early 1990s the National Council of the State Boards of Nursing (NCSBN) proposed a second licensure for advanced nursing practice. Professional nursing organizations, particularly the American Nurses Association, opposed this movement. The discussion and proposals for regulating advanced nursing practice continues yet today.

One of the issues that becomes difficult to resolve is the use of the term "advanced practice nurse" to represent four different advanced practice roles. Given that clinical nurse specialists, nurse practitioners, certified nurse midwives and certified registered nurse anesthetists all expand the role of the registered nurse, each one has its own scope of practice. However, from a legislative and regulatory standpoint, it is beneficial to represent all four advanced practice groups to facilitate successful passage of any legislative or regulatory statutes. The flip side would be to have four separate legislative actions with the potential for having four separate methods of licensure or regulation.

Utilizing one term to represent all four advanced practice groups presents some difficulty for certain groups and issues. For example, when many states were proposing legislation regarding prescriptive authority, some certified registered nurse anesthetists were concerned that the autonomy they previously had would be jeopardized. More recently, clinical nurse specialists, in particular, the National Association of Clinical Nurse Specialists, have concerns related to regulations that require specialty certification for prescriptive authority (Lyons, 2004).

Historically, nurse practice acts were created to protect the public from unsafe nursing care. The early acts were written with minimal requirements to enhance enforcement of the statutes. For regulation of advanced nursing practice, there is a fine balance between preventing unnecessary barriers and protecting the public (Lyons, 2004). Two levels of licensure would

complicate any disciplinary action that may be needed. For example, if an advanced practice nurse was found to be negligent in advanced practice, would that nurse's professional nursing license also be in jeopardy (Malone, 1993).

How advanced nursing practice is defined within a state is often influenced by who has the authority to regulate APNs. Over half the states have no statutory or regulatory requirement for collaboration or direct supervision of advanced practice nurses (Pearson, 2004). Some states require physician collaboration, others require supervision. Five states currently regulate advanced nursing practice through the board of nursing and the board of medicine.

Multistate licensure for registered profession nurses was approved by the National Council of State Boards of Nursing in 1998 with implementation in Maryland, Texas, Utah, and Wisconsin in 2000. As of September 2004, nineteen states had enacted the RN and LPN/VN Nurse Licensure Compact (NCSBN, 2004). The Uniform APRN Licensure/Authority to Practice Requirements was developed and approved in 2000 by NCSBN and is the basis for the APRN (advanced practice registered nurse) compact. The APRN Compact allows states to mutually recognize APRN licenses/authority to practice. Utah was the first state to implement the APRN Compact in March 2004. To be eligible for the APRN Compact, a state must be a member of the current nurse licensure compact for RN and LPN/VN or must enter into both compacts simultaneously (NCSBN). The APRN Compact provides the avenue to increase access and accessibility for qualified APRNs. A copy of the APRN Compact can be obtained through the NCSBN web site (www.ncsbn.org).

CERTIFICATION

Certification is becoming an increasingly important issue for advanced practice nurses. Certification by a national board is often a requirement for regulatory processes and prescriptive authority. Certification differs from licensure in that certification is a process by which a nongovernmental agency or association certifies that an individual licensed to practice a profession has met certain predetermined standards specified by that profession for specialty practice. The purpose of certification is to assure various publics that an individual has mastered a body of knowledge and acquired skills in a particular specialty.

Certification in nursing is murky, and equipped with no uniform standards. Many specialty organizations certify nurses with varying educational backgrounds at one general level. Most certification agencies now require a master's or higher degree to be eligible for certification at an advanced practice level. Previous attempts to set up one umbrella certification have been unsuccessful. The proliferation of nurse practitioner and blended nurse practitioner/clinical nurse specialist programs during the 1990s has added to the concern that educational programs preparing individuals for certification have common criteria for evaluation. The wide range and variability of advanced practice nursing programs during this time facilitated the discussion by the National Council of State Boards of Nursing for second licensure. The NCSBN acknowledged that the American Nurses Credentialing Center (ANCC) certification exams meet their goals, verifying that they can be used for regulatory purposes and legal defensibility (ANCC, 2004).

The ANCC provides certification for the nursing profession which guarantees to the public that nurses have a certain level of knowledge or skill. The ANCC grew from the American Nurses Association (ANA) certification program established in 1973 to an independent center through which ANA would serve as its own credentialing program. ANCC certification protects the public by enabling anyone to identify competent people more readily. Simultaneously, it aids the profession by encouraging and recognizing professional achievement. Certification also recognizes specialization, enhances professionalism and, in some cases, serves as a criterion for financial reimbursement (see, for example, http://www.nursingworld.org/ancc/certification/cert/certfaqs.html).

ANCC offers certification for clinical nurse specialists in eight areas: adult psychiatric and mental health nursing, child/adolescent psychiatric and mental health nursing, gerontological nursing, medical-surgical nursing, home health nursing, pediatric nursing, community health, and advanced diabetes management. ANCC also certifies nurse practitioners in eight clinical areas: adult, family, gerontological, pediatric, acute care, adult psychiatric and mental health, family psychiatric and mental health, advanced diabetes management. Certification in these areas is recognized by the credential APRN, BC (advanced practice registered nurse, board certified). Advanced practice certification is available for other disciplines including advanced diabetic management for pharmacists and dieticians and palliative care.

Other organizations offer certification opportunities for advanced practice nurses. The American Academy of Nurse Practitioners is recognized by most regulatory state agencies and offers certification for adult and family nurse practitioners (AANP, 2004). Although most specialty organizations provide certification for professional nursing practice, few offer certification at an advanced practice level. Recently the American Psychiatric Nurses Association (APNA) began offering certification for advanced practice psychiatric mental health nurses. The National Certification Corporation (NCC) for the Obstetric, Gynecological, and Neonatal Nursing Specialties offers certification for women's health care nurse practitioner and neonatal nurse practitioner. NCC also offers a subspecialty certification in gynecologic reproductive health along with the two core certifications. NCC was formerly known as the NAACOG Certification Corporation. NAACOG has since been renamed the Association for Women's Health, Obstetrics and Neonatal Nursing and became an independent certification organization in 1991. Pediatric nurse practitioners can also be certified by the National Board of Pediatric Nurse Practitioners and Associates. The Oncology Nursing Society through the Oncology Nursing Certification Corporation offers certification for nurse practitioners (AOCNP) and clinical nurse specialists (AOCNS).

Certified nurse midwives obtain their certification through the American College of Nurse-Midwives. Due to multiple factors and aspects of many of the CNM educational programs, a master's degree is desirable but not required for certification. Certified registered nurse anesthetists are certified by the Council on Certification of Nurse Anesthetist. CRNA programs are accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs.

One of the concerns related to certification is the multiplicity of acronyms that are used to indicate certification and that each certifying body uses its own credentials. Within an agency, there can be multiple changes to signify certification. For example prior to 1993, nurse practitioners certifying with ANCC were given the title "C" to indicate certification. Clinical nurse specialists were given the credentials "CS". From 1993–2000 both CNSs and NPs were given "CS" as the credential to use. Since 2000, NPs and CNSs have the credential APRN, BC to indicate advanced practice registered nurse, board certified. It should be noted that nurse practitioners and clinical nurse specialists take different exams, even if it is within the same specialty area.

Criteria for Certification

Each certifying body has its own set of eligibility criteria. Certification corporations certifying nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists require the master's degree. Some of the early nurse practitioners and certified registered nurse anesthetists graduated from nonmaster's certificate programs and have been "grandfathered in." Each specialty area may have different practice or recertification requirements. Given the dynamic nature of certification and professional standards, the reader is referred the specific certification web site for the desired advanced practice role. Table 6.1 provides a list of web sites offering information on eligibility and the application process.

Educational program approval continues to be a topic of ongoing discussion. Guidelines for educational programs educating advanced practice nurses have been developed. Criteria for the Evaluation of Nurse Practitioner Programs were developed by the National Task Force on Quality Nurse Practitioner Education in 2002 and are often used by graduate nurse practitioner programs as a standard for certification (National Task Force on Quality Nurse Practitioner Education, 2002). The National Association of Clinical Nurse Specialists provides a published statement on Clinical Nurse Specialist Practice and Education (NACNS, 2004). Certified Nurse Midwifery programs and certified registered nurse anesthetist programs must be accredited by the Division of Accreditation of the American College of Nurse Midwives and the Council on Accreditation of Nurse Anesthetist Educational Programs, respectively, in order for their graduates to be eligible for certification.

Advanced practice educational programs may have separate CNS and NP tracks or programs or may offer an integrated advanced practice pro-

TABLE 6.1 Certification Web Sites

American Nurses Credentialing Center	http://www.nursingworld.org/ancc
Council on Certification of Nurse Anesthetists	http://www.aana.com/council
ACNM Certification Council	http://www.accmidwife.org
American Academy of Nurse Practitioners Certification Program	http://www.aanp.org/certification
Oncology Nursing Certification Program	http://www.oncc.org
National Certification Corporation	http://www.nccnet.org
American Psychiatric Nurses Association	http://www.apna.org

gram within a specialization. Graduates from these programs must meet certification requirements for both NP and CNS certification if they choose to obtained dual certification. This often results in graduates taking additional course work and clinical hours in order to be dual certified.

Prescriptive Authority

Historically, the issue of prescriptive authority has been a barrier to autonomy in advanced nursing practice. The ability to prescribe medications allows the APN more flexibility in implementing care for clients. Although great strides in legislative efforts have been made in recent years, the lack of legislative consistency across states has restricted the APN's ability to practice fully within the realm of nursing (Pearson, 2004).

Prescriptive authority can be granted in several ways. The greatest independence is in those states where advanced practice nurses are allowed to prescribe medications, including controlled substances, independent of any physician involvement. Some states allow advanced practice nurses to prescribe medications, including controlled substances, but require some degree of physician involvement or delegation. Other states allow APNs to prescribe medications, but exclude controlled substances and require some degree of physician involvement or delegation (Pearson, 2004).

The first states to provide legislation granting prescriptive authority were Washington, Oregon, and Alaska during the 1970s. These three states have the least restrictive laws governing prescriptive authority. Recent legislative efforts of advanced practice nurses have resulted in broader prescriptive authority in several states (Pearson, 2004). All states allow some form of prescriptive authority, although the degree of medical supervision or collaboration varies.

Another issue surrounding prescriptive authority is the language used in regulations and legislation. Some rules and regulations specify "nurse practitioner," excluding clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Increasingly, legislation is written to reflect the expanded advanced practice title. Terms that have been used include "midlevel practitioner," midlevel provider," "advanced practice nurse" and "advanced practice registered nurse". Terms such as "midlevel provider/practitioner" often refer to nurse practitioners, clinical nurse specialists, and physician assistants. Active participation in the political

process by professional nursing lobbyists and individual advanced practice nurses has resulted in positive legislative benefits for advanced practice nurses.

Once legislation is passed, most laws go to administrative rules for interpretation. It is extremely important for advanced practice nurses to be "at the table" during these discussions. Special interests groups can influence whether rules are broadly or narrowly interpreted. One such example is how states define "collaboration" or "supervision". Other trends serve to restrict or limit prescriptive practice. These include movement toward joint regulation (joint board with pharmacy, medicine, and nursing); reluctance to "grandfather" in nurses with existing prescriptive authority; ignoring state boards of nursing actions by other governmental agencies; restricting drug utilization review boards to pharmacists and physicians; and reluctance by pharmaceutical agencies to acknowledge APNs. Inconsistencies between states related to prescriptive authority contribute to the frustration of APN's ability to prescribe medications.

In 1991, the Drug Enforcement Agency (DEA) proposed rules for affiliated practitioners (i.e., nurse practitioners, physician assistants) that would have imposed restrictive regulations for nurses in advanced practice that superseded state laws. The DEA rules did not acknowledge the existing prescriptive regulations in many states. Nurses in independent practice would have been affected by the ruling. However, the DEA withdrew these proposed rules following a massive protest from the nursing community. A second ruling entitled "Definition and Registration of Mid-Level Practitioners" was proposed in 1992 (Federal Registrar, 1992). The ruling is less restrictive regarding prescriptive authority for advanced practice nurses. APNs are encouraged to apply for individual DEA registration numbers. DEA registration numbers allow APNs to dispense controlled substances from Schedules II through V as allowed by state law (Inglis & Kjervik, 1993).

Drug Utilization Review Programs mandated by the Omnibus Budget Reconciliation Act of 1989 effective January 1, 1993 were designed to reduce fraud, abuse, overuse, or unnecessary care among physicians, pharmacists, and patients. Currently, no state specifically provides for the inclusion of nurses or other health care members of the review program board. The exclusion of advanced practice nurses from these boards is of concern, since prescriptive practice by advanced practice nurses will be evaluated by individuals who lack a nursing perspective.

CLINICAL PRIVILEGES

Clinical privileges are "authorizations granted by the governing body of a hospital to provide specific patient care services within well-defined limits, based on the qualifications reviewed in the credentialing process" (Cooper, 1998, p. 30). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) specifies characteristics of a process for the delineation of clinical privileges. JCAHO's 2005 Critical Access Hospital Standards state that medical staff must credential and privilege all licensed independent practitioners (LIP). Nonlicensed independent practitioners such as physician assistants (PAs) and advanced practice registered nurses (APRNs) may be privileged through an established medical staff process that reflects the JCAHO credentialing and privileging standards.

Clinical privileges have been successfully obtained for certified nurse-midwives (CNM) and certified registered nurse anesthetists (CRNA). Set standards are processes established typically through the appropriate medical departments (i.e., obstetrics or anesthesia). Clinical privileges for clinical nurse specialists and nurse practitioners have been more difficult to obtain. The great diversity in qualifications for APNs, including CRNA and CNMs, makes it difficult for agencies to develop uniform clinical privileging guidelines. One area of concern lies in the lack of uniformity in the titles used for APNs. Not only do various terms denote a nurse in advanced practice (i.e., nurse clinician, acute care nurse practitioner, CNS, NP), but variability exists among institutions as to how privileging is used and defined.

Although there is some variability in the credentialing process, there is a series of steps that is recommended by JCAHO. Credentialing is the first step in the process that leads to privileging. Typically, the credentialing process includes the application, verification of credentials, evaluation of applicant-specific information, and recommendation to the governing medical board for appointment and privileges. The medical staff has the discretion to use the information provided to make the appropriate decision regarding privileges. Information required should include data on qualifications such as licensure, education, experience, and clinical competence.

Advanced practice nurses must go through a similar process of credentialing to obtain clinical privileges. Each institution has a specific process and form, although they all contain components required by JCAHO. Therefore, an APN requesting clinical privileges at four different hospitals is likely to undergo four separate application procedures and reviews. The

title given to the APN also varies according to the institution. Designations such as "allied health provider," "associate allied health provider," and "non-physician provider" are often used in granting clinical privileges for advanced practice nurses.

Institutions must not only have a credentialing process in place, there must also be a review process, including peer review every 2 years, to renew clinical privileges. Temporary privileges may be granted for a limited time. Most institutions utilize the same application forms and process for licensed independent practitioners (LIP) and non-LIPs. These forms are medically focused and often difficult to use for nonphysician providers. State laws and hospital policies determine who can practice independently. JCAHO defines an LIP as "any individual permitted by law and organization to provide care, treatment, and services, without direction or supervision" (JCAHO, 2004).

As advanced practice nurses continue to expand their scope of practice within acute care facilities, clinical privileges become more important. The process for obtaining clinical privileges will be facilitated by the use of a common language about advanced practice among institutions and across states. The placement of nurses in high administrative posts in agencies as well as having advanced practice nurses on credentialing panels will facilitate the ability of APNs to obtaining clinical privileges. Educating staff, physicians, institutions and communities regarding advanced nursing practice is necessary before clinical privileges are granted without question for APNs.

LEGAL ISSUES

As advanced practice nurses assume more autonomy and independence, liability issues arise. It is critical that advanced practice nurses practice within their scope of practice, maintain certification, including continuing education requirements, and maintain adequate liability coverage.

An increased number of malpractice claims have been filed against nurse practitioners in recent years. This trend may stem from the belief that attorneys often name anyone associated with the case as a way to increase their client's award or recovery costs. Most legal experts recommend that APNs carry their own liability insurance and not rely on their employer's insurance because often there may be a conflict of interest within a given

claim. On the other side of the argument is that APNs may be named in a claim *because* they carry their own insurance (Wright, 2004).

Malpractice for an advanced practice nurse occurs when the APN fails to exhibit the skill and competence that is expected of that professional based on professional standards and practices (Buppert, 2004). Malpractice often occurs when negligence on the part of the practitioner is identified. Negligence can occur when an APN fails to follow up with a patient appropriately, refer when necessary, disclose information to a patient, or provide appropriate care. This would include failure to monitor or observe a patient's health status, diagnose or delay diagnosis, perform procedures safely and competently, treat appropriately (including medications), communicate patient information in a timely manner, protect patient from avoidable injuries, and practice within the scope of nursing education and the position description.

Recently the United States has experienced a medical malpractice crisis in that malpractice premiums have risen by 300% and many firms that have provided malpractice in the past have discontinued offering coverage (Thorpe, 2004). During the 1970s the United States experienced an increase in the frequency and severity of claims. Medical liability premiums increased greatly during the 1980s particularly in obstetrics (Yeo & Edmunds, 2004).

APNs must become familiar with legal terminology to avoid committing unintentional acts of negligence. Table 6.2 briefly outlines terms often unfamiliar to APNs. One term, *intentional tort,* meaning that an APN commits an act that brings about an intended result, may be somewhat confusing for the APN. Common examples of intentional torts are assault and battery (forcing an individual to take a medication), invasion of privacy (breaking confidentiality), defamation (slander or libel) (Wright, 2004). For further in-depth discussion and information, the reader is referred to an excellent legal reference by Buppert (2003).

APNs can protect themselves from potential malpractice claims in several ways. First and foremost, the advanced practice nurse must practice within their professional and legal scopes of practice as determined by their individual state. Second, APNs need to carry professional liability insurance either through their employer and/or by purchasing personal professional liability insurance. Arguments can be made both ways in terms of whether or not to carry both employer-based and personal liability insurance. For example, if the APN only carries liability insurance through the employer, the policy may or may not cover private duty, volunteer, or off-duty incidents.

TABLE 6.2 Legal Terminology

Duty:	occurs when a provider-patient relationship is established
Malpractice:	failure to perform to the degree of an average, reputable member of the profession
Standard of Care:	care provided by a reasonably prudent advanced practice nurse
Tort:	injury or wrongdoing
Tort liability:	individual injured has the right to be made whole again
Intentional tort:	individual (APN) commits an act with intent to bring about the result
Negligence:	failure to meet responsibility resulting in injury to an individual

Note: Adapted from Buppert, C. (2004). *Nurse Practitioner's Business Practice and Legal Guide,* 2nd ed. Boston: Jones and Bartlett Publishing, p. 235–237.

Personal liability coverage, on the other hand, may invite more lawsuits and can be expensive. For example, some liability coverage can cost approximately $1,000 per year for family nurse practitioners and $20,000 for certified nurse midwives (Yeo & Edmunds, 2004).

Advanced practice nurses should also understand which type of insurance policy best fits their needs. The two most common types of insurance available are "occurrence" and "claims made." An occurrence policy is one that covers an advanced practice nurse for any incident that occurs during the time insured. A claims policy covers the APN only during the time that the policy is in effect (Wright, 2004). With a claims policy, the advanced practice nurse is not covered for any incident that occurred during employment once he or she leaves that employment. If the APN chooses to change employment, the APN needs to purchase a "tail" policy to cover any claims that may be brought forth after leaving that employment.

An advanced practice nurse can take several preventive measures to avoid legal or malpractice claims. The importance of thorough and accurate documentation cannot be overemphasized. If ethical or legal issues arise, the APN should report concerns to proper persons or authorities. The APN should know the roles and responsibilities within their scope of practice. Negligence or malpractice can occur if the APN does not keep current on standards of practice or treatments. The importance of a good client relationship cannot be underestimated. The APN must also have a good sense of delegating appropriately to avoid any negligence.

