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## Chapter: The Advanced Practice Nurse in the Community

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## Chapter

### The Advanced Practice Nurse in the Community

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## Objectives

After reading this chapter, the student should be able to do the following:

1. Briefly discuss the historical development of the roles of the advanced public health nurse and the nurse practitioner
2. Describe the educational requirements for population-focused advanced practice nurses
3. Discuss credentialing mechanisms in nursing as they relate to the role of the advanced practice nurse
4. Compare and contrast the various role functions of population-focused advanced practice nurses
5. Identify potential arenas of practice
6. Explore current issues and concerns related to practice
7. Identify five stressors that may affect nurses in expanded roles

## Key Terms

**administrator, p. <<**

**certification, p. <<**

**clinical nurse specialist, p. <<<**

**clinician, p. <<<**

**competencies, p. <<<**

**consultant, p. <<<**

**educator, p. <<<**

**Healthy People 2020, p. <<<**

**independent practice, p. <<<**

**institutional privileges, p. <<**

**Interprofessional collaboration, p. >>**

**liability, p. <<<**

**nurse practitioner, p. <<<**

**nursing centers, p. <<<**

**parish nursing, p. <<<**

**portfolios, p. <<<**

**prescriptive authority, p. <<<**

**primary health care, p. <<<**

**professional isolation, p. <<<**

**protocols, p. <<<**

**researcher, p. <<<**

**third-party reimbursement, p. <<<**

*See Glossary for definitions*

## Chapter Outline

Historical Perspective

Competencies

Educational Preparation

Credentialing

Advanced Practice Roles

- Clinician

- Educator

- Administrator

- Consultant

- Researcher

Arenas for Practice

- Primary Care

- Independent Practice

- Government

- Other Arenas

Issues and Concerns

- Legal Status

- Reimbursement

- Institutional Privileges

- Employment and Role Negotiation

Role Stress

- Professional Isolation

Liability

Interprofessional Collaborative Practice

Conflicting Expectations

Professional Responsibilities

Trends in Advanced Practice Nursing



This chapter explores the roles of the advanced practice nurse in the community. Why, one might ask, is this chapter in the text? For a few good reasons as it is the intent to provide the BSN student with an understanding of the career opportunities that may be chosen for continuing one's education to the graduate level. For the nurse in a graduate program the chapter will provide an in-depth understanding of the role in the specialty area that has been chosen. The advanced practice nurse roles described in this chapter offer excellent choices for exciting careers which will assure satisfaction that a major contribution can be made to making a difference in health outcomes and improved health status of clients at all levels.

The advanced practice nurse is a licensed professional nurse prepared at the master's level/ or doctoral level to take leadership roles in applying the nursing process and public health sciences to achieve specific health outcomes for the community; this nurse is often referred to as an **advanced public health nurse** (APHN) or public health **clinical