In summary, legal issues related to negligence and malpractice can be cause for concern and create stress for health care providers, including

advanced practice nurses. It is important for APNs to take preventive measures to limit the risk of having claims filed against them.

SUMMARY

This chapter has discussed several professional issues that lie within the core of advanced nursing practice. These issues are constantly evolving and changing as the arena of health care changes. Advanced practice nurses are encouraged to keep up to date on current professional issues and maintain an active role in promoting advanced nursing practice.

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Chapter 7

REIMBURSEMENT REALITIES FOR APNS

Linda Lindeke

ACCESS, QUALITY, AND COST

Health care costs are rising worldwide as costly technology is incorporated, life expectancy increases, and infant survival rates reach lower gestational levels. In 2003, overall U.S. health service costs rose 7.4%, greatly exceeding increases in salaries, inflation, or gross domestic product (GDP). In addition, employers raised employee cost sharing for health care for the third year in a row (Strunk & Ginsburg, 2004). There are 50 different state-specific configurations of health care because most reimbursement laws and policies are developed at the state level. Health care is costing patients, employers, and payers more each year and has become a very closely watched economic indicator.

The fiscal structure of health care is affected by multiple forces, many of which are political. Reimbursement politics are played out in Congress, state legislatures, and within county governments. Political processes may also take place at APN worksites as employment agreements and organizational policies are negotiated. APNs must understand the various health care forces and players, particularly issues related to *access, quality, and cost.*

Access to care is complex in the U.S. and directly related to cost issues. Over 43.6 million individuals in the United States lack insurance coverage and access to health care (U.S. Census Bureau, 2003). Some of those individuals either choose or are forced to self insure, some are unable or unwilling to negotiate the bureaucracy necessary to obtain coverage from public programs for which they are eligible, and others are ineligible for

public or employer-based coverage (frequently because of part-time employment). Access to care for the uninsured, as well as the underinsured, remains one of the most pressing issues facing American society today. Even Americans with insurance have concerns as copayments increase and benefits become more and more limited. Many health plans restrict access to specialty care by having primary care providers act as gatekeepers through a system of referrals and prior authorizations for the more costly health care components. Additionally, some health plans limit patients to only seeing the providers on their salaried staff (staff-model health maintenance organizations or HMOs), or to a contracted list of specialists and agencies (preferred provider organizations, PPOs). Thus, Americans with and without health care coverage have concerns about access to needed care. While there are no "stated" limits on health care health plans, there are de facto limits in many systems that exist by way of "triage" or "tiering" of clients by the types/price of coverage offered by employer plans and insurance carriers. HMOs, self-insured companies and small businesses may have high deductibles, copayments and prior authorization procedures that limit choices of providers, procedures and referrals.

Quality of health care in the U.S. is also a continuing public concern. Supreme Court deliberations about the rights of patients to sue managed care organizations (MCOs) and attempts to pass a Patient Bill of Rights in Congress (so far unsuccessful) are expressions of this concern. The Patient Bill of Rights initiative is based on a public perception that health care quality has declined as a result of the MCOs' quest for a profitable bottom line. Cuts in Medicare and Medicaid benefits have also increased the public's concern that the quality of care may be further reduced in the future.

While *health care costs* continue to increase worldwide, the American health care system remains the most expensive in the world. For example, health care spending as a percentage of the U.S. gross domestic product (GDP) was 13.9% in 2001 (Reinhardt, Hussey, & Anderson, 2004). This rate is in striking contrast to that of other countries providing a similar quality of health care. For instance, Canada spent only 9.7% of its 2001 GDP on health care. Factors contributing to higher U.S. costs include a fragmented payer system creating weakness on the demand side of the market, high administrative costs (almost 25% of health care expenditures), and resistance to the idea of putting limits on health care (Reinhardt, Hussey, & Anderson, 2004).

U.S. REIMBURSEMENT TRENDS

The U.S. health care delivery system hardly resembles the system in place just a decade ago, and a whole new language has developed that APNs must understand (Table 7.1). Congress failed to pass the 1993 Clinton health care reform initiative ostensibly in the effort to develop systems to control rapidly increasing health care costs. Repercussions of this failed legislation included 1) rapid mergers of health care systems; 2) formation of integrated service delivery networks; and 3) competitive contracting between employers and service providers. As a result, the U.S. health care industry has wholeheartedly adopted the bottom-line oriented, profit/loss mentality of the business world. As this trend pervades American health care, APNs can offer ways of assuring access and quality of care while keeping costs reasonable for consumers.

Capitated systems are becoming the norm, meaning that payers contract with provider groups to pay a per-member amount to cover the cost of member health care services over a certain time period. Capitated care in managed care organizations (MCOs) now dominates the industry. Many MCOs, in turn, have undergone multiple mergers to form large provider organizations (PPOs) and networks. Services are increasingly delivered in outpatient clinics as shortened hospital stays (affected by Diagnostic-Related Group regulations, DRGs) become the norm. Prescription drug use has increased, partly due to direct-to-the-consumer advertising that urges patients to contact their health care providers for the latest "miracle" drug. Medicare regulations have become more complex, and employer-paid health care benefits, not surprisingly, have become a very contentious issue in labor negotiations.

Since APNs can now be directly reimbursed for their services, they must be knowledgeable about payment systems and reimbursement schedules. APNs will be successful in their practices to the extent that the value of their services is recognized by payers and employers and is equitably rewarded. APNs must be cost-effective and must track their productivity within complex systems; however the rapid pace of change in reimbursement legislation, policies, and procedures makes this a daunting task.

Federal and state legislation currently regulates APN reimbursement. For example, the 1997 federal Balanced Budget Act (PL 105–33) provides direct Medicare reimbursement for nurse practitioners and clinical nurse specialists, effective January 1, 1998. Rules to implement this law were

TABLE 7.1 Reimbursement Vocabulary

Terminology	Definition
Actual charge	The amount of money a provider charges for a particular service, which may be more than the amount payers approve
Additional benefits	Health care services not covered by Medicare. Additional benefits are subject to cost sharing by plan enrollees.
Adjusted community rating	Premium rates based on regional differences in health care costs; leads to great regional differences in Medicare payment rates to providers
Advanced beneficiary notice (ABN)	A notice that a provider must give Medicare beneficiaries to sign when providing a service Medicare does not consider medically necessary. If the patient does not get an ABN to sign before the service is provided, and Medicare does not pay for it, the patient does not have to pay for the service.
Affiliated provider	A health care provider or facility that is paid by a health plan to give service to plan members (i.e., a credentialed provider).
Ancillary services	Professional services by a hospital or other inpatient facility (i.e., x-rays, drugs, laboratory services)
Appeal	A formal complaint made to a health plan
Approved amount (or approved charge)	The fee a payer sets as reasonable for a covered service (may be less than the amount charged by the provider)
Balance billing	A situation in which private fee-for-service providers can charge and bill Medicare patients 15% more than the plan's payment
Beneficiary	The name for a person who has health insurance through the Medicare or Medicaid program
Capitation	A per-member amount paid to providers to cover the cost of member health care services for a certain time period.
Carrier	A private company that has a contract with Medicare to pay Medicare Part B bills.
Catastrophic limit	The highest amount of money patients have to pay out of pocket during a certain time period for certain charges.
Center for Medicare & Medicaid Services (CMS)	Federal agency that runs Medicare and works with the states to run Medicaid programs.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	A law that makes an employer continue to cover an employee for a period of time after spousal death, job loss, divorce, or hours benefits reduction; typically requires payment of both employee and employer shares of the premium
Coordination of benefits	Process where two or more health plans share costs of a claim
Cost sharing	The cost for medical care that patients pay (copayment, coinsurance, deductible)

TABLE 7.1 ***(continued)***

Terminology	Definition
Covered benefit	A service that is paid for (partially or fully) by a health plan
Diagnosis-related group (DRG)	A payment system begun in 1983 to pay hospitals for health care based on patients' diagnosis, age, gender, and complications; DRGs affects length of hospital stay
Durable medical equipment/goods	Reusable equipment that is ordered for use in the home (walkers, etc) and paid for under Medicare
Facilities charge	A charge billed to a health plan or provider for the facility in which the service was received; results in two bills (provider bill and facility bill)
Fiscal intermediary	A private company that contracts with Medicare to pay Part A and some Part B bills; located in various regions of the U.S.
Fraud and abuse	Fraud: To purposely bill for services that were never given or to bill for a service at a higher reimbursement rate than the service produced; Abuse: Payment for items or services that are billed by mistake
Health maintenance organization/network	A health plan that contracts with group practices of providers to give services in one or more locations
Managed care plan with point-of-service (POS) option	A managed care health plan that lets patients use providers and hospitals outside the plan for an additional cost
Medically necessary services	Services deemed by Medicare to be proper and needed for a medical diagnosis or specific treatment
Medical savings account (MSA)	A Medicare health plan option made up of two parts: 1) Medicare MSA Health Insurance Policy (has a high deductible); 2) Special savings account where Medicare deposits money to help patients pay their own medical bills
Preferred provider organization (PPO)	A managed care plan where hospitals and providers belong to a network and contract together with payers/employers to provide services at predetermined rates.
Prior authorization	MCO approval that is necessary prior to receiving care from providers who are out of the PPO or not on staff list (can be verbal or is a written form from the MCO)
Referral	A written document that must be received by a provider before giving care to a health plan beneficiary
Resource-based relative value scale (RBRVS)	A Medicare fee schedule established in 1989 to reimburse providers based on relative work value units (RVUs)

written by the Center for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration, HCFA) and finalized in November, 1998. These Medicare laws and rules influence the policies of nongovernmental payers, although there is a great deal of variability from state to state.

The Health Insurance Portability and Accountability Act (HIPAA) is a law passed in 1996 (also sometimes called the "Kassebaum-Kennedy" law). It expands health care coverage related to job loss or transfer and provides some patient protection by limiting ways that insurance companies can use preexisting medical conditions to deny health insurance coverage. Though HIPAA generally guarantees the right to renew health coverage, it does not replace the states' role as the primary regulators of health insurance. It also standardized health care billing and payment mechanisms across systems, a move that promises to reduce costs once it is fully implemented. As part of that standardization, stringent patient privacy regulations were also instituted.

REIMBURSEMENT STRUCTURES

Third Party Payers

APNs must understand many issues about health care regulation (Figure 7.1.), including the relationships between entities that pay for and provide services, for example:

1. For-profit insurance companies known as "indemnity providers," (e.g., Aetna, Prudential, etc.)
2. Government payment programs (i.e., Medicare, Medicaid, Tricare/CHAMPUS, the military health system)
3. Nonprofit corporations (i.e., Blue Cross/Blue Shield)
4. Self-insuring corporations or coalitions (e.g., union health care plans)

Although payer policies and procedures differ greatly, most are influenced by CMS Medicare regulations. Payers pay fee-for-service bills, the traditional way that health care has been funded. More recently they pay for health care delivered under service contracts that provider systems must compete and bid for. Employers may offer their employees a choice of approved health plans that they contract with, or they may self-insure by

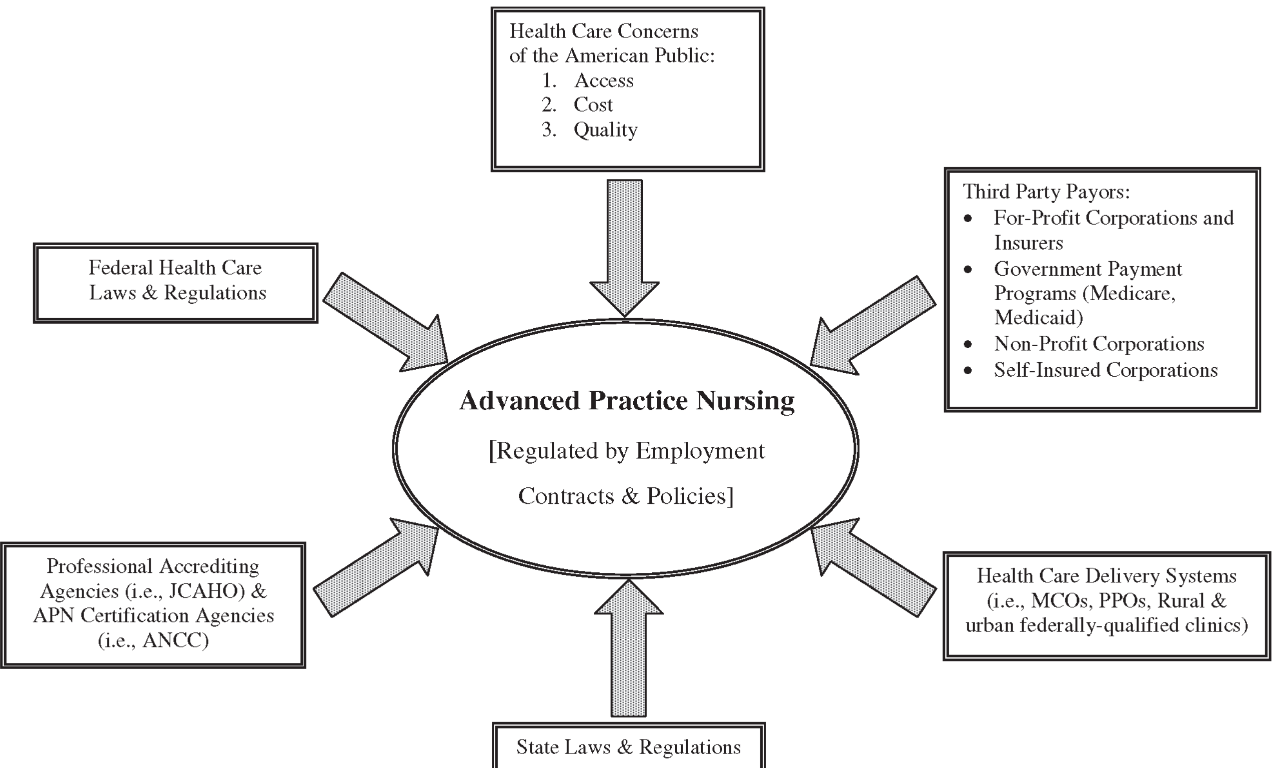

FIGURE 7.1 Reimbursement regulation for advanced practice nurses.

directly contracting with provider networks for their employees' care. These competitive contracts are frequently renegotiated in response to rising health care costs. Health care finance is complex and volatile, and provider system costs are under constant review by payers and regulators.

APNs must be individually identified through payer credentialing to obtain reimbursement under their own names. Credentialing makes APNs visible because their contributions can be specifically identified. While many payers allow APNs to bill individually, others refuse to reimburse APN services, even in states with laws mandating third-party APN reimbursement. Medicare and Medicaid have moved many clients from fee-for-service payment systems into managed-care reimbursement systems, in which case MCO policies overlay CMS regulations. Therefore APNs must be cognizant of the many layers of reimbursement policies and procedures in their state, region, and organization.

Provider Systems

U.S. health care is delivered by many types of providers, each with policies and practices affecting APN reimbursement:

1. Managed care organizations (MCOs)
2. Managed care networks
3. Health maintenance organizations (HMOs)
4. Preferred provider organizations (PPOs)
5. Nurse-managed centers (NMCs)
6. Fee-for-service private practices
7. Home health care agencies
8. Public health agencies
9. Community health centers
10. Federal qualified health centers (FQHCs)
11. Migrant health clinics
12. Indian Health Board (IHB) clinics and hospitals.
13. Rural health clinics (RHCs)

Some types of federally-funded clinics (FQHCs) have policies which mandate that NPs be employed in order for the clinic to receive funding dollars. These regulations were passed based on federal studies that demonstrated NP safety and cost-effectiveness. FQHCs credential NPs for reimbursement and hospital privileges, provide them membership on provider

panels, and validate their scope of practice. In most other systems, however, APNs must negotiate for their place and power. APNs must strive to obtain leadership positions in provider systems so that their contributions to patient outcomes are identified and valued by administrators and payers. Examples of leadership roles include administrative functions, participation on policy committees, and conducting research projects.

One way in which APNs have shown leadership and achieved greater independence is through the creation of nurse-managed centers (NMCs). Often serving underinsured and uninsured populations with the associated limitations in funding, NMCs have had mixed results in terms of longevity (Vincent & Mackey, 2000). Characteristics of financially stable NMCs include low administrative overhead costs, low fixed costs, and the ability to generate sufficient patient volume. The same tools used to evaluate NMCs, combining both cost analysis and cost-effectiveness measures, can be used to demonstrate the benefits of APN practice in other settings as well. This evidence is essential to secure the place of APNs in today's health care system (Joel, 2004).

SELECTED ENTITIES AND PROVIDER SYSTEMS

Medicare

Medicare was established in 1965 as part of President Lyndon Johnson's Great Society initiative; its programs are primarily oriented to acute care. The goal was to create a safety net for the nation's elderly who had endured hardships in the world wars and the Depression during the 1930s. Medicare is a two-part, federally-funded health care program; approximately 95% of the nation's elderly are enrolled in Medicare Part A. Part A provides hospital insurance that covers inpatient services, up to 100 days in a skilled nursing facility following hospitalization, and some home health care (Buppert, 2004). Although there are no premiums for Part A Medicare, patient cost sharing is required. Cost sharing consists of an annual deductible as well as a payment percentage. Medicare does not cover eye examinations, medications, or long-term nursing care. Medicare Part B pays for physician visits, services and supplies, outpatient services, and home health care, all at rates set by the federal government.

The 1997 Balanced Budget Act (PL 105–33) allows Medicare reimbursement of services provided by nurse practitioners and clinical nurse

specialists if the services are reimbursable when provided by a physician and if the services are within the APN scope of practice. The law removed all restrictions on the practice setting; NPs and CNSs can submit fees for services rendered in hospitals, skilled nursing facilities, nursing homes, comprehensive outpatient rehabilitation facilities, community mental health centers, and rural health centers. Payments for NP and CNS services are 80% of the lesser of either the actual charge or 85% of the physician fee schedule amount.

To track billing, NPs and CNSs are required to submit billing claim forms (called Form 1500) using their unique provider identification numbers (UPIN) that are obtained from each state's health department for Medicare and Medicaid billing. The UPIN is site-specific, so an APN who works at several institutions would have one for each place of employment. As part of HIPAA, a new system is being implemented that will replace UPINs with National Provider Identifier numbers (NPIs). The NPI will be provider-specific, not site-specific, and will be used by all systems for administrative and financial transactions.

Medicare has long had a payment system for services rendered under physician supervision called "incident-to" billing. Incident-to billing allows APNs to bill under physician names for services that are provided incident to physician services. Payment then equals 100% of the physician fee schedule (Abood & Keepnews, 2002). Although incident-to billing increases the revenue that APNs can generate under current reimbursement rates, this billing practice raises red flags for fraud and abuse because it is governed by a tangle of Federal regulations. The APNs' work is integrated into daily physician practice, which is typically interpreted as implying direct supervision of APNs by physicians. The supervising physicians must be physically present (though not in the room) at all times when APNs are providing billable services, and physicians must do all initial visits and establish the plans of care that APNs then follow. "Incident-to" billing limits APN autonomy and may be impractical; for example, if the physician leaves the building for lunch or vacation, the APN could not bill "incident-to:" for patients seen during that time frame. (Note: They could, however, bill for this care under their own names if they were individually credentialed as providers with the payer; the practice would receive 85% of the physician fee if they did so, rather than the 100% "incident-to" fee.) "Incident-to" billing makes the contribution of APNs to the fiscal output of organizations invisible. Billing under their own provider numbers is now strongly

encouraged to increase productivity, to avoid the potential for billing fraud, and to permit full utilization of the legal APN scope of practice.

Another Medicare billing practice incorporates a system that reimburses providers based on relative work value units (RVUs). Established in 1989, the Resource-Based Relative Value Scale (RBRVS) is a system aligned with Current Procedural Terminology (CPT) codes. Each CPT code is assigned a relative dollar value by CMS based on practice research (Hsiao, Braun, Yntema, & Becker, 1988; Kahan, Morton, Farris, Kominski, & Donovan, 1994) about work and practice expenses and professional liability insurance costs. Allowable service charges are determined annually by multiplying this RVU by a standard dollar amount conversion factor established by CMS, based on CMS's determination of regional cost variations (the geographic adjustment factor, GAF). CMS publishes its RBRVS annually in the Federal Register and practices then use the RBRVS to determine their fees. The goal is to have a logical system of national fees set annually in relationship to actual costs and ongoing research. The result is New York practitioners will have higher Medicare payments than practitioners in Iowa, for example, because it costs more to run a practice in New York than it does in Iowa (Medlearn, 2000). With support from the American Nurses Association (ANA), Sullivan-Marx and Maislin (2000) carried out a study comparing NP and family physician RVUs; there was no significant difference between the provider groups. The ANA continues to work with the American Medical Association's Health Professional Advisory Committee on reimbursement issues, including ways to fairly integrate NP billing practices into the RBRVS structure (Sullivan-Marx & Maislin, 2000).

The 1997 Balanced Budget Act (PL 105–33) provided both access and barriers to Medicare reimbursement for APNs. During the rule writing process for the 1997 Balanced Budget Act (PL 105–33), the definition of "collaboration" was debated. The primary debate was about the impact of regulatory collaboration language on APN practice in states where physician collaboration is not required and advanced practice nurses practice independently. This contentious issue continues to be closely monitored federally and in each state by APN professional groups. Because state APN practice laws by and large determine APN practice, collaboration is a continuing and important issue for all APNs. Most contentious was the language in the 1997 BBA that set APN reimbursement at 85% of the physician rate; this was a compromise and the bill would not have passed had APNs not agreed to this requirement.

PL 105–33 regulations require that in order to be credentialed as Medicare providers NPs or CNSs must:

- hold a master's degree
- be registered nurses authorized to practice as NPs or CNSs by the state in which the services are furnished
- be certified as NPs or CNSs by recognized national certifying bodies that have established standards

The requirements have been problematic for many CNSs because national certification has not been highly pursued by CNSs in the past and in many cases no national certification examination exists to reflect their practice specialty. Although CNSs meet the master's degree requirement, certification continues to be an issue of debate within their ranks (Ponto, Sabo, Fitzgerald, & Wilson, 2002). CNSs in psychiatry/mental health are an exception because they have pursued reimbursement since the early 1970s and typically are nationally certified.

The rules also contained a time-limited "grandfather" clause to allow certified NPs without master's degrees to obtain provider numbers if they applied prior to January 1, 1999. In general, PL 105–33 was a victory for NPs and CNSs and met the intent of the law which was to increase greater consumer access to NPs and CNSs. The legislation lifted some of the barriers to APN reimbursement.

Medicaid

Medicaid is a program that expanded the 1965 federal Medicare system by providing funds for states to pay for health care of low income groups. Federally supported and state-administered, Medicaid covers costs of care for vulnerable groups through programs such as Aid to Families with Dependent Children (AFDC). Low-income elderly and some individuals with disabilities are also covered under this program. Medicaid is different from Medicare in that it is a vendor program; that is, providers offering services to these individuals or families must accept the Medicaid reimbursement as full payment and cannot request copayments from patients. Because Medicaid payments are low (typically less than 50% of submitted bills), many providers (including dentists) restrict the number of Medicaid clients that they serve. Some states enroll Medicaid patients in MCOs by establishing

contracts with MCOs in programs called "prepaid medical assistance programs" (PMAPs).

Section 6405 of the Omnibus Budget Reconciliation Act (OBRA 1989, PL 101–239) authorizes Medicaid payment for services of certified pediatric nurse practitioners and certified family nurse practitioners. Requirements necessary for reimbursement include possession of a current RN license in the state where services are provided, compliance with state APN legal requirements, and certification by a national APN certification board. APN Medicaid reimbursement rates vary between 70–100% of physician fees, depending on the state.

Indemnity insurers

Indemnity insurers are traditional insurance companies that pay for but do not deliver health care. They typically require an annual deductible that members self-pay; once this deductible is reached the company will pay 80% of their members' health care costs on a per-person, per procedure basis (Buppert, 2004). Reimbursement rates are based on "usual and customary charges," which vary between regions and companies. If provider charges are more than what the indemnity insurer allows, patients are responsible to pay the balance. Some indemnity insurance companies will pay for APN services. APNs can contact these companies to negotiate for recognition as reimbursable providers.

Managed Care Organizations (MCOs)

Capitated managed care developed rapidly in the 1990s in response to many economic and political forces. One factor was that the U.S. post-World War II baby-boom generation is transitioning into middle age, increasing the aging population who will be high consumers of health care. This trend is projected to greatly increase costs, particularly for expensive, emerging technologies. MCOs sell health service packages to employers, individuals, or governmental agencies. Services are provided by the MCO panel of health care providers who may or may not be MCO employees. APNs can apply to become primary care providers (PCPs) on MCO provider panels, but this recognition has been slow in coming. MCOs reimburse PCPs using fee-for-service, a capitated or fee-per-member basis, or a combination of fee-for-service and capitation.

MCOs are growing rapidly in the U.S. and are typically large, complex organizations. They stress the importance of health promotion, chronic care management and patient education, and they typically provide their members with preventive services. They have so far been unable to demonstrate the expected cost savings (Strunk & Ginsberg, 2004). Some managed care strategies, such as employing economies of scale in purchasing, centralizing services such as emergency care, and developing systems for referrals and after-hours care have been cost-effective. However, administrative costs are very high (Woodhandler, Campbell & Himmelstein, 2003).

Managed care is frequently interpreted as "managed costs." Efforts by CMS to uncover fraud in Medicare/Medicaid billing has added to the negative light in which many providers and consumers view MCOs. APNs are also voicing their discomfort with MCO policies, particularly about the expectations that limit the length of patient visits to 10–15 minutes (Joel, 2004). RVU billing in MCOs is also a system that concerns APNs who value time and care continuity with their clients (Sullivan-Marx & Maislin, 2000). In high-production managed care models, APNs may not be able to fulfill their responsibilities to prevent illness, coordinate care, and teach patients about their treatment plans.

CNM and CRNA Reimbursement

Certified nurse midwives (CNMs) successfully obtain third-party reimbursement for their services, based on their cost-effectiveness and high level of consumer satisfaction. Excellent research about CNM outcomes is compelling to payers seeking safe care at reasonable cost. In 1973, Washington was the first state to enact state laws permitting CNM reimbursement by private and public benefit plans; currently 33 states have such language in their statutes. Seven other states have "any willing provider" laws that include midwives. The American College of Nurse-Midwives (ACNM) provides its members with excellent resources for billing, coding, and reimbursement through its web site and publications. Declercq, Paine, Simmes, and DeJoseph (1998) documented that the single best predictor of CNM practice success was the degree to which state laws and regulations were in place to support CNM activities, including reimbursement. This emphasizes the importance of APNs being active in public policy formulation in order to establish favorable legal and regulatory practice climates.

Although few of their clients qualify for Medicare, CMS Medicare regulations restrict midwifery payments to 65% of the physician fee schedule. ACNM is currently lobbying to increase Medicare reimbursement to 97%; in part, this is because Medicare regulations impact all payers by setting precedent, i.e., establishing a widely used payment process. ACNM is also lobbying to have freestanding birth center facility costs covered in state Medicaid regulations. In some systems CNMs work in "incident-to" relationships with physicians, which raises the potential for fraudulent claims if all the aspects of incident-to regulations are not strictly followed. Billing under their own names is strongly recommended for all APNs, including CNMs so that autonomous practice can provide the best possible care to clients and families.

Despite many difficulties, certified registered nurse anesthetists (CRNAs) have been successful in obtaining third party reimbursement. The Omnibus Budget Reconciliation Act (OBRA) of 1986 granted CRNAs the right to be directly reimbursed for their services to Medicare recipients. CRNA services are also reimbursed directly by Medicaid and a number of commercial carriers. When both a CRNA and an anesthesiologist participate in the same case, the services of both anesthesia providers can be billed according the extent of their involvement in the case. Independently billing CRNAs provide savings for government programs and for private payers because they typically charge less than their physician counterparts (Cromwell, 1996). Many complex issues regarding CNRA working relationships with physicians (including anesthesiologists) affect their work environments and billing practices. The American Association of Nurse Anesthetists offers CRNAs many reimbursement resources.

DOCUMENTATION AND CODING TO GAIN REIMBURSEMENT

Documentation is the key to reimbursement and must be sufficient to support the level of charge being requested. In addition, APNs must understand their billing process and be able to use several types of diagnostic and procedure codes. One type of code is called the Health Care Common Procedure Coding System (HCPCS), which assigns a dollar amount to patient care activities. (For example, there are HCPCS codes for immunization and wound suturing). Each patient visit is also coded using Current Procedural Terminology (CPT) codes, another part of the uniform coding

language. The CPT coding directory covers all possible types of patient-provider interactions. It is owned and updated annually by the American Medical Association (AMA, 2004) and has been adopted by Medicare and other third-party payers. A subgroup of CPT codes are the Evaluation and Management Codes (E&M Codes), the CPT codes most used by APNs (typically CPT codes 99201 through 99456). These 5–digit codes are based on the levels of history-taking and physical examination, complexity of decision making, counseling, and minutes of face-to-face time in each patient encounter. APNs must distinguish between new patients and established patients in their choice of codes because new patients are reimbursed at a higher rate than established patients. A new patient is considered to be one who has not received professional services within the past 3 years from a provider in the same specialty in the same practice. Telephone communication, however, is considered a professional service (Buppert, 2004).

In addition to assigning a CPT code on the standard claim forms (called Form 1500), APNs must select appropriate diagnostic codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9). ICD-9 is based on the World Health Organization disease classification. Its periodic modification is the responsibility of the National Center for Health Statistics and CMS. It classifies symptoms and diseases into six-digit numerical codes. A new version, ICD-10 is currently under development.

Documentation begins with a concise statement of the chief complaint, usually stated in the patient's own words in the medical history (Table 7.2). The classic seven variables should be used to document the chief complaint (location, quality, severity, duration, timing, context, modifying factors, signs/symptoms). For billing purposes, there are four categories of history-taking: *problem-focused, expanded problem-focused, detailed, and comprehensive*; each level expands the history according to the level of history-taking required to investigate the chief complain. A *problem-focused* history consists of the chief complain and brief history of the present illness (HPI) or problem. An *expanded problem-focused* history adds a problem-pertinent review of systems (ROS). The ROS has data categories including constitutional, ear/eye/nose/throat, cardiac, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, breast, neurological, psychiatric, endocrine, hematology/lymphatic, and allergic/immune. The *detailed* level extends the HPI and ROS and adds a pertinent past/family/social history (PFSH). The PFSH consists of three components: past history with illnesses, operations, injuries, and treatments; family history of relevant diseases; and an age-

TABLE 7.2 Documentation for Reimbursement

Component	Level 1	Level 2	Level 3	Level 4	Level 5
History	Minimal	Problem-focused; 1–3 elements in History of Present Illness (HPI); no Review of Systems (ROS); no Patient/Family/Social History (PFSH)	Expanded problem-focused; 1–3 HPI elements; ROS for 1 related system; no PFSH	Detailed; 4+ HPI elements; 3+ chronic conditions; ROS for 2–9 systems; 1+ items of PFSH	Comprehensive; 4+ HPI elements; 3+ chronic conditions; ROS for 10+ systems; 1+ items from 2+ of 3 PFSH areas
Exam	Minimal	Problem-focused; 1–5 elements of body or organ system exam	Expanded problem-focused; 6–12 exam elements of body or systems	Detailed; 12–18 exam elements of body or systems	Comprehensive; 18+ exam elements in at least 9 systems of body areas
Decision-making Examples	Minimal	Straight-forward	Low complexity (i.e., routine meds; OT/PT; IVs)	Prescribed meds; MRI; closed reduction of fracture	Meds; monitor meds; resuscitate; refer for major surgery
Risk	Minimal	Minimal	Low	Moderate	High
Time	5 min.	10 min.	15 min.	25 min.	40 min.

appropriate review of past and current social activities. If a PFSH is on the chart from an earlier encounter, it does not need to be restated, but it must be documented that the PFSH was reviewed with the patient and updated. The *comprehensive history* involves an extended HPI, complete ROS, and complete PFSH.

The physical examination follows a similar pattern with the same names for the four levels. The *problem-focused* examination is limited to the affected body area or organ system. The *expanded problem-focused* examination adds examination of other symptomatic or related systems. The *detailed* examination is similar but more detailed, and the *comprehensive* examination is a complete single-system or multisystem examination.

The levels of decision making refer to the complexity of establishing the diagnosis or treatment plan and are influenced by the number of possible diagnoses or management options, the size and complexity of the medical record, tests or other information that must be reviewed and analyzed during the visit, the risk of significant complications, morbidity or mortality, and the diagnostic procedures and management options. There are four categories of decision making: *straightforward, low complexity, moderate complexity, and high complexity. Straightforward* decision making, the first level, involves a minimal number of diagnoses or options, minimally complex data and a minimal risk of complications. *Low complexity* increases those components to a limited level from the minimal level. The *moderately complex* level involves multiple diagnoses or options, moderate complexity of data and a moderate risk of complications. The *high complexity* level is an encounter that deals with an extensive number of diagnoses or options, extensive complexity of data, and a high risk of complications.

Four additional components can be used to alter the coding, which include *counseling, coordination of care, complexity of the presenting problem,* and *amount of time spent with the patient.* To use those elements, careful documentation is necessary. The *time* category can include face-to-face time, plus review of the patient chart, writing of notes, communicating with other professionals and patient family members. Time is the key billing factor to use if *counseling and coordination of care* exceeds 50% of the total visit time.

APNs can bill for services rendered in nursing homes and skilled nursing facilities. They can also bill for hospital services as long as they are not employees of the hospital. There are three levels of encounters in those settings: *Detailed, detailed-comprehensive,* and *comprehensive,* each with corresponding required components. Another way to bill is using three categories

of subsequent nursing facility care (*one-problem history, expanded focus,* and *detailed*). Physicians are allowed to bill Medicare for 12 nursing home client visits per year; NP/physician teams are allowed 18 visits per year. APNs also can bill for their services in emergency rooms, using special codes that are appropriate to that setting.

Some specific pointers regarding documentation are important. When a diagnosis is uncertain, coding the presenting symptom is advisable, such as "pain" or "fever." Listing "rule out" differential diagnoses on the encounter form is not acceptable, nor are the terms "possible" or "suspected." "Abnormal" is not an acceptable term without further description; however "normal" and "negative" are allowed. A checklist is also acceptable, with positive items further explained. All laboratory test and radiographic requests must be justified to Medicare in terms of the medical necessity of their charges.

An example of a satisfactory way to document with billing based on *time* would be: "total time, 25 minutes; counseling, 15 minutes; discussed results of tests, provided 3 options for treatment; follow-up in 3 months." To document *care coordination,* chart notes might say: "Spent 25 minutes reviewing medications with family and explaining laboratory tests; appointments coordinated for return visit in 3 months; public health nurse contacted regarding need for medication supervision." An APN can list multiple codes for a single visit and can bill for both an E&M visit and a procedure (e.g., examination with suture removal). In complex patients, APNs can bill for two visits in one day (a general examination and a special teaching/counseling session, for example) if a special modifier is used in addition to the two sets of coding and documentation; patients might have to pay two copayments in that circumstance.

Organizations must submit bills quickly because there is typically a 3-month turnaround time from the payers which affects the revenue flow. It is important to remember that the amounts billed out may be very different from the amounts collected from payers. For example, in many states Medicaid pays less than 50% of typical billed amounts.

Health care organizations employ coding specialists and hire consultants to conduct audits and teach staff about these important issues. Consultants often find that organizations are undercoding for their services. Coding too high (called upcoding) can trigger Medicare fraud investigations. Medicare carriers expect to see a bell-shaped curve with most visits at the CPT code 99213 level (problem-focused history, expanded problem-focused examination, low complexity decision making). However, this is problematic for practices that provide a great deal of care to patients with complex or chronic illnesses.

Most organizations design a "super bill" for processing claims that incorporates all of the coding information in one place, including procedures, facility charges, vaccines, E&M codes, ICD-9 codes and any other relevant information. The document trail must be available for internal and external audit purposes. APNs must communicate regularly with billing, coding, and audit staff and participate in regular revision of the "super bill." The increasing use of computer-based charting is leading to more standardization of these processes and forms.

Inadequate documentation and coding results in loss of revenue to organizations, and therefore to providers, inability to track outcomes of care, and possible penalties if audits turn up discrepancies. Inadequate documentation also leaves APNs open in legal investigations. Thorough, accurate documentation provides an auditable evidence trail for reimbursement.

Documentation also is used to audit care quality. Some MCOs and PPOs reward practices and providers for complying with established practice protocols and standards as part of their quest to implement best-practice, evidence-based care. APNs must be cognizant of coding requirements and provide documentation that reflects the excellence of their care.

CONCLUSION

U.S. health care has undergone tremendous change during recent decades. For example, DRGs were put in place to control costs as part of a prospective payment system, and that decreased hospital stays, causing an explosion in the need for skilled nursing facilities (SNFs), and home health care programs and increased patient visits to outpatient clinics. With health care costs burgeoning, APNs are cost-effective providers of quality patient care. To prove the affordability and quality of their care, however, APNs must be visible to payers and consumers. Visibility is enhanced when APNs obtain their own provider numbers, lobby for direct reimbursement from insurance companies, document appropriately, and accurately speak the language of coding and billing. Furthermore, APNs become visible as they develop strong relationships with administrators and billing staff and track their billing and collections outcomes. APNs must share their reimbursement expertise with each other in order to raise the performance of all APNs (Charsha, 2001). There is evidence that many APNs are currently not well informed about their practice revenue generation, which puts

them at a disadvantage in determining their fiscal impact on systems (Schaffner & Vogt, 2004).

Typically APNs individually negotiate their own employment contracts, a process greatly strengthened by having productivity and financial data. Additionally, tracking APN cost-effectiveness, productivity, and fiscal outcomes is essential to the entire nursing profession as it makes nurses' work visible in the bottom line of organizations. The ANA has been lobbying for direct reimbursement for all registered nurses since 1948; coalitions of nursing organizations continue to pursue the goal of unbundling nursing's contribution from overall cost analyses (Mittelstadt, 1993; Weinberg, 2003). Measuring care outcomes is one of nursing's highest priorities.

APNs were traditionally educated to provide care closely aligned to specific settings. Now they face the additional challenge of understanding multiple systems that change rapidly and reimbursement policies that constantly evolve. APNs must not only practice competently but also understand health care economics. Therefore, basic and continuing education of APNs is essential, and nurse educators and administrators must understand and teach about APN reimbursement. Content on leadership, financial management, politics, and health policy is essential to keep APNs' place at the table where decisions are made, policies are developed, and systems are designed.

Lobbying at various legislative levels is also crucial for APN reimbursement. There is a pressing need for consistent payment policies across states that are reflected in federal laws and regulations. Legislative and regulatory goals include:

- legislation requiring APN payments that are on par with physicians (the "equal pay for equal work" principle)
- laws that would ensure the public's access to APN care (i.e., changes to the Employee Retirement Income Security Act of 1974 (ERISA) that exempts self-insured organizations from state regulation, and allows them to be more restrictive than regulated organizations)
- laws requiring payers to credential and list APNs as licensed independent providers (LIPs), thus placing APNs on MCO provider panels as specialty and primary care providers (PCPs)

Research must continue to examine the characteristics, quality, and cost-benefit ratio of APN care (Jackson, Kennedy, & Slaughter, 2003). APN care that is evidence-based needs to be carefully studied to document its

specific components and outcomes, including fiscal outcomes. Regulatory compliance could be studied as well as the effectiveness of various methods of educating APNs about these vital issues.

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Chapter 8

ETHICAL ISSUES IN ADVANCED PRACTICE NURSING

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Advanced practice nurses are active in a wide variety of clinical, educational, and executive roles with varying degrees of involvement in and influence on clinical practice. Advanced practice nurses are often looked upon as experts that can serve as a mediator or resource for other nurses as well as patients or families who are facing ethical dilemmas. Identifying ethical frameworks to support the complex moral and ethical health issues that advanced practice nurses face is a challenging task.

Advanced practice nurses are confronted with a variety of everyday ethical conflicts including: 1) patient or family conflicts when the prognosis or goals of care are unclear (Wiegand, 2003); 2) family conflicts when there is uncertainty over the aggressiveness of care in chronically ill incompetent patients; 3) clients in the community whose care is compromised because of inadequate knowledge or use of resources; 4) conflict between public financing and family responsibility; 5) conflicts between insurer/payer system care guidelines and the perceived most appropriate care (Ulrich, Soeken, & Miller, 2003); 6) inadequate hospital staffing for the complexity of patients served; and 7) clients struggling with a cascade of difficult decisions related to chronic disease management in the community. There is relatively little research exploring nursing ethics, particularly in areas such as the value foundations of human behavior, ethical problems between nurses and organizations, or empirical research into ethics in nurse caring (Leino-Kipli, 2004). This chapter will review basic ethics definitions, discuss keys to application of ethical guidelines for advanced practice nursing challenges, and briefly critique current ethical decision frameworks.

ETHICAL CONCEPTS AND DEFINITIONS

The term *ethics* is used broadly to examine and explain the moral life, norms, social customs and rules that define "right" and "wrong" behavior or actions in society. Ethical theories organize concepts or principles into a framework that can be used to approach ethical conflicts. *Consequentialist* theories identify an action as right or wrong based on the outcome or consequences of that action (Beauchamp & Childress, 2002). The end (consequence, if it is a good one) justifies the means (the action taken). The action that is considered morally right, is the action that produces the best overall result. *Utilitarianism* is perhaps the most well-known of the consequentialist theories. This theory asserts that utility is the fundamental and only principle of ethics (Beauchamp & Childress, 2002). Nurses who follow this theory would take that action that produces the greatest good for the greatest number. For example, advanced practice nurses who embrace this theory might work to decrease public funding for individual transplants, and increase the funding for vaccinations and other preventive measures.

Deontological theories differ widely from consequentialist theories. These theories, based on the works of Immanuel Kant, identify actions as morally right or wrong based on basic underlying moral principles (Frankena, 1988). Kant requires all actions to meet the categorical imperative, which is that one ought never to act except in such a way that one can also wish for that action to become a universal law (Beauchamp & Childress, 2002; Frankena, 1988). In other words, actions must be reasoned through to determine whether or not one would want all others to take that same action in all cases of that kind. Kantian ethics requires the test of "universalizability" for all ethical decisions. For example, an advanced practice nurse would perceive that lying to a patient would be wrong in every case (universalizable veracity), even though the family of one patient requests that she cover the truth because of their concern over the patient's emotional status.

In health care, application of bioethical theories arose out of the field of acute care medicine when advances in medical technology to preserve life began to conflict with the quality of the life that was preserved (Moody, 1992; Dierckx de Casterle, Roelens, & Gastmans, 1998). These bioethical theories focused on principles as a way to examine ethical conflicts. The deontological approach to ethical problem solving focused on the specific bioethical principles of autonomy, beneficence, nonmaleficence, justice, and rules of veracity, confidentiality, and fidelity (Table 8.1). This principle and

TABLE 8.1 Principles of Biomedical Ethics

Principle	Definition	Corresponding Virtue
Respect for Autonomy	Self-determination	General respectfulness
Nonmaleficence	Avoiding harm	Nonmalevolence
Beneficence	Doing good	Benevolence
Justice	Treating people fairly	Fairness
Rules		
Veracity	Telling the truth	Truthfulness
Fidelity	Keeping promises	Faithfulness
Confidentiality	Respecting privileged information	Respect for privacy

Note: From Beauchamp & Childress (2002). Reprinted with permission of the author.

rule-oriented framework encouraged specific decision strategies to apply the theory to practice.

Other ethical theories are also emerging as relevant and helpful guides to health care practitioners. Virtue ethics offers a framework that provides a warmer, interpersonal view of ethical decisions when compared with the calculated reasoning that Kantian principles require. Virtue ethics examines the character traits that affect a person's judgement and actions and dispose them to act in accordance with professional guidelines (Beauchamp & Childress, 2002; Gillon, 2003). The ANA Code for Nurses (ANA, 2001) is a good example of incorporating virtue ethics into the ethical and legal obligations for the nursing profession (Table 8.2). Respectfulness and integrity are identified in this code.

Beauchamp and Childress (2002) refer to virtues of compassion, discernment, trustworthiness, faithfulness, and integrity as character traits that would produce correct actions in health professionals. Cameron (2003) based a model of ethical decision making on virtue ethics, which focused on the behaviors and attributes of a morally good person. These virtues are supported in her research when she interviewed nurses about ethical and spiritual values that guided their practice. Nurses included the following ethical values: beneficence, honesty, justice, integrity (which nurses described as excellent, sound, incorruptible character), nonviolence (resolving issues peacefully), respect for the environment, and respect for human rights. They identified seven spiritual values, including: compassion, happiness, meaning (seeing one's life as part of a bigger picture), meditation, peace, sacredness, and spirituality (Cameron, 2003).

TABLE 8.2 ANA Code for Nurses

1. The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of the health problems.
2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
4. The nurse assumes responsibility and accountability for individual nursing judgements and actions.
5. The nurse maintains competence in nursing.
6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
8. The nurse participates in the profession's efforts to implement and improve standards of nursing.
9. The nurse participates in the profession's effort to establish and maintain conditions of employment conducive to high-quality nursing care.
10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
11. The nurse collaborates with members of the health care professions and other citizens in promoting community and national efforts to meet the health care needs of the public.

Note: From ANA (2001). Code of Ethics for Nurses with Interpretive Statements. Reprinted with permission.

Ethical Issues Versus Legal Issues

Before discussing a decisional framework for ethical issues, it is important to identify the difference between ethical and legal issues. Ethics can guide the development and enforcement of laws. However ethics and legal issues can conflict. For example, there are some legal actions that are considered immoral or unethical by some people (for example, capital punishment) and some actions that are illegal but are viewed as moral by some people (voluntary euthanasia for terminally ill patients).

Ethical concepts or principles are not black and white concepts. Ethics reflect social customs and rules and are influenced by them. Ethical principles may be applied differently as scientific advances and social mores alter the way society views these norms. For example, movies from the 1940s and 1950s often show someone dying peacefully (or melodramatically),

with no life-saving efforts being taken. Beneficence (doing good), at that time, meant to provide comfort. But as technology changed, applying the principle of beneficence began to include the application of full technological resources to attempt to sustain life (Moody, 1992).

Advanced practice nurses often confuse ethical issues with legal issues, and seek to understand the legal liability of a situation without fully exploring ethical implications. The case study below, clearly illustrates the conflict between legal and ethical issues in a real-life setting.

> Mr. Jones is living independently as a resident in a retirement housing setting. His wife had recently been discharged from the dementia unit of the assisted living section of the same community to a local nursing home. The staff noted that Mr. Jones continued to visit the dementia unit after his wife's discharge and had made suggestive sexual comments to other residents in the unit. He was found nude in a female resident's room making advances which were clearly distressing and unwanted by the female resident. The police were summoned, the incident was reported to adult protection services, and Mr. Jones was discharged from the retirement community. The victim's family decided not to press charges against the man as long as he was discharged from the retirement community. A week after discharge, the director of the assisted living community received a call from another retirement community indicating they were admitting Mr. Jones but had questions about his background, including his reason for moving. Mr. Jones and his daughter had not signed a release of records form. Therefore, the ethical obligation to respect resident confidentiality conflicted with the ethical obligation to warn a new community about potential risks to other vulnerable adults. Their lawyer advised that since no charges were pressed against Mr. Jones, they should act "as if the incident hadn't occurred" and the community had no legal obligation to disclose. The gerontological nurse practitioner who cared for the residents on the dementia unit was uncomfortable with the lack of disclosure.

As this case indicates, the community managers addressed the legal aspects of the case, but the advanced practice nurse will still need to resolve the ethical conflict between confidentiality of the resident and her obligation of beneficence or protection of other vulnerable adults.

Nurses who are strongly influenced and focused on the legal aspects of an ethical conflict, may come to a premature conclusion about which actions to take. This approach may leave the underlying ethical conflict unresolved, and create internal misgivings about how to approach other ethical situations.

KEYS TO APPLYING ETHICAL GUIDELINES

Advanced practice nurses must embrace both the reasoned approaches to decision making and the virtues and relational guidelines that help them sort through the multitude of complex ethical issues that confront them in practice (Leino-Kipli, 2004). Several nurse ethicists have developed decision-making tools to assist nurses in the application of bioethical principals. Two examples of these decision-making frameworks are Crisham's (1981) Moral Framework and Calabro and Tukoski's (2003) Participative Ethical Decision Making. In Crisham's model, nurses are encouraged to identify the dilemma, the stakeholders, the underlying values, the conflict, and the decision maker, and then work through a process using bioethical principles to reach consensus.

This approach has been modified and updated by Calabro and Tukoski (2003) to specifically assist nurse practitioners in resolving ethical conflicts. They identify several steps to participative ethical decision making. These include: 1) identify the ethical dilemma; 2) delineate the variables in the dilemma (persons involved, time frame for decision, etc.); 3) assess the NP's perspective; 4) assess the patient's perspective; 5) share the assessment and exchange goals in a participative way; 6) identify a mutually acceptable ethical framework; and 7) identify a potential solution.

Unfortunately, both of these decision-making models are fraught with problems related to their underlying assumptions. First, both models assume that there can be a shared style of analysis and problem solving of an ethical issue between health care professionals and patients (Botes, 2000). In the real world of clinical care, significant educational differences and language barriers can create huge gaps in comprehension and can preclude any reasoned discussion. Calabro and Tukoski's model actually requires health care professionals and patients to identify a mutually acceptable ethical framework. This step assumes that somehow the patient and the professional will eventually come to an agreement. Given that many ethical dilemmas arise because there are huge differences in the beliefs of the health professional and the patient, this assumption is particularly problematic.

A second common problem with decision-making models based on bioethical principles is that they tend to prioritize individual autonomy (a deeply embedded Western culture principle). Gillon (2003) argues that autonomy is a necessary component of all of the basic biomedical principles and must be the guiding principle for all ethical decisions. However, this principle takes on distinctly less importance in, for example, Chinese cul-

ture, where the good to the family or community may be seen as more valuable than individual autonomy (Gillon, 2003). Principle-oriented frameworks ignore the role of individual character in ethical deliberations and leave out the texture of the lived experience of each of the individuals. The principle-oriented framework, in its assumption of a rational reasoned approach, neglects the importance of the style of communication, the personal attributes of the nurse, the nonverbal connections, and the interpretation of the meaning of the problem (Cameron, 2003; Dierckx de Casterle, Roelens, & Gastmans, 1998; Gadow, 1989; Moody, 1992; Volker, 2003).

Third, these models assume that there is some certainty regarding the treatment possibilities or outcomes in health care. In reality, advanced practice nurses will continuously be faced with the uncertainties of treatments and outcomes. For example: Will this cancer treatment put the patient into remission, or will it damage their immune system in such a way that they cannot recover? Many patients and families seek information as they sort through tough treatment decisions, only to find that the patient responds physiologically in a way that is completely different from what was expected. Sometimes explaining the uncertainties of a particular treatment assists the patient or family member in deciding whether to opt out of treatment instead of trying to please the specialist who is offering hope. Ruddick (1999) points out that, while hope is a powerful force in bioethics, it can be deceptive in ethical decisions and can change both the patient's and the health provider's decision making.

Fourth, principled decision-making frameworks assume that ethical decision making is a reasoned process, made within a structured group, by participants who are well informed about ethical principles. It is just as likely that ethical dilemmas are resolved in a moment of uncertainty, with less than adequate information, leaving advanced practice nurses and patients to sort through the process at a later date, or not at all. In today's health care systems, acute changes in status happen quickly, and are sometimes completely unanticipated. The APN often deals with families who are faced for the first time with making a decision for someone who, for the first time in their life, lacks the capacity to make a decision. These families need a supportive presence and reminders of the personhood of the patient. Families often are afraid of making a "wrong" decision for a loved one, and thus decide to do many things that the person may not have done. These overwhelming crises make reasoning through an ethical process unlikely or difficult at best.

Finally, decision-making frameworks assume that health care organizations or working conditions allow time and supportive resources for a

participatory, reasoned model of decision making (Botes, 2000; Moody, 1992). In some settings, advanced practice nurses may be left out of the decision-making loop at a critical time. Not all advanced practice nurses are able to quickly identify the process required for ethical decisions. In non-hospital care settings, ethics committees and ethics experts are less common. Practitioners with ethical concerns are more likely to get referred to a risk manager (who will identify legal concerns, not ethical processes) for assistance with ethical conflicts.

Rest's Four-Component Model

Rest identified four integrated abilities that determine moral behavior for health professionals (Rest & Narvaez, 1994). These conditions or components offer guidelines that allow for more than the simple application of bioethical principles, and they include the virtue ethics and interpersonal qualities that can assist in resolving ethical conflicts. The first condition is *ethical sensitivity.* This is the ability to see things from the perspective of others. Rather than a focus on one's own views, a person with greater ethical sensitivity can interpret a situation from other points of view and show sensitivity to the feelings and reactions of others. This sensitivity includes a knowledge of legal, professional, and institutional codes and norms. An advanced practice nurse who is ethically sensitive seeks information and listens carefully. Cameron (2004) identifies ethical listening as paying full attention in order to hear an ethical problem in what someone says. This active ethical listening involves compassion, establishing rapport, using open-ended statements, and encouraging the person to examine the conflict on a deeper level. Ethical listening requires the professional to avoid lecturing, giving advice, or correcting comments, so that the person feels free to talk openly and move closer to a resolution. Advanced practice nurses who use ethical listening skills become skilled at uncovering underlying ethical conflicts that require resolution.

The second component of the four-component model is *moral judgment.* Moral judgment requires knowledge of concepts, codes of conduct, and ethical principles. Moral judgment helps to identify the guidelines that support a decision for a right action. Advanced practice nurses need to be familiar not only with the ANA Code for Nurses (ANA, 2001) and ethical theories and principles, but they also need to be aware of the research that helps to guide clinical decisions. Part of assisting patients in decision making includes assuring that they are fully informed and not coerced. Ad-

vanced practice nurses should develop teaching skills that allow them to present potential risks and benefits of treatment in an unbiased manner.

The third component of Rest's model is *moral motivation,* that is, the difference between knowing the right thing to do and making it a priority. Moral motivation has to do with the importance given to competing choices. Deficiencies in moral motivation occur when personal values compete with concerns for doing what's right. A nurse practitioner who decides to spend less time with each patient so that she can have the highest number of patients billed per month, may overlook important clinical needs at the patient's expense (Ulrich, Soeken, & Miller, 2003). A nursing administrator who decides to "staff short" without agency staffing as a backup so that her department will exceed the budgeted revenue goals (giving her an administrative bonus) has a problem with moral motivation.

The fourth and final component of Rest's model is *moral character.* This component requires the professional to persist and have courage in implementing their skills. Bebeau writes, "A practitioner may be ethically sensitive, may make good ethical judgements and place a high priority on professional values; but if the practitioner wilts under pressure, is easily distracted or discouraged, or is weak-willed, then moral failure occurs (Bebeau, 2002, p. 287). Nurses in advanced practice roles need to identify how they would carry out their specific moral action. Clinical situations will expose them to a variety of problems that may require a necessary ethical action. For example, a nurse midwife identifies a clinically incompetent or negligent performance on the part of a staff nurse, but decides not to report it because she is not the nurse's direct supervisor. She is missing the final important ingredient in ethically sound advanced practice.

SUMMARY

We have discussed three ethical decision-making frameworks as guides for advanced practice nurses. Although nurses may be more familiar with the bioethical principles, the principle-oriented frameworks are not as well equipped to address the many everyday ethical decisions in health care that are not about life-or-death issues. These day-to-day decisions may be best served by Rest's Four-Component Model, which identifies the need to assure heightened ethical sensitivity and ethical implementation.

Advanced practice nurses should work to improve their awareness of ethical issues by active ethical listening. They should be educated about

ethical theories and principles, and should be aware of codes of conduct that will have an impact on their moral judgement. They should examine their own professional conduct and the choices that will compete with the ethical decisions to be made. Finally, APNs should work to improve their ability to follow through with appropriate ethical actions.

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Chapter 9

APPLYING RESEARCH IN ADVANCED PRACTICE NURSING

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We are living in a time of unprecedented changes and challenges in our nation's health care system, changes that require nurses to step forward now more than ever and answer the call to advance health through research.
—Patricia A. Grady, PhD, RN

Research is an essential foundation of high-quality care. It is more important than ever to demonstrate the cost-effectiveness of nursing activities in an evolving managed care environment. Innovative approaches to patient care that "make a difference" must be documented. The accumulation of evidence to support the evaluation of the cost-effectiveness of nursing care can be accomplished through nursing research. In fact, nursing's commitment to producing quality, cost-effective patient outcomes requires that a scientific basis for practice be established. Substantial strides have been made over the past 25 years to increase the amount of nursing research being conducted and to improve the quality of that research. The advent of doctoral education in nursing and the growth in the number of advanced practice nurses (APNs) with master's or doctoral degrees are factors that have had a positive impact on the advancement of nursing research. Nursing truly "came of age" with the institution of the National Center for Nursing Research of the National Institutes of Health in 1985 and its elevation to institute status in 1993.

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Nursing as a profession continues to build practice on broad and accessible scientific knowledge. Nursing research has become an integral part of the scientific enterprise focused on improving the level of health in the United States. Amidst rapid changes in health care, members of the nursing profession need to continue to develop the knowledge that underlies nursing. Many opportunities exist for APNs to expand perspectives and acquire new knowledge for practice.

While studies from other disciplines are helpful, research from the nursing perspective is essential to establish parameters for the use of specific interventions in nursing practice and to document nursing's unique contribution to the achievement of desired patient outcomes. Research is critical to the development of the discipline of nursing and fundamental to the expansion of the scientific knowledge base underlying nursing practice. However, accumulated knowledge has little value unless it is applied in practice. The responsibility of nurses to use new knowledge in practice is clearly described by the American Nursing Association (ANA) in *Nursing: Scope and Standards of Practice* (ANA, 2004). Research needs to be incorporated into practice to provide high-quality, evidence-based care.

Although a discipline cannot expect its practitioners to be expert researchers (Cronenwett, 1995), APNs have unique and critical roles in the dissemination and application of research findings to practice settings (Michel & Sneed, 1995). APNs are uniquely prepared and positioned to foster research utilization, support evidence-based practice, and contribute to the conduct of practice-related research. Research is one of the elemental components of advanced practice (Benner & Tanner, 1987; Hamric, Spross, & Hanson, 2004), but it is frequently the one that receives the least attention. A variety of factors may account for the lack of time that APNs devote to research, including lack of administrative support for research, lack of peer support (since few nurses with a master's or doctorate may work in any given setting), APNs' responsibility for numerous patients and care units and the institutional projects that compete for their time, and the inclusion of little research content in the APN curriculum (Robinson, 2001). Despite the fact that APNs have indicated that they give minimal attention to research (Stetler, 2001), the importance of the research component of the APN role cannot be minimized. This chapter will address APNs' involvement in research-based knowledge acquisition, the use of research findings in practice, the use of models of evidence-based practice, and the APN's role in the research process.

ACQUISITION OF RESEARCH-BASED KNOWLEDGE

Research-based knowledge is the substance required to practice. Recent advances in information technology have reduced the time required for information transfer and have exponentially expanded the volume of information available. The rapid expansion of information accessibility via the World Wide Web provides an enlarged, worldwide resource to be tapped to acquire knowledge and to explore solutions to clinical problems. Electronic mail, electronic discussion groups, listservs, and electronic newsletters are commonly used communication channels that unite nurses with colleagues locally, regionally, nationally, and globally. Computer technology has expanded the capacity of APNs to access information in order to stay abreast of new knowledge and meet the challenges of practice. Competency in the use of computer technology is vital to a career in nursing. Cronenwett observed that:

> . . . new knowledge is generated so rapidly that what health care providers learn during their academic programs is unlikely to be "best practice" within a few years. Professionals cannot plead ignorance of new knowledge. Society demands that health care providers and systems be efficient and effective in helping patients achieve their maximum levels of health. (Cronenwett, 1995, p. 430)

It is common knowledge that all the information that is available is not necessarily accurate nor applicable. APNs will need to be prepared to sort, evaluate, and interpret the information for clients and colleagues. The ability to read, interpret, and synthesize research is critical to this end. However, it has been estimated that almost half of practicing nurses have not had a research course (Cronenwett, 2002). Although nurses with master's degrees have been said to have no impact on research utilization (Coyle, & Sokop, 1990), they were found in a later study to be more likely than baccalaureate nurses to relate and to use findings of research in their practice (Michel & Sneed, 1995).

APNs have important roles to play in bringing the findings of research to practice. Continuing education, reading, and professional development will ensure continuing improvements in APNs' knowledge and skill. APNs are close to practice. Thus, they can easily identify clinical problems and they are in key positions to find, interpret, and use research findings, as well as act as change agents in the practice setting (Davies, 2002; Stetler, Bautista, & Vernale-Hannon, & Foster, 1995).

Strategies to Access Research-Based Information

Many resources and strategies exist to provide nurses with the information needed to deliver high-quality, evidence-based practice. A few selected resources and strategies will be described below.

Comprehensive Reviews

Integrative review journals and review articles are rich resources that provide nurses with a summary of the current body of knowledge. Critical and integrative review articles are helpful sources of research information, particularly those that summarize relevant studies and provide overall conclusions from the synthesized findings. These reviews generally provide readers with information on the breadth of the literature reviewed and inform the reader about all relevant studies in the area that was critiqued. To be useful, reviewers should critique the studies rather than present solely a narrative of the studies. A critique of this nature should be objective in presenting positive and negative aspects of each study, and studies that address the same or similar questions should be chosen. High-quality reviews of nursing interventions provide an excellent source of information for nurses who are considering the use of a particular intervention for a specific population. Inclusion of such reviews in clinical nursing journals is beneficial to practitioners. The Cochran database, a collection of systematic reviews of research, organized by topic, is another very useful resource.

Clinically focused research journals such as *Applied Nursing Research* and *Clinical Nursing Research* provide useful research-based information that is applicable to clinical practice. Reviews of research related to specific phenomena or areas in nursing are presented in *Annual Review of Nursing Research* published yearly by Springer Publishing. Sigma Theta Tau International's *World Views on Evidence-Based Nursing* is an example of a journal with synthesized knowledge that is available

APNs are encouraged to use review resources for updating clinical practice when relevant, current reviews are available. Other current updated information can be found on the Web.

Internet and Online Resources

Some information today is made available only in electronic form (Sparks & Rizzolo, 1998). Knowledge regarding various search engines and data-

TABLE 9.1 Selected Web Sites for Grants and Health-Related Research-Based Information

Agency for Healthcare Research and Quality <http://www.ahrq.gov>
American Academy of Nurse Practitioners <http://www.aanp.org>
American Association of Critical-Care Nurses <http://ww.aacn.org>
American Association of Neuroscience Nurses <http://www.aann.org>
American Association of Nurse Anesthetists <http://www.aana.com>
American College of Nurse-Midwives <http://www.acnm.org>
American College of Nurse Practitioners <http://www.nurse.org/acnp>
American Heart Association <http://www.americanheart.org>
American Nurses Association <http://www.nursingworld.org>
Association of Operating Room Nurses <http://www.aorn.org>
The Cochrane Collaboration <http://www.cochrane.org>
EBN Online: Evidence-Based Nursing <http://ebn.bmjjournals.com>
Emergency Nurses Association <http://www.ena.org>
Foundation Center <http://fdncenter.org>
The Joanna Briggs Institute <http://www.joannabriggs.edu.au>
Midwest Nursing Research Society <http://www.mnrs.org>
National Guideline Clearinghouse <http://www.guidelines.gov>
National Institute of Nursing Research <http://ninr.nih.gov>
Oncology Nursing Society <http://www.ons.org>
The Pew Charitable Trusts <http://www.pewtrusts.com>
The Robert Wood Johnson Foundation <http://www.rwjf.org>
Sigma Theta Tau International <http://www.nursingsociety.org>

bases, including their advantages and disadvantages, as well as strategies for combining these tools, can help APNs to locate Web resources more effectively. MEDLINE and CINAHL (Cumulative Index to Nursing and Allied Health) are examples of bibliographic databases of journal articles. The clinician can combine subjects to either narrow or expand the search fields to find desired information. For example, a nurse practitioner may combine a drug name with side effects and a specified clinical population and get citations, article abstracts, or full text articles related to side effects of that drug when prescribed for the specified population. Trying synonyms for unusual words, and using more than one search tool are strategies that are generally recommended (Sparks & Rizzolo, 1998), as is the use of a professional reference librarian.

Several useful Web sites are listed in Table 9.1 with their uniform resource locators (URLs). These international, national, or specialty organizations provide research, practice, and funding information at these sites. In

addition to the organizations listed, other local organizations may also be useful for research, practice, or grant information including local chapters of Sigma Theta Tau International or local chapters of specialty nursing organizations, schools of nursing, alumni associations, and state nursing organizations.

Synthesis and Consensus Conferences

Proceedings of conferences sponsored by the National Institutes of Health to review interventions used to treat particular disorders are another source of synthesized research-based, practice-relevant information. An extensive review of research literature is done by a multidisciplinary panel of experts who are convened to discuss the findings in a targeted area of interest. At the conclusion of the conference, the experts recommend the most appropriate intervention to use for treating the disorder and make suggestions for policy and further research. The Midwest Nursing Research Society has sponsored consensus conferences, also known as *synthesis conferences.* Nurse experts in a particular area present reviews of relevant studies in the context of these conferences. After discussion by the experts and conference participants, conclusions are drawn regarding the state of the art in the area and the direction that future research should take.

The Agency for Healthcare Research and Quality (AHRQ) of the United States Public Health Service, Department of Health and Human Services, has facilitated the development of research-based clinical practice guidelines and recommendations to assist clinicians in the prevention, diagnosis, treatment, and management of clinical conditions. Multidisciplinary panels of clinicians and experts are convened to develop statements on patient assessment and management for selected conditions. To accomplish this task, extensive literature searches are completed, as are critical reviews and syntheses. The agency disseminates the research-based practice guidelines to health care providers, policy makers, and the public. Some of the health problems for which guidelines have been developed include acute pain, pressure ulcers, urinary incontinence, cataracts, depression, Alzheimer's disease, and HIV infection. A well-known source of guidelines, the National Guidelines Clearinghouse, sponsored by AHRQ, maintains a topically organized database of guidelines.

APNs can play a pivotal role in assisting health care agencies to change care policies so that research-based guidelines are adopted as part of the institutional care policies. In so doing, the organizational practices should be assessed and any necessary modifications to the guideline should be

considered by either a research utilization committee of the organization or a task force for each practice guideline (Kirchhoff & Beck, 1995; Stetler, 2003). Knowledge regarding the individual and the organizational change process is necessary in planning, implementing, and evaluating proposed changes in practice or care policy. APNs have a critical role in the selection, refinement, implementation, and evaluation of the guidelines used in their specific setting. APNs may also develop guidelines for their setting if none exist for a topic of concern.

Literature Search, Review and Critique

When comprehensive critical reviews are unavailable or insufficient, literature reviews must be undertaken. Identifying the studies to be reviewed is time-consuming, but thoughtful attention to the quality and comprehensiveness of the articles reviewed is necessary, especially when developing guidelines or introducing new interventions into practice. Reviews must include studies that present various perspectives rather than just including those that support a particular point of view (Moody, 1990). Limiting and focusing the area of interest and the population through careful specification of key search words are crucial steps in the process before identifying the studies to be reviewed.

Some study findings in the research literature may be practice-ready and prescriptions for application are fairly well established. Other research findings are fragmented or not yet synthesized. These require efforts to critique research literature in an area to determine the applicability of the research findings to practice.

Numerous criteria have been developed to guide nurses' efforts to critique research studies and determine their relevance for practice (e.g., Polit & Beck, 2004; Pyrczak, 1999). In determining the quality of research reports and the suitability of their findings to practice, numerous factors are considered. These considerations include such things as the appropriateness of the study variables to the practice problem and population to which it will be applied, the quality of the study methods, and the perceived feasibility of the application. The study methods should be clearly described so that the study may be properly evaluated and its merits assessed. Good clinical judgment should be used to determine the probability that interventions would be feasible, safe, and effective in the setting to which it would be transferred. It is advisable that studies be replicated before broadly implementing interventions across practice settings.

A limited amount of funding means that the maximum usage must be made of studies that have been conducted. Meta-analytic techniques enable maximum use of research by bringing together the results of a collection of smaller studies into one larger pool of findings for statistical analysis.

Meta-analyses

Meta-analyses go beyond the typical narrative literature review by employing a systematic method of review of experimental studies (Johnston, 2005) or descriptive research (Reynolds, Timmerman, Anderson, & Stevenson, 1992). Conducting a meta-analysis of studies related to a particular intervention may provide more information regarding appropriateness, indications, and effectiveness of a specific intervention than can be derived from merely examining results from individual studies.

APNs may choose to conduct a meta-analysis when the accumulations of findings that are available in an area are not substantial. Meta-analyses pull together findings of related studies that are identified by specific criteria developed by the author. Meta-analytic techniques are generally employed with very stringent criteria for the inclusion of studies to minimize bias. The criteria for study selection should be decided before examining possible studies for inclusion. Rigor in selecting studies and in conducting the analyses helps to ensure the quality of the meta-analysis. For example, one might select only studies that used random selection of subjects. Meta-analyses can be used to increase the estimates of the effect size (mean differences in standard deviation units) and to increase statistical power. This enables the resolution of uncertainties when results among studies are conflicting or inconclusive, or to answer questions not posed when studies were conducted. One strength of the meta-analytic technique is the ability to arrive at conclusions about interventions even though different instruments were used to measure the outcomes.

Nurse researchers have used meta-analyses to evaluate potential outcomes of interventions. For example, a meta-analysis was used to assess analgesic role of antidepressants in psychogenic and somatoform pain (Fishbain, Cutler, Rosomoff, & Rosomoff, 1998). In patient education, Theis and Johnson (1995) reported that planned and structured strategies for teaching patients yielded the greatest effect. In the practices of midwives, Olsen (1997) conducted a meta-analysis of six controlled observational studies of low-risk pregnant women to examine the safety of planned home birth backed up by a hospital system. Planned home birth, as compared

with planned hospital birth, was associated with fewer risks and involved fewer medical interventions. Results of meta-analyses can be carefully considered by APNs to determine whether the interventions and practices that have been scrutinized are acceptable and feasible alternatives to existing ones in their practice settings (Fishbain, Cutler, Rosomoff, & Rosomoff, 2000).

Journal Clubs

A journal club is a strategy that APNs can implement to increase staff nurses' and their own knowledge about the research process and applicability of findings for practice (Goodfellow, 2004; Wright, 2004). Lindquist, Robert, and Treat (1990) noted that journal clubs promote the critique of research in a nonthreatening manner. Their suggestions for a successful journal club included having a regular meeting date, providing an outline to use for critiques, and using a moderator to facilitate discussion. Kirchhoff and Beck (1995) suggested various formats of journal clubs according to the purpose of journal club, including one article, one journal, or one topic with or without premeeting preparation. Membership in journal clubs varies depending upon the purpose and the organizational climate. For example, if the journal club is aimed at unit-based research utilization, staff nurses and APNs may be included. If it is aimed at bridging the gap between research and practice in a university hospital setting, faculty members and graduate students could be included in addition to the hospital employees. If the purpose is to involve a whole organization, interdisciplinary team members should be included. If practice changes are desired, scientific merits, risks to the patients, clinical merits, feasibility of implementation, and the potential for clinical evaluation or replication should be considered (Kirchhoff & Beck, 1995). Some journals, such as the *American Journal of Critical Care,* highlight one article in every issue to be used specifically for journal clubs.

Caution is a judicious element when applying research findings to practice. With all the sources of information, it is important to evaluate the quality of the source—including studies and guidelines—and the database that is used. From the findings of specific studies, good judgment is needed to determine what is the appropriate population to which results can be generalized. Many interventions require replication studies to further establish the effectiveness or to extrapolate findings from one setting or population to another. Careful clinical evaluation of interventions is warranted so

that their suitability for achieving desired outcomes in selected populations can be demonstrated prior to widespread use. Criteria may include such things as the strength of research findings of individual studies, the overall quality of the research, and the amount of evidence (Stetler, et al., 1998). Efforts should be made to evaluate the application of research findings with respect to clinical practice. Evidence-based practice is the process of incorporating knowledge, including research, into practice.

EVIDENCE-BASED PRACTICE: SYNTHESIZING EXISTING KNOWLEDGE AND APPLYING IT TO PRACTICE

Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Sackett, Straus, Richardson, Rosenberg, & Hayes, 2000). There are two principles underlying evidence-based practice (Guyatt & Rennie, 2000). The first is that evidence in isolation is insufficient to create practice changes; APNs must also consider benefits, risks, costs, and patient-relevant factors. The second principle directs APNs to evaluate the strength of the evidence being used to make practice decisions.

APNs are not only accountable for developing evidence-based protocols: they also are accountable for cultivating the culture of evidence-based practice within the organization or institution (Advisory Board Company, 2003). Efforts to promote and develop evidence-based practices can be facilitated by numerous online resources, for example the Evidence-Based Nursing Web site (http://ebn.bmjjournals.com) and the Joanna Briggs Institute for Evidence-Based Nursing and Midwifery (http://www.joannabriggs.edu.au).

Research utilization has been a key concern of the nursing profession for more than four decades, yet it has just come of age in the mid 1990s (Crane, 1995). Research utilization is a crucial process that underlies evidence-based practice, including the updating of organizational policies and clinical procedures, and continuous quality improvements in health care. Incorporating research findings into clinical practice is challenging, however, because it requires careful critique and "translation" of research findings before application to specific patient populations or practice settings.

Research utilization has been defined as "a systematic process of synthesis, transformation, application, and evaluation of research findings into practice to meet patient care needs" (Lekander, Tracy, & Lindquist, 1994). Two types of utilization, *instrumental* and *conceptual,* have been identified

(Cronenwett, 1995; Cronenwett, 1990). Instrumental utilization occurs in a very concrete and direct manner (e.g., specific research findings help clinicians choose a specific action, write a targeted policy, or make a decision). Conceptual utilization is an indirect and cognitive process in that research findings change clinicians' understanding of phenomena or influence the way they think about a given situation. Both types of utilization have value and are used by APNs, but conceptual utilization has a more gradual, almost intangible effect on practice settings over time.

Despite the acknowledged value of research-based practice, nurses have been slow to utilize research findings in practice (Lindquist, Robert, & Treat, 1990; Stetler, Corrigan Sander-Buscemi, & Burns, 1999). Many nurses have not been taught how to use research methods within the context of their practice. Nursing students in undergraduate and graduate programs have been taught how to conduct research, but not how to utilize research findings. Faculty members, in most cases, have expertise in conducting research, but not in the process of applying the research finding to the practice setting (Crane, 1995). APNs can play a key role in the facilitation of the utilization process.

Some major barriers to research utilization include: (1) availability of research findings; (2) knowledge and attitudes of nurses; and (3) environmental support (Morrola, 1996). The lack of availability of research findings may be attributable to insufficient methods for dissemination and presentation of research findings (Lekander, Tracy, & Lindquist, 1994). Research journals may not be readily accessible to clinicians in small, space-constrained practice settings, and research findings published in clinical and practice journals are limited. Full-text online journals are examples of a solution to this problem. The cost of online subscriptions may be a limiting factor but one that should be considered.

The lack of research knowledge and negative or indifferent attitudes (a lack of perceived value) of nurses toward research may result from minimal or insufficient educational preparation in research (Lekander, Tracy, & Lindquist, 1994; Funk, Tornquist, & Champagne, 1995). Researchers are encouraged to articulate the clinical relevance and specific practice recommendations because some clinicians may be unfamiliar with the language specific to research and statistics.

Environmental barriers include: a lack of authority to change patient care procedures autonomously, a lack of motivation to change practice, funding constraints, and a lack of time due to the multiple role demands on the time of APNs (Funk, Tornquist, & Champagne, 1995; Carroll, et

al., 1997). Administrative support for nurses to participate in quality improvement committees, to have access to expert consultation, or to apply for small utilization grants would minimize environmental barriers.

Research Utilization Projects and Evidence-Based Models

Numerous models for evidence-based practice are available to assist APNs in the process of the systematic application of knowledge to their practice. These models vary in their purpose, organizing framework, and target population (individual, group, or institutional), but have similarities in their processes. Evidence-based models generally include identification of clinical problems, assembly and critique of the literature, assessment of applicability of the findings, design of innovation, implementation, and evaluation (Nicoll, & Beyoa, 1999). One example, the Stetler Model for Research Utilization (Stetler, 1994) has been used in a variety of practical and educational settings to facilitate individual and organizational change process. The model has been updated to facilitate evidence-based practice (Stetler, 2001). The model helps APNs to make structured decisions appropriately and effectively by raising consciousness and the critical thinking abilities of potential users. Another example, the Iowa Model of Evidence-Based Practice (Titler, , et al., 2001) is a model that focuses on improvements in the quality of care.

Other Activities

Beyond the role that APNs have in seeking and synthesizing research findings, APNs frequently provide peer review of research manuscripts, abstracts, and research proposals for professional organizations, and research protocols for institutional conduct (Lindquist, Tracy, & Treat-Jacobson, 1995). APNs serve as members and chairpersons of nursing research committees, nursing research utilization committees or research-based policy-making bodies. Participating in professional organizations that promote research and the dissemination of research findings is important to the career development of both professors and APNs.

Sometimes APNs may need to expand the nature of their documentation to support evidence-based practice, including such things as guidelines and consensus of experts. When these are not enough, APNs often conduct their own research or participate in research studies as part of a team to generate the needed information.

CONDUCTING RESEARCH

Nursing research is essential to develop the knowledge base that may be applied to clinical nursing practice. Although the research of other disciplines may have applicability to practice, nurses may have unique questions, perspectives, methods, and solutions. The "how to" of research goes beyond the scope of this chapter. For more detailed presentations relating to the conduct of research, the reader is referred to research texts, research colleagues, research seminars, educational offerings, and university graduate coursework.

It is helpful to get expert advice and input from friends, colleagues, and consultants with relevant expertise when embarking on a program of research. A feasibility study with pilot data is a strength because it can provide funding agencies with empirical data regarding the subjects under investigation as well as evidence of investigator expertise and experience with research subjects and materials. "Pilot work" (test run) is an advisable first step in the conduct of a research protocol (Lindquist, 1991; Melnyk & Cole, 2005). Pilot work may provide preliminary data, but it may also be a test ground for methods of recruitment, intervention protocols, and study measures that have been developed or selected.

Many funding sources support the development of a program of research and ongoing investigations that are built on the strength of insights and knowledge in well-defined areas. Grant awards for research typically increase with the experience of the investigator, paralleling the quality of the proposed research, expertise of the investigative team, and substance of their publications that document excellence. The size of the awards is generally larger from regional organizations than from local sources, and larger still from national than from regional sources. Local chapters of national and international specialty organizations often award seed monies to support research. Funds may also be solicited from vendors in health-related industries. Research grant information can be found on the Web, providing timely, up-to-date sources of available funding. Selected examples of organizations with grant programs and their URLs are listed in Table 9.1.

It is advisable to submit a proposal where it will receive the most favorable review. Thus, effort should be given to finding an appropriate funding source. The proposal should highlight the potential significance of the outcome relative to the goals of the funding agency to which it is sent. Often multiple submissions and revisions of a grant are required prior to its funding. Many proposals that are not funded after the first submission are abandoned by their authors even when they contain good ideas.

Some national and specialty nursing organizations develop research priorities so that desired new knowledge relevant to a practice role or specialty area may be systematically developed. APNs can use the research priorities to focus their work and to establish the relevancy of their proposed research.

Roles

Research expertise, like clinical expertise, is developed and sharpened over time through education and experience. There are many levels of commitment and ways to become involved in the research process. Investigative teams draw together the strengths of individuals who comprise it, and each person brings to a project his or her unique expertise.

The *principal investigator* takes overall responsibility for the integrity of the research project. The principal investigator assumes responsibility for writing or coordinating the writing of the proposal and overseeing its conduct. Knowledge about the entire research process is necessary, from proposal generation to analysis, including the dissemination of the study findings. Typically, funding agencies recognize one designated principal investigator who has the overall accountability for the conduct of the project and expenditure of the resources. This person is named first in the list of project investigators. The authority that comes with the accountability of this role may ensure that the project does not become deadlocked in disagreements among investigators. The principal investigator generally assumes personal as well as professional responsibility for the project's success.

A *coprincipal investigator* shares the leadership in the implementation of a research study. A participant in this role may have been integral to the development of the project and continues in an active role through all phases of its conduct and dissemination. A *coinvestigator* or *investigator* is a member of the research team, but usually assumes responsibility or shares responsibility for a specific aspect or aspects of the study. For example, an APN who is a coinvestigator may be responsible for identifying potential subjects for recruitment, implementing an intervention protocol for selected patients, or coordinating other aspects of the study such as follow-up phone calls or mailings to study participants. They may also contribute expertise as to how to conduct the study in the clinical setting. The amount of time and degree of responsibility varies from study to study. Regardless of the extent of the involvement, the APN's experience of being a part of

a research team provides opportunities to expand personal knowledge about research while contributing to knowledge development for the group as a whole.

A *project director* or *study coordinator* takes responsibility for the day-to-day conduct of grant activities. Key elements of this role typically include subject recruitment, teaching the necessary protocol activities to staff or data collectors, maintaining protocol integrity as it is implemented, and solving problems that arise throughout the course of the study. APNs are well-suited to the role of project director since they possess extensive clinical knowledge as well as knowledge of the research process. As project directors, APNs can expand their research expertise and specific knowledge in the area that is under investigation. Therefore, it is an excellent opportunity for professional growth for APNs who are considering a career in research.

Collaborator is a general term used to identify individuals working together on a project. The role can carry with it a variety of general or specific responsibilities. For example, an APN in the role of midwife can collaborate on a colleague's project and can assume responsibility for patient recruitment in their clinical work setting. As *consultant,* APNs may offer their specific expertise to a project. For example, an APN specializing in mental health/psychiatric liaison nursing may be sought to select measures or develop a protocol to identify acute confusion in a study of postoperative falls. A gerontological CNS may be sought as a consultant to ensure that a study of the effects of early discharge after heart surgery includes age-appropriate measures and protocol accommodations for elderly subjects (e.g., enlarged font size for enhanced readability; rest periods for elderly subjects if they are fatigued).

Patient outcomes are important research considerations due to the widespread concern regarding the quality of health care (Brooten & Naylor, 1995). APNs in clinical settings are able to identify practice-relevant outcomes and are able to design research protocols that systematically explore data to meet practice goals. For example, the ambulatory surgical setting provides a cost-effective means of performing surgery. Short-acting anesthetic agents have been developed and are being used to facilitate more rapid recovery from surgery. However, the relative efficacy of agents for use in particular settings is a significant unresolved issue for nurse anesthetists working in those settings. In one randomized study in the ambulatory setting, discharge time (time from admission to the post-anesthesia recovery until discharge) was examined when patients received general anesthesia

with fentanyl versus alfentanil. No differences were found between groups; both agents were judged adequate and comparable for short outpatient procedures (Heather & Martin-Sheridan, 1993). This highlights a research project that is directly applicable to the APN's role in using research-based evidence to inform clinical practice.

Challenges and Opportunities

Despite the ostensible receptivity of clinicians to studies at clinical sites, there are clinical priorities that may create conflict with respect to study protocol implementation. The conduct of research in service settings is difficult since the immediate clinical physical needs of patients are, understandably, often given higher priority than protocol activities. Attention should be given to the design of the study protocol in order to maximize feasibility of protocol adherence in the midst of practice. In the acute-care setting, the clinical nurse specialist can play a key role in developing strategies to balance the competing demands of patient care, research, and research utilization (Miller, Johnson, Mackay, & Budz, 1997; Stetler, Bautista, Vernale-Hannon, & Foster, 1995). Research project budgets should be planned so as not to burden staff with protocol activities without payment.

Using a personal approach is possibly the most effective method to enlist the cooperation of participating personnel and to engage them in the work (Stetler, Corrigan, Sander-Buscemi, & Burns, 1999). Where there is no sense of ownership by staff involved in protocol implementation, and a top-down approach is used to introduce research into a clinical area, research may be seen as an academic pursuit that is of no relevance to practice. The APN can help change this viewpoint and the consequent derailing of protocols by highlighting the relevance of the research to practice. Where there is no respect between researchers and clinicians, the clinicians who may be key to recruitment and the success of the protocol may not get involved. An APN who is familiar with the personnel and the work setting can be the spokesperson and can assist in integrating the protocol to enhance feasibility. In interactions, the investigator can emphasize the clinical significance of the research, establish an atmosphere of collaboration, and identify informal peer leaders who will support the effort.

Good leadership is a critical ingredient of the APN's role in research. Good communication and the accommodation of the concerns of the practice setting with regard to protocol conduct will facilitate study success. APNs are well positioned to be responsive to the concerns of researchers and clinicians alike, and may play a key role in conflict resolution. APNs may be viewed as clinical "insiders" and, as such, may build interest and relationships in the conduct of research and research utilization among nurses and interdisciplinary professionals. As a result, a clinical unit may be more willing to "take on" a study as a unit project and take pride and ownership in the project.

Research studies conducted at one site are often limited with respect to sample size and generalizability. Multisite research permits increase sample size, and allow broader sampling, faster accrual rates, and more meaningful subgroup analyses through efficient use of resources. Multisite studies also provide for opportunities to learn from other facilities and to expand professional perspectives. However, there are challenges in communication, reliability of measures, standardization of protocol, and data integrity in multisite research. Considerable planning is required to maintain consistency and standardization across divergent practice sites. The APN can serve as the link between sites and investigators and participating personnel in the clinic, hospital, or community. For example, Meeropol and Leger (1993) conducted collaborative research through a regional nursing consortium to investigate the incidence and nature of latex allergies in children. Often, more subjects, greater statistical power, greater diversity, broader generalization, and more conclusive results can be achieved by a nursing consortium than by a single practice setting.

Networking is another tool to facilitate multisite research that may be effective for nurse practitioners and primary health providers. Little research has been conducted with regard to the efficacy of primary care providers and the broader applicability of research findings to settings serving the general population. This is partly because of the limited number of subjects in each individual primary care setting (Grey & Walker, 1998). To address this concern, Grey and Walker (1998) suggested practice-based research networks for studying clinical problems and practice patterns occurring in community-based primary care practices.

The final stage of the research process is dissemination. Once research findings are generated, they should be made available in summary form with recommendations for their application. Research must be presented to

audiences or published so that others can evaluate the work for its clinical utility. It is through dissemination of findings that the information becomes available and may add to the knowledge base (Grimshaw, Eccles, & Tetroe, 2004). A work that is disseminated in journals, the Web, and in other media becomes accessible to others for the process of research utilization. In the process of dissemination, valuable feedback may also be obtained relative to the application of findings or to future research. Oral and poster presentation skills are frequently developed by APNs, and numerous published resources are available to assist them in this work (e.g., Garity, 1999; White & White, 2003). Unfortunately, the findings of many studies have never been presented or published and as a result, the professional community has never been informed about findings that may be relevant to patient care.

CONCLUSION

The ultimate goal of any profession is to establish a base of knowledge that will guide the practice of its members. APNs can and do play an integral role in identifying key practice problems for which research is needed. An equally important role exists for APNs in the utilization of research findings and other credible information to support evidence-based practice. Although many APNs have not given research a high priority, increased emphasis on this function is needed for the improvement of patient care. The imperative to establish an evidence-based practice as well as an expanding base of clinically relevant research in nursing should be clear. Well-developed programs of research in conjunction with organizational, administrative, and environmental support will foster a climate of openness to innovative practice changes and an evolving evidence-based practice.

The challenges of conducting and utilizing research, instructing evidenced-based nursing practice require leadership from nurses in advanced practice roles. With the exponential growth of information available by means of evolving information technologies, APNs are in key positions to sort, synthesize, and interpret information for clients, families, and other professionals. APNs are encouraged to continue their professional development and contribute to the quality of evidence-based practice by actively participating in research utilization and in the conduct of research. Involvement in research is essential and provides the avenue and opportunity for continued professional growth and improvement in the quality and effectiveness of nursing care.

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UNIT III

TRANSITIONS TO THE ADVANCED PRACTICE ROLE

Chapter 10

PUBLISHING AND PRESENTING: YOU, THE READER, AND THE SUNSET

CeCelia R. Zorn

You receive an invitation to view vacation slides at your neighbor Leslie's home. To be friendly, you grudgingly agree. Hugging a bowl of fruit salad, you and your partner walk over to Leslie's house Friday evening to watch over 200 slides from his winter break in Hawaii. Anticipating the delicious buffet to follow, you patiently sit through the slideshow, which includes 62 pictures of the sunset on Waikiki. Shifting around on the couch with each passing minute, you find yourself forcing excitement into your muttered "ooohs" and "aaahs."

Reflecting on the long and tedious slide show, you realize that what was missing in the pictures was Leslie. How was Leslie affected by the sunset? What meaning did the sunset have for him? You also realize that *you* were not "in the picture". Instead, you were passively squirming on the couch, doing your best to act engaged from the margins.

So it is with writing and presenting. You, as the photographer-author, and the sunset, which is the content or the substance of your message, *must both be visible* in your professional writing and presenting. The content cannot stand alone; it needs to be you and the content. What meaning does the content have for you? How were you changed through learning the content? It follows naturally, of course, to also focus on how the readers might be changed. What meaning does the sunset have for the reader or the audience? Publishing and presenting, then, must include you, the reader, and the sunset; otherwise, the result is a dull Friday evening.

Acknowledgment: My deepest gratitude to Wilma Clark, Mary Thelen, and John Hildebrand—for teaching and learning with me about the writing journey, the bumps along the road, and the sunset.

The invitation in this chapter is to examine the publishing and presenting process with an emphasis on linking yourself with the reader and the sunset. As you transition to the advanced practice role, these guidelines will enhance your success as a writer and presenter in your professional development.

MAKING THE TRANSITION

The transition begins where you are now. Your life is bubbling over with graduate coursework, research requirements, employment, family, friends, and personal activities. In all of this bubbling, you are developing new expertise and feeling the growing wings of confidence (at least on most days). As part of the graduate school experience, your "voice" changes and intensifies.

Olshansky summarized the role that writing plays in developing one's voice: writing demands introspection, which leads to self-reflection, and then growth occurs. Being self-reflective is essential as you accept the new challenges of the advanced practice role. "Writing is a way of living the examined life" (Olshansky, 2003, p. 177), and the examined life is necessary for a healthy transition.

This transition into the advanced practice role does not begin after graduate degree completion. It really began when you first started thinking about graduate school: Is graduate school for me? Can I be successful? Do I have the skills? How will it help me and how might my professional work be different? Similarly, writing for publication and polishing your professional presentation skills must begin while you are in the graduate program. Waiting until "after I'm finished" means it may never happen.

Recently, I accompanied a friend to an informational meeting for potential applicants to a nursing doctoral program. Discussing the application, someone asked, "I'm in trouble . . . I completed my master's degree 8 years ago and I was planning to write an article once I began working as an NP, but that never happened . . . what do I do about this now in my application portfolio?" Another individual concurred, "I'm glad I'm not the only one . . . I wrote one article in a CNS journal 12 years ago when I was a student . . . is that too old?" The ensuing dialogue was a "hunt" for other ways the applicants could demonstrate professional writing and thinking skills.

I believe that both applicants possessed the thinking skills necessary for doctoral work. The problem, however, was that their identities as advanced practice nurses did not include professional writing and presentation, re-

gardless of their future interest in doctoral study. Because of this gap, their expertise and contributions to the nursing body of knowledge were missing. They were disengaged from this medium of professional discourse, which "allows us to grapple with controversies and sift out the various arguments in the hopes of making decisions and advancing the discipline" (Olshansky, 2003, p. 177).

An advanced practice role must include professional writing and presenting. These are both opportunities and responsibilities and are an integral part of your identity in this new role. By not valuing, practicing, and developing these skills while in graduate school, it is easy to slide down the slippery slope into a technical conceptualization of the role.

Transition models often include some notion of "connectedness." For example, Bridges (1991) described the *reorientation phase* as a final step in transition; in this phase, connectedness is associated with a redefinition, new meanings, and a new identity. According to his three-step model, transition commences in an *ending phase,* where familiar ways are "let go." A *neutral phase* follows, as a bridge to *reorientation.* Confusion, disequilibrium, and a loss of harmony and familiarity often fill the *neutral phase,* where one recognizes that previous expectations or actions no longer work. Publishing and presenting are part of the connection with, or "buying into," the new advanced practice role in the *reorientation phase.*

ONE GRADUATE STUDENT'S STORY

So how is this transition experienced? What insights can be learned from connecting with publishing and presenting? I recently enjoyed a luncheon discussion with a current master's degree student nurse and her experience with the publishing process. Rose (not her real name) is a coauthor of one article in press, and a second submitted manuscript, both reports of nursing education research.

Rose related several key things that she learned. First, she realized that "normal people write;" it is not only the established, nationally known nurse scholars who are authors. "It could be a new father writing at the kitchen table with a child in the high chair next to him, or a young mom in the dining room with a toddler throwing food across the table," she laughed. For Rose, it also changed the way she examined articles, focusing on author biographies, thinking about positions they held, and placing herself more intimately in the "hall of authors".

Second, Rose gained a deeper insight into the writing process. Not only did she develop skill in condensing and identifying major points (e.g., decreasing a six-page literature review to five paragraphs), but she also appreciated writing as hard work (sometimes even bordering on drudgery). "I may not always feel inspired . . . it may not always flow naturally," she was quick to point out, but "it was always fulfilling . . . and I improved with practice." A helpful strategy, particularly during the harder, less-inspired writing times, was to break the entire piece down into smaller, more manageable components.

This and other approaches are described creatively in *Bird by Bird,* where Lamott (1994) presented various lessons about writing. Beginning with lessons learned on the floor of her father's study as a child, she described such things as getting started, short assignments, perfectionism, help along the way, and publication. Lamott warned, however, "publication is not all that it is cracked up to be. But writing is. Writing has so much to give, so much to teach, so many surprises" (p. xxvi).

Finally, Rose appreciated the power of professional discourse. In this process, she developed a keener ability to review others' writing and also open herself more to peer critique of her own writing. This fostered a richer relationship with the coauthors. Also, the manuscript submission procedure was demystified: "I could do this myself now." Through this professional discourse, Rose felt a greater sense of responsibility in her authorship than in papers she had written merely as course requirements: "this was something *real* people will use, I knew it had to be true and it had to make sense . . . . our articles really may influence how other people teach . . . I found this experience was good for me and good for others."

THINKING ABOUT THE READER OR THE AUDIENCE

Readers read professional literature for a reason and you need to figure out the reason. This underpins the move from writer-based presentation, where the description was focused primarily on what you learned or what happened to you, to reader-based presentation. Hooking the reader or the conference attendee is the goal. Begin with an issue or question from the reader and one for which you have some response. What have you solved, developed, or examined that will be useful to others? This may be a method, a population-specific intervention, a program, or an insight. The unique idea may relate to direct patient care, to a resource issue, or to collaboration

within the unit or larger system of health care. You may already have done a substantial examination and some writing about the readers' issue or question. Furthermore, in a persuasive piece, you may convince the readers that they have an issue or a question that begs exploration and that you have a valuable perspective.

Knowing the reader, then, is paramount. In your daily advanced nursing practice, you will meet the readers as your nurse colleagues. Reviewing the target audience of a particular journal or the attendees at a conference where you will be presenting is also essential. Are they nurse practitioners involved directly with clients and families? Are they clinical nurse specialists working largely with staff development? Are they nurses, as well as non-nurses? Are they educators or researchers? Several months ago, a colleague asked me to review a manuscript she was close to submitting. "What journal are you planning to submit this to . . . .and who are the readers?" were the first questions I asked. Believing her manuscript was nearly "polished," she quickly realized it was not "shaped" for the intended readers, since the journal and hence the audience had not been considered.

Your own graduate student experiences in selecting a journal for manuscript submission will be helpful. What journals have you found to be comprehensive and pertinent to the content area? What is the research base in their articles? For whom are the articles intended? How organized, clear, practical, and accurate is the writing? If you have found numerous errors in the references, for example, or heavy use of secondary sources framed as primary sources, you may suspect other credibility gaps as well.

In addition to your practice and reading experiences, journals also publish a brief section guiding authors. Identified as "information for authors" or "manuscript guidelines," this information is available in the printed journal and online. Reviewing these carefully is a must, since the manuscript types and content areas that are accepted by the journal are delineated (e.g., practice-focus, research, literature reviews, policy, opinion pieces). Also, skimming articles in a recent issue to examine style, tone, research base, and intended audience will help you decide if your manuscript "seems to fit." Finally, the journal's information for authors will identify the specific writing format to be used in preparing the manuscript, for example, American Psychological Association (APA, 2001) or Modern Language Association (Gibaldi, 2003).

Several references guiding journal selection and examining readership are available. Northam, Trubenbach, and Bentov (2000) published results of a nursing journal survey, including numerous characteristics of over 70 journals

such as areas of focus, acceptance rate, reasons for rejection, and acceptance to publication details (i.e., time for acceptance, time for publication, editorial style, etc.). Daly (2000) also summarized descriptions of nursing periodicals in a useful handbook format.

Selecting a journal that is peer reviewed is a basic criterion. In the peer-review process, two or three content and/or method experts provide a double-blind review to assist the journal editor in making publication recommendations to the authors. The peer-review process assures a minimum standard of quality in the published literature. For beginning writers, however, it may be advantageous to select state, regional, or national newsletters or other non-peer-reviewed publications as initial writing outlets. Not only is there a faster turnaround time to dissemination, but the submission process is less complex and one's confidence is boosted along the way. Moving toward a peer-reviewed publication then can often follow more easily.

GUIDELINES AND STRATEGIES

And now let's look at the sunset. Thinking about the reader or audience frequently occurs simultaneously with the process and structure of writing. Several key writing tips are provided in Table 10.1, such as overcoming writer's block, focusing on structure, writing with others, and seeking a mentor. Often, the most challenging barrier is to work through an idea, or even to select one of many swirling ideas. Using a free-writing exercise, put your pen to paper (or fingers to keyboard) and simply write anything that comes to your mind, without stopping, for a limited period of time (e.g., 10 to 15 minutes). To get started, begin with the phrase "I don't know what to write, but . . . ." Free-writing exercises can be done on several different occasions, a few days apart. After some time away, go back and circle "hot spots" (a new or key idea, an insight) that may provide an impetus for a manuscript or even a thesis statement. Compiling a list of anything that comes to mind, without deleting an idea because it "doesn't seem very good," also can generate or shape ideas. Thinking out loud with someone who is a skilled listener and can probe with questions that unravels your web of ideas serves a similar purpose.

In advising emerging scholarly writers, an English professor friend maintained that a *top priority is specific and dense content*: "provide an example with a few words . . . it needs to be tight and sparkling . . . the reader

TABLE 10.1 Guidelines and Strategies for Writing and Presenting

Overcoming writer's block
- Use free-writes, lists, thinking out loud
- Write small pieces

Focusing on structure
- Organization
- Specific and dense content
- Readability

Writing and presenting with others
- Peer review and dialogue
- Consensus building and order of authors

Seeking a mentor
- Be deliberate
- Stay connected with academe
- Develop a network with other scholars
- Provide mentorship to others

quickly says, 'I got it!'" To achieve this writing density, she suggested brevity: "write a piece, and then cut it in half . . . use one- or two-syllable words, not four- or five-syllable words." The structure must be organized, where the reader can move quickly and easily through the writing. If the reader is struggling to stay with you in format, language, or organization, your message may be lost, no matter how notable the content; disorganization and confusion prevent the reader from "getting it." Award-winning ideas can be lost in murky, musty writing swamps.

Dexter (2000) described specific writing tips, including strategies to enhance clarity, precision, accuracy, logic, and depth. For beginning writers, the following may be helpful: (a) use an outline to plan and organize the paper; (b) after setting aside a manuscript, read it out loud (grammar problems, incomplete sentences, extra long sentences or paragraphs will be more easily heard than seen); (c) use transitions within and between paragraphs to strengthen flow and connections; and (d) paraphrase and use references precisely.

Writing or presenting with others is a strategy that may be beneficial. By providing feedback and receiving critique from coauthors, your writing abilities will further develop. In addition, meetings and scheduled timelines with others provide structure, since it may be tempting to set aside writing opportunities. Of course, sharing the brainstorming and dialogue enriches and enlivens the process. However, especially with multiple authors who

have not written together, consensus building and blending different writing styles can take more time. A word of caution: clearly determine author order (primary, secondary, etc.) at the outset, based on agreed-upon contributions and responsibilities.

Mentorship in publication and presentation is essential. As a beginning writer, be deliberate in choosing one or several individuals that agree to be your writing coaches. More recently it has been recognized that mentoring relationships (which are more long-term, collegial, and transformational for both parties than a preceptor relationship) rely not only on the mentor seeking and supporting the mentee, but also on the mentee explicitly asking for mentorship.

The connectedness, as well as the new identity and meanings of the reorientation phase in transition continue as lifelong endeavors. Publication and presentation do not end with graduate education or the years that immediately follow. Staying connected with mentors from your academic setting will provide continuing support of your scholarship. This can be done individually, or through alumni associations, honor societies, or school-sponsored activities, as well as through an adjunct faculty position. Establishing links with other scholars who are involved in publishing and presenting in your work setting or in professional organizations will also expand your network. Professional journal meetings, coauthorships, or unit-based presentations are examples.

Finally, in your transition to publishing and presentation, take nurse colleagues with you. All too often, nurses in advanced practice roles move away from the staff nurses, literally and figuratively.

MOVING AN IDEA FORWARD

Here we will provide a brief overview of the publication and presentation process. Nemcek (2000) and Oermann (2002) have described this process in detail and their discussion will be helpful to both beginning and more seasoned writers.

As can be seen in Table 10.2, selecting publication or presentation is an early decision. Presentations may be appealing for those who are less attracted to writing as a medium, and dissemination via presentation usually occurs more quickly. Often, early presentations may involve a description of what is being done in your work setting. With this type of content, being a national expert is not expected. You are presenting a practice change,

Table 10.2 The Publication and Presentation Process

- Publication or presentation?
- Peer review from colleagues
- Submission, following manuscript guidelines
- Awaiting the journal or organization response
- Preparing the presentation
- Celebrate the dissemination

for example, "what is being done in my setting . . . and what we have learned." Recognizing that others value your message and want to learn from your experiences is empowering and confidence building. On the other hand, presentation often demands more spontaneity, including dialogue with conference attendees, whereas writing tends to be less public and at a pace that may better suit your personality. Finally, a mentor early in my career suggested that I first present a topic at a conference, learn from the dialogue, and then revise and shape the piece for publication. She assured me that this sequence would result in a greater chance of publication and a stronger article.

In addition to choosing presentation or publication as a method of dissemination, presenting with a poster format is also a possibility and is sometimes seen as less intimidating. In poster presentations, content is summarized visually using text, pictures, graphs, models, and the like. Posters are then exhibited in an open area with an opportunity for dialogue with interested individuals. Frequently, networks are established and maintained around an area of interest in this format. Also, poster abstracts are often included in conference proceedings for later reference.

Securing peer review from colleagues is a second component of both publishing and presentation. Forming a circle of writers with a variety of skills is helpful: a conceptual, abstract thinker; an organized, structured, logical thinker and writer; and an "editor type," detailed reviewer. Everyone in the writing circle must be committed to honest and thorough feedback. Skimpy or superficial responses, like "this is a good piece" or "suitable for presentation" are rather useless.

Precise adherence to the manuscript guidelines or the organization's call for abstracts is essential, particularly page limits or word counts, format, and content focus. A response from the journal editor after manuscript submission can vary from 6 weeks to nearly a year. Following the ethics of publishing, a manuscript can only be submitted to one journal at a time.

The editor's response also may vary; he or she compiles the peer reviewers' appraisal and then typically decides to (a) publish as is, (b) reconsider after suggested revisions, or (c) not publish.

Interestingly, I have received peer reviews on the same manuscript from the same journal from both ends of the continuum: "publish as is" from one reviewer and "do not publish" from the second reviewer. After receiving the review from the two peer reviewers, the editor took the middle ground, recommended revisions (which I did), and published the article. I learned about the "humanness" of the process and the value of perseverance.

Thoughtfully preparing a professional presentation for a conference meeting is a must. There is nothing duller than listening to a paper read word-for-word for 20 or 30 minutes. Times and formats for presentations vary significantly; they can be grouped into 5–6 ten-minute summaries in one hour, or they can be 60–90 minutes long for one detailed presentation and dialogue. There is usually a format choice to be made when submitting the abstract. Consider presentation aids carefully: handouts, PowerPoint, overheads, and the like. As with publications, the same principle applies to professional presentations: they must contain you, the audience, and the sunset.

With both manuscript and abstract submission, rejection is a possibility. Recognizing that everyone has a "pink slip" in their file, mentors are invaluable in helping you stand back up, dust yourself off, and revise, reshape, and resubmit. It may be worthwhile, also, to invite another coauthor to the manuscript for a fresh look at additions and revisions.

Regardless of the outcome of your article or presentation, you must celebrate your achievement. Not only is basking in the warmth of the accomplishment important, but it also reenergizes a forward movement. As the publishing and presenting process unfolds, there is value in having several different pieces in various phases, rather than a single linear progression (i.e., write, publish, write again, publish, etc.). If one article is rejected, another may be accepted, and you can sustain a livelier momentum by keeping several "irons in the fire."

CONCLUSION

Throughout this chapter you have been examining yourself in transition to professional writing and presentation, considering the reader, and exploring guidelines and "how-to's" with regard to content (the sunset). This transi-

tion is never complete. These lines from "The Journey" by Mary Oliver (1986) reflect the patience and calling, as well as the pleasure and personal nature of moving forward: "But little by little, as you left their voices behind, the stars began to burn through the sheets of clouds, and there was a new voice, which you slowly recognized as your own, that kept you company as you strode deeper and deeper into the world." (p. 38–39) May your journey into the world of publishing and presenting be filled with the joyful challenges of intellectual inquiry and the glow of living the examined life.

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Chapter 11

MARKETING AND NEGOTIATING ADVANCED PRACTICE ROLES

Jennifer Peters

Changes in the health care system will continue to dramatically shape the careers of advanced practice nurses (APNs). The health care marketplace of the 21st century presents challenges and opportunities for APNs. Understanding and using principles of this marketplace will enable APNs to position themselves for successful and dynamic careers. This chapter addresses strategies that APNs can use to manage their careers and market themselves in an APN role.

HEALTH CARE DELIVERY IN THE 21ST CENTURY

Prediction is at best an inexact science; particularly in the rapidly evolving field of health care delivery. Understanding the realities of the health care delivery system will enable APNs to anticipate career opportunities and avoid significant career hazards. Over the next decade the following characteristics of the United States health care system will likely affect the careers of APNs (Bodenheimer & Grumbach, 2002; Institute of Medicine, 2003; Pew Health Professions Commission, 1998; Porter-O'Grady, 2003):

- Expanded efforts to control health care costs
- Consumer and payer demands for care that is
    - safe
    - high quality
    - accessible
    - equitable

    - effective
    - individualized
- Increased competition between providers for market share
- Use of evidence-based systems to guide clinical interventions and analyze outcomes
- Reduction in institutional care, particularly acute care services
- Increasing focus on primary care, including alternative and nontraditional therapies
- Greater demand for chronic care services, particularly for an aging population
- Development of service models to address increasing ethnic diversity of the population
- Expansion of capitated, subscriber-based systems
- Development of interdependent, rather than independent, practice models
- Rapid growth of medical and pharmaceutical technology
- Expansion of computer information systems for service delivery, outcomes analysis, and cost control
- Persistence of the registered nurse shortage
- Contraction of the overall job market, with increasing competition for desirable positions

MAXIMIZING APN OPPORTUNITIES: A MARKETING APPROACH

Success in this competitive marketplace is dependent on the ability of APNs to deliver valuable services and to effectively market these services (Lachman, 1996). Marketing is determining what the client wants or needs, designing a product/service to meet that need, and then communicating information about the product/service to potential clients (Dayhoff & Moore, 2004; Lachman, 1996). The marketing process is guided by four concepts—the four Ps: product, price, place, and promotion. In addition, the potential client, market segment, or target population of the marketing effort must be identified.

For some APNs, marketing may seem uncomfortable or even unprofessional. Negative images of salespeople, the "hard-sell," and aggressive advertising may come to mind. Marketing is not any of these. In essence marketing is about establishing a relationship between the APN and potential clients that demonstrates the competence, necessity, and value of APN services in meeting a need of the client (Dayhoff & Moore, 2004).

Depending on their career stage, APNs target their marketing efforts to diverse prospective clients. During a job search, APNs market themselves and the APN role to potential employers. Current employers may be the focus of marketing to diversify services or achieve a job promotion. Consumers, the community, and other health care providers may be customers for entrepreneurial or independent practice ventures.

Whatever the target market, the characteristics of potential clients need to be examined. Geographic, demographic, economic, and psychosocial variables should be explored (Pakis, 1997). Sources of information on potential clients include census data, newspaper and media reports, employment offices of potential employers, needs surveys, focal groups, web sites, and personal contact with potential customers. The objective is to focus on potential clients and work with them to identify the services they need and want (Dayhoff & Moore, 2004).

The first P of marketing, *product,* refers to the APN him/herself. Components of the APN "product" include education, certification, experience, and achievement. Unique and special characteristics of the APN should be highlighted to distinguish them from competitors. The individual APN should seek to define a personal niche.

The second P of marketing, *pricing,* involves exploration of the worth of the APN product in the market. Salaries and fringe benefits should be carefully analyzed for specific geographic regions and work environments. Once again, analyzing the competition and the current market through personal, informal contact is helpful. Much salary information is also available on the web sites of APN associations.

The third P, *place,* refers to the geographic places and health care institutions where APN services are to be delivered. Questions to explore include: Are APNs currently practicing in this environment? How many? What kind? What are the characteristics of the environment that are conducive to APN practice? What barriers to APN practice exist?

The fourth P of the marketing process, *promotion,* or selling a service should only occur after the product, price, and place of the service have been identified.

Specific APN Marketing Strategies

Self-Inventory

Self-inventory and reflection are elemental components of APN career development and must occur as precursors to the market plan. Critical, reflective questions to ask include:

- Who am I?
- What do I believe and value?
- Where and what do I come from?
- Where am I now?
- Where am I going and why that direction?
- How will I get there?
- How will I know when I have attained my goals? (Neubauer, 1998, p. 3)

Price (1998) suggests the exploration of five points during self-reflection: abilities, interests, values, needs, and characteristics. Abilities can be analyzed through identification of skills, achievements, and failures. In addition to clinical and care giving skills, APNs should consider abilities such as communication, teaching, consultation, research, leadership, organization, computer proficiency, mentoring, writing, political action, and others. Interests may be identified by listing desirable professional activities. Values are those principles or qualities that guide life and work. Listing and prioritizing values can clarify the relative importance of competing interests such as career, family, friends, and other demands.

Needs are identified by listing satisfiers and dissatisfiers in prior work situations. Desired levels of control, power, salary, independence, security, recognition, creativity, and achievement often appear on a list of needs. Finally, individual physical, emotional, and intellectual characteristics relevant to career and job performance should be listed. Factors such as physical limitations, endurance, stress tolerance, enthusiasm, creativity, sensitivity, knowledge level, and learning ability are but a few individual characteristics to inventory (Price, 1998). For APNs unfamiliar with self-inventory, detailed and helpful formats are available in the popular press (Bolles, 2003).

Knowledge Building

Demonstration of clinical knowledge and competency is the cornerstone of the APN marketing process. In addition to clinical knowledge, APNs must also possess knowledge about professional issues, the health care needs of the community, and the marketing process. To successfully market oneself and the APN role, APNs must develop a working knowledge of:

- Standards for clinical practice in the specialty area, including current research
- Regulations affecting advanced practice including licensure, certifica-

tion, prescriptive privileges, institutional credentialing, and collaborative practice
- Reimbursement patterns and regulations
- Health care services and unmet needs in the target market
- The role and services of competitors in the target market
- Communication skills including professional networking and negotiation
- The target market's perception and utilization of APNs

Sources of information include professional APN associations, APN publications, governmental websites, and the web sites of relevant state boards of nursing. The journal *Nurse Practitioner* publishes state by state annual reviews of legislative issues and regulations that affect APNs, and are particularly helpful (Pearson, 2004).

Developing an Ideal Job Description

For APNs seeking employment or promotion, developing a sample job description can be a helpful step in identifying and prioritizing the desirable attributes of a position. This job description provides a basis for informed negotiation during job interviews. Self-inventory, literature, and information from fellow APNs provide a basis to formulate the job description. It is important to be specific about desired job functions and job benefits. Specific dollar amounts should be attached to salary and monetary benefits. Specific amounts of time should be identified for vacation and leave time. Specific percentages of time spent in various job functions should be considered. Table 11.1 lists information to include in a sample job description (Bolles, 2003; Shapiro & Rosenberg, 2002).

Developing a Career Portfolio

Career portfolios are personal files containing evidence of professional knowledge, development, and achievement (McMullan, et al., 2003). Development of the portfolio continues throughout an individual's career. The career portfolio is the resource from which documentation can be selected to use in marketing. Most individuals maintain two types of portfolios, closed and open. The closed portfolio is personal, only viewed by the individual, and serves as the master file documenting career achievement. The open portfolio is used as a marketing tool and shared with potential

TABLE 11.1 Elements of a Sample Job Description

Position functions and responsibilities

- Percentage of time (productivity expectations) for clinical care, client education, consultation, and research
- Usual and additional work locations
- Usual hours of work and on-call, weekend and holiday responsibilities
- Collaborative and independent responsibilities

Position qualifications

- Academic and continuing education
- Certification and licensure
- Professional experience
- Other (insurance, practice agreements, institutional credentialing)

Position in organizational structure

Performance evaluation

- Frequency
- Criteria for evaluation
- Evaluators

Salary range desired

Benefits desired

- Paid vacation days
- Paid sick days
- Paid holidays
- Retirement benefits (employer contribution, time required for vesting)
- Medical and dental insurance (individual and family coverage, portability, preexisting conditions coverage, pregnancy coverage, prescription coverage, long-term care options)
- Life insurance
- Short and long-term disability insurance
- Malpractice insurance
- Licensing and certification fee reimbursement
- Continuing education (travel, conference fees, meals, lodging)
- Orientation period (duration and content)
- Tuition reimbursement or waivers
- Professional membership dues
- Subscriptions to journals and texts
- Office, parking, computer, E-mail access, office supplies, medical supplies/equipment, personal digital assistant (PDA)
- Medical and clerical support personnel
- Answering service, pagers, and cell-phone
- Mileage reimbursement
- Interview and relocation expense coverage.

TABLE 11.2 APN Professional Portfolio

- Current resume and curriculum vitae
- Official transcripts of all academic programs post high school
- Copies of nursing licenses and certifications
- Current list of references with addresses and phone numbers
- Malpractice insurance policies
- Records of continuing education attendance
- Reprints of publications
- Abstracts or brochures documenting conference presentations
- Newspaper or media recognition
- Evidence of honors or awards
- Prior references, recommendations, and performance evaluations
- A sample job description listing desirable job functions and benefits
- Examples of clinical and leadership achievements such as patient education programs/tools; history and physical examinations; quality improvement projects; and research utilization projects
- Professional organization memberships
- Health records pertinent to APN employment
- Volunteer and community activities

employers and target markets. The open portfolio contains selected elements of the closed portfolio that are relevant to the current market. Open portfolios can be very powerful tools in the marketing or job search process because they demonstrate achievement and an organized approach to marketing (Weinstein, 2002). All professionals should maintain a hard-copy portfolio. However, electronic portfolios are also available through academic web sites. Table 11.2 lists items that APNs may want to include in a closed or open personal career portfolio.

Since the APN role is relatively new and often poorly understood in some potential markets, it is also helpful to maintain a master portfolio of documents describing and validating the APN role. Sharing this information with potential employers or markets can be very helpful. This portfolio includes research articles demonstrating the effectiveness of APNs, copies of APN practice regulations, and brochures from practice organizations that document the role of APNs.

Résumés and Curricula Vitae

Résumés and curricula vitae (CVs) are powerful tools for individual marketing. A current résumé and CV are essential components of the APN

portfolio. They are used to communicate professional credentials to prospective employers, current employers, and colleagues. While both describe professional and educational accomplishments, they differ in format and application.

Résumés are one or two page overviews of an individual's professional career. They are used to quickly communicate one's credentials and abilities to potential employers. Brevity is important. There is no single, correct format for a resumé; it should be tailored to the prospective position. Functional resumés highlight areas of skill and expertise. Chronological resumés present the job history in chronological order. Critical information for any resumé includes name, address, phone numbers, e-mail numbers, fax numbers, education/degrees earned, professional employment, and licensure/certification (no license numbers). If space allows, selected information about publications, honors/awards, research/grants, presentations, teaching experience, consulting experience, membership in professional organizations, specific clinical or professional objectives, languages spoken, community service, or military service may be included. Information is often presented in reverse chronological order, with the most recent events being listed first in each category of the resumé. Table 11.3 shows a typical chronological resumé for an APN.

Curricula vitae are more lengthy descriptions of professional career and qualifications. They are often called academic resumés because of their use in academic settings. There is no maximum length for a CV; they will typically address all of the essential and additional information categories listed in the preceding discussion of resumés.

Résumés and CVs are usually designed by APNs on a personal computer. Use of the personal computer enables updating and individualizing for prospective employers. Books, journal articles, and software are readily available to guide those less familiar with the process. Inexpensive, helpful resources include Bolles (2003), Coxford (2001), and VGM Career Horizons (2001). Most academic institutions have free-access web sites available to assist with resumé and CV composition. Resumé design services are also available through professional printers.

The physical appearance of these documents is extremely important. They are often the first impression a potential employer has of an APN. A poorly designed resumé or CV may close the door to interviews with prospective employers. They should be neat, concise, well-organized, visually appealing, and contain no errors in spelling or punctuation. High-quality paper should be used in printing. White or off-white paper with

TABLE 11.3 Sample APN Resume

	Maria R. Lewis, MSN, RN 2231 Echo Lane St. Paul, MN 55105 (615) 222–2222	
Objective	Gerontological Nurse Practitioner in a Community Setting	
Education	2004	University of Minnesota Minneapolis, MN Master of Science in Nursing
	1992	University of Michigan Ann Arbor, MI Bachelor of Science in Nursing
Experience	1995– present	Eastbrook Long-Term Care Center Roseville, MN Clinical Coordinator
	1993– 1995	Midwest Regional Medical Center Ann Arbor, MI Nurse Manager—Coronary Care Unit
	1990– 1993	Midwest Regional Medical Center Ann Arbor, MI Staff Nurse—Coronary Care Unit
Licensure	RN, Minnesota	
Certification	Gerontological Nurse Practitioner, ANCC	
Honors/Awards	Gerontology Scholarship, University of Minnesota, 1997 Sigma Theta Tau, 1990	
Publications	Lewis, M. (1996). Assessing cardiac function in older adults. *Long-term Care Nursing, 12,* 221–223.	
Professional Organizations	American Nurses Association Minnesota Gerontology Association	
Languages	Fluent in Spanish and French	
References	Available on request	

black print is most commonly used to give a traditional, professional appearance to the resumé or CV. It is helpful to have colleagues review and proofread these documents.

Information on résumés and CVs must be accurate and truthful. Many prospective employers define the information or format that should be

used. Some things should not appear on the resumé or CV including: professional license numbers; names of references; salary expectations; and personal information such as age, gender, ethnic background, height, weight, marital status, health status/disabilities or social security number.

When a resume or CV is sent to a prospective employer, a cover letter should always accompany it. The cover letter introduces the APN to the prospective employer. It should be individualized to a position and express enthusiasm for future employment. The cover letter is direct, brief (no more than one page), and written in standard business format. Whenever possible, address the cover letter to specific person. The letter should include the reason for writing and briefly highlight accomplishments. The previously suggested resources for resumé writing also have many helpful examples of cover letters. Table 11.4 is a sample cover letter to accompany an APN resumé or CV. It is important to follow up by telephone or mail on all resumés/CVs that have been sent to prospective employers. Follow-up indicates enthusiasm and persistence; two attractive qualities in potential employees. This communication should be initiated within 2 weeks of sending these documents.

Locating Opportunities

For most APNs, career opportunities do not just materialize; finding a great position is not just a matter of luck. Preparation, persistence, and personal contacts are fundamental requirements. Most positions are located through personal contacts or networks. Developing a network is not difficult, but it does require the willingness to meet and communicate with new people. Every person the APN knows or knows of should be considered a potential contact. Helpful networks for APNs to explore include local professional organizations, other APNs already working in the same role, nurse managers in local health care organizations, faculty, and anyone else who may have knowledge of APN opportunities. Telephone contacts and personal meetings are both effective means of making contact. Meeting contacts over breakfast or lunch is a tried and true networking technique.

Traditional job search strategies should not be ignored. Weekly review of newspaper and web site employment listings is important. In addition, professional journals often advertise for APNs. Mass mailings of resumés are generally not advisable, unless they are preceded by personal contact (Bolles, 2003). For APNs planning to use a professional job search firm, it is advisable to thoroughly research the track record of the firm and their experience/success in placing APNs.

TABLE 11.4 Sample APN Cover Letter

Maria R. Lewis, MSN, RN
2231 Echo Lane
St. Paul, MN 55105

September 1, 2004

Jane S. Parsons, PhD, RN
Director, Clinical Services
Gerontology Nurse Associates
3640 Simpson Street
Minneapolis, MN 55455

Dear Dr. Parsons:

We spoke briefly at the Minnesota Long-Term Care Conference about a position for a Nurse Practitioner at Gerontology Nurse Associates. I am writing to express my interest in that position. I have recently completed my graduate nursing studies and have received my certification as a Gerontological Nurse Practitioner. I would like to pursue a career as a GNP in community and long-term care settings. My prior clinical and leadership experience in long-term care and cardiovascular nursing provides me with an excellent background for this field. In addition, my fluency in several languages is an asset in today's health care environment.

I have enclosed a copy of my resume for your review. I am interested in interviewing for the position and I can be reached at (615) 222–2222 or at lewis1234@online.com. Thank you for your consideration. I look forward to speaking with you.

Sincerely,

Maria R. Lewis, MSN, RN
Enclosure

Interviewing

Numerous books have been written about job interviewing; however successful interviewing is not difficult. Essentially, the interview is an opportunity for the applicant and the prospective employer to meet, exchange information, and evaluate whether or not there is a "fit" between the organization and the candidate. Both parties are trying to determine if they

have something to offer each other by exchanging very subjective information and cues.

In a competitive environment, APNs should expect to complete several interviews before locating an acceptable position. Typically employers will utilize a series of interviews when hiring for APN positions. Applicants are screened in initial interviews. Follow-up interviews are scheduled for those applicants who progress beyond the screening. The interview process may take many weeks to complete. Usually APNs will meet with several individuals from the organization during the interview process.

Interviewing requires homework. As previously discussed, APNs need to be informed about the characteristics of the organization. Physical preparation for the interview is also important—first impressions count enormously. Dress neatly and conservatively. Arrive for the interview on time. Bring the organized, open portfolio in a folder that can be left with the interviewers. Psychological preparation is essential. While nervousness during an interview is typical, the ability to project self-confidence is important. For APNs unfamiliar with interviewing, Bolles (2003) offers detailed strategies for coping with interview anxiety. Anticipating questions that interviewers are likely to ask and developing a list of questions to ask are two means of reducing the anxiety of interviewing. Questions for APNs to ask during an interview are easily generated from the ideal job description. The following are questions typically asked of APNs in the interview process:

- What type of position are you interested in?
- Could you tell me about yourself?
- What are your strengths? Your weaknesses?
- What do you know about our company?
- What would you do in this situation (typical situation described)?
- Why are you leaving your present job?
- What are your professional/career goals?
- What do you enjoy most about work? Least? Why?
- Why should we hire you for this position?
- What salary do you expect?
- What questions do you have about this position? This company?

Federal law prohibits asking certain questions during the interview. It is unlawful for an interviewer to ask about age, date of birth, children, age of children, race/ethnicity, religious affiliation, marital status, military dis-

charge status, arrest records, home ownership, spousal employment, and organization/club memberships (Bolles, 2003). When such questions are asked, it is usually not out of malicious intent. However, it is best to prepare a gracious way of not answering these questions.

During the interview project a positive attitude, interest, and enthusiasm. Be friendly, smile, and make eye contact. Listen as well as speak. Be professional in all interactions. Focus on the position, qualifications, and experience. Ask for the job. Thank the interviewer for the opportunity and ask when the hiring decision will be made. Finally, follow-up with a written letter expressing thanks and continued interest in the position.

Negotiation and Employment Contracts

At some point in the interviewing process, the parties are likely to have different perspectives about the position, responsibilities, salary, or benefits. Negotiation is the process of resolving these differences. Negotiation should not be considered a win-lose, adversarial interaction. Rather, it is a win-win, or a gain-gain situation for all parties (Laubach, 1997). Successful negotiation requires preparation, innovative thinking, integrity, respect for the other party, and superior listening skills. Negotiations should be focused on outcomes/results rather than emotions (Shapiro & Rosenberg, 2002). The point of time to begin negotiation is after the prospective employer has expressed interest in hiring, but before the APN has agreed to take the job.

In the managed care marketplace, one of the most critical factors for APNs to understand and negotiate is the employment relationship. It is imperative to be absolutely clear on whether the position is classified as independent contractor or employee. In addition, critical questions about billing, primary provider listing, and productivity expectations need to be clarified. Finally, the level of collaboration or independent control APNs have over practice issues such as ordering tests, diagnostic procedures, and specialty care requires attention (Cady, 2001; Shapiro & Rosenberg, 2002; Stuart, 2001).

As part of the negotiations, the issue of whether or not an employment contract will be used should be discussed. In the past, APNs were often hired based on an informal verbal contract and handshake. Today it is much more likely that APNs will be asked to sign formal employment contracts or agreements. Employment agreements are legally binding contracts between employers and employees stating the terms of a working

relationship. The employment contract provides for job security since it limits and specifies the reasons for termination. In addition, the contract provides a vehicle to describe salary, benefits, productivity expectations, job functions, and hours of work. Before signing an employment contract, the APN should carefully review the contract, negotiate areas of confusion, and, if necessary, seek legal advice (Shapiro & Rosenberg, 2002; Stuart, 2001).

Employees hired without a contract are termed "at will." Technically, at-will" employees may be terminated at any time without cause. Most state laws provide some protection for employees who face termination without contract protection, but accessing this protection may be a lengthy process requiring legal advice (Cady, 2001).

When negotiating an employment contract, APNs should note covenants not to compete and termination clauses in the contract. A covenant not to compete is a contract clause that restricts an employee from practicing within a certain number of miles from an employer's business for a certain period of time after the employee leaves the employer's business. Covenants not to compete are legal and enforceable if the courts deem them reasonable. They protect the employer from APN competition in the event the APN leaves the employer. But, they restrict the ability of the APN to continue to practice in a geographic area. Table 11.5 contains an example of covenants not to compete. If possible, APNs should seek a contract that does not contain a covenant not to compete. If the employer insists on including the clause, the APN should seek a clause that is less restrictive in terms of duration or geographic area (Blumenreich, 1996; Buppert, 1997; Stuart, 2001).

A typical employment contract will contain a termination section which will list events that are bases for termination of the employee "with cause." These events include loss of license/certification, gross negligence, death, or conviction of a felony. Some contracts include a termination "without cause" clause that states that the employee may be terminated at anytime, for any reason, with 30 days notice. Rarely, should APNs sign a contract containing a termination "without cause" statement. It effectively removes the employee job security that the contract provides. The only circumstance in which "without cause" termination would be acceptable is when the APN is unable to commit to the full duration of the contract (Buppert, 1997). Table 11.5 contains examples of "with-cause" and "without-cause" termination clauses.

TABLE 11.5 Contract Agreements and Clauses

Covenants Not To Compete

Restrictive: "Upon termination of employment for any reason, the CRNA agrees not to practice within 50 miles of any present or future office of this practice for a period of 5 years."

Less Restrictive: "Upon termination of employment for any reason, the CRNA agrees not to practice within 25 miles of the current office of this practice for a period of 1 year."

Termination Clauses

Termination for Cause: "The employer may terminate this agreement at any time by written notice to the CRNA for any of the following reasons:

a. The CRNA dies or becomes permanently disabled;
b. The CRNA loses his or her professional license;
c. The CRNA is restricted by any governmental authority from rendering the required professional services;
d. The CRNA loses his or her staff privileges;
e. The CRNA conducts him or herself in a grossly negligent way."

Termination without Cause: "The employer may terminate this agreement at any time, for any reason, after giving the CRNA 30 days written notice."

SUMMARY

Changes in the health care marketplace will continue to generate opportunities for APNs who demonstrate competence, enthusiasm, and commitment to the role. Marketing strategies enable APNs to take full and timely advantage of these opportunities. Self-inventory, knowledge building, portfolio development, and positive negotiation can be used to build a successful and rewarding APN career.

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Chapter 12

LAUNCHING YOUR CAREER AS AN ADVANCED PRACTICE NURSE

Mary Zwygart-Stauffacher and Michaelene P. Mirr Jansen

Oh, the places you'll go. Today is your day. You're off to Great Places! You're off and away!

Dr. Seuss

Dr. Seuss (Geisel & Geisel, 1990) encourages graduates to risk, enjoy, and see what is ahead of them without apprehension and with excitement. This is excellent advice, and yet for advanced practice nurses completing the final papers, graduating, and beginning that first position, that time can be quite overwhelming. Transitions of any kind hold for the participant an opportunity for great growth and reward, but also a time that can be very challenging, and a little (or even very!) frightening. This array of emotions is all occurring during a very important time in one's professional life.

Certainly, one has heard horror stories of new APNs overwhelmed with their new positions, yet there are hundreds of APNs every year that complete their work week with feelings of great satisfaction and excitement for the weeks ahead. What is it that one can expect during that first year as an APN? What are some of the strategies that have been identified to assist the new APN in assimilating this new role? How does one not only survive, but also thrive, during those first few months as an APN? These are only a few of the many questions APNs face as they anticipate and enter that transition from graduate student to graduate prepared advanced practice nurse.

ROLE SOCIALIZATION

Role socialization and professional role development literature is replete with theories and strategies on role transition. Brykczynski (2000) identifies component process including 1) aspects of adult development; 2) development of clinical expertise; 3) modification of self-identity through initial socializing in school; 4) development and integration of professional subrole components; and 5) subsequent resocialization in the work setting. The APN begins the role transition while in graduate school with the acquisition of new knowledge and role performance expectations and implements this role socialization during the work experience. Role stress can occur at any time along this continuum. Great stress can occur for the new graduate nursing student, moving from the role of very capable experienced BSN prepared nurse to that of graduate student (Cusson & Viggaino, 2002). This role transition also occurs for newly graduated APNs as they launch into their first position.

The classic work of Kramer (1974) has been identified as having relevance for role socialization for APNs (Andrews, 2001) Reality shock, as contended by Kramer, could be diminished for novices if they were provided with real-world situations during their formal education. This work served as impetus for many schools of nursing to consider utilizing preceptorships for graduate nursing programs.

Kelly and Matthews (2001) in their qualitative study on the transition to the first position as a nurse practitioner found that participants, when asked to give a word or thought that would describe how they felt during the transition, included responses such as, "exciting, nervous anxiety, overwhelmed, scared, uncertain, panicky, novice, inadequate, halting, stressful, and frustration" (p. 3). Clearly this time can be a very emotional one for the new APN.

ROLE TRANSITION

Five essential factors have been found to influence role transitions (Schumacher & Meleis, 1994). They are: 1) the personal meanings of the transition, while related to the degree of identity crisis experienced; 2) the degree of planning, which involves the time and energy devoted to anticipating the change; 3) environmental barriers and supports, which refer to peer, school, family, and others; 4) level of knowledge and skill, which

related to prior experience and school experiences; and 5) expectations, which are related to role models, literature, media, etc. Therefore, the role transition one experiences following graduate studies is a process that begins as the student enters graduate school. During graduate school students are experiencing role acquisition as they rehearse new roles, develop clinical knowledge, and create support networks (Brykczynski, 2000).

A research-based model developed by Brown and Olshansky (1997, 1998) provides the new APN with helpful and practical guidance during the first year of practice. Initially based on the NP's role transition, it has been referenced as a model with probable utility for all advanced practice nurses. The process they describe is "limbo to legitimacy" with four categories/stages and several subcategories. Stage one, *laying the foundation,* is the time period immediately after finishing graduate studies, when the student is not yet a certified advanced practice nurse. Time is spent recuperating from school, negotiating the bureaucracy related to licensure and certification, and job searching. All the worry associated with these activities consumes the new APN. The time requires the APN to be busy doing both the external work of becoming a legitimate APN and the internal work of establishing a new personal role identity. It is important to keep in mind that there is no "perfect APN" position, only the more ideal beginning position for each individual. Therefore, new APNs must be clear on what their own needs and desires are, not what the expectations of others may be. Taking the needed time to prepare for one's initial position is important and one should not rush to start the new position.

Stage two, *launching,* is the beginning of the first position and continues for at least 3 months. An underlying aspect of this stage is a transition from the self-confident, competent RN to the uncertain APN. The APN works hard at "getting through the day"and is concerned with feeling real and confronting anxiety. It is also a stage in which one is battling time, being slow with the tasks and functions of the new role, and also impatient with oneself. Enormous effort is required to get through the day and perform the tasks required of the position. Basic daily work activities are strenuous and therefore the APN has little reserves. There also never seems to be enough time, and the new APN needs to schedule additional time for new tasks, and be willing to accept help and guidance from others.

Stage three *is meeting the challenge.* The APN is more realistic about expectations of the role. It is apparent as one become more competent and more comfortable in the system. APNs begin to build internal support systems to help meet professional challenges. They have increased competence

as defined by external manifestation, measurements, or behavior that reflects skillful professionals.

Stage four, *broadening the perspective,* occurs when one has a feeling of enhanced self-esteem and a solid feeling of legitimacy and competence. The APN is affirming progress based on feedback from others, and is now able to seek opportunities to develop even more complex skills. Comfort in the role is achieved and one is seen as a fully contributing member of the agency with a strong sense of accomplishment.

As the APN moves through the transition, to managing the change and challenges ahead, Draye, and Brown (2000) provide helpful suggestions in their work, "Surviving the Proving Ground: Lessons in change from NP Pioneers." These include suggestions such as, work to insure one's competence, maintain a clear nursing identity, and preserve one's autonomy. Additionally, an APN should recognize that control over one's own practice is essential when making decisions regarding clinical care/management, investing in the APN collective, advocating for quality care, and strengthening networks.

No role transition is ever without challenge, and for some the first APN position may not hold all that was anticipated. So what does one do if that first position is not what was expected? Sometimes, even after a careful and thorough job search, one can find oneself in an agency that simply is not a good or healthy fit. Thankfully, this does not happen very often, and if it does occur, the APN needs to carefully explore other options and be sure that a change in position versus a change in approach or attitude is what is truly needed. Hopefully, with an understanding of the transition process, the new APN will be able to discern if the conflicts and anxieties may be consistent with their role development or clearly a misfit.

Transitioning to the role of the APN can be a very rewarding and exciting phase in ones' career. Dr. Loretta Ford's shared words may be most fitting, "My final word for current NP's . . . is to take risks, chart new directions, study the results, learn from your mistakes, and enjoy the change" (Ford, 1997, p. 6). For today is your day! Your mountain is waiting . . . .So, get on your way! (Geisel & Geisel, 1990).

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Appendix

USEFUL WEB SITES FOR ADVANCED PRACTICE NURSES

www.aana.com	American Association of Nurse Anesthetists
www.aanp.org	American Academy of Nurse Practitioners
www.acnm	American College of Nurse Midwives
www.nacns.org	National Association of Clinical Nurse Specialists
www.awhonn.org	Association of Women's Health, Obstetrics and Neonatal Nursing
www.nche.edu	American Association of Colleges of Nursing
www.nursingworld.org	American Nurses Association
www.aone.org	American Organization of Nurse Executives
www.napnap.org	National Association of Pediatric Nurse Practitioners
www.nursingworld.org/ojin	Online Journal of Issues in Nursing
www.cms.hhs.gov	Center for Medicare and Medicaid Services
www.medicare.gov	Medicare (consumer)
www.thomas.loc.gov	Legislative Information on the Internet—Library of Congress
www.georgetown.edu/research/kie	The Kennedy Institute of Ethics
www.thehastingscenter.org	Hastings Center
www.nursingethicsnetwork.org	Nursing Ethics network

www.ispub.com/journals/ija.htm	Internet Journal of Advanced Nursing Practice
www.nih.gov	National Institutes of Health
www.ahcpr.gov	Agency for Healthcare Research and Quality
www.guideline.gov	National Guideline Clearing House
www.nurse.org.acnp	American College of Nurse Practitioners
www.npwh.org	National Association of Nurse Practitioners in Women's Health

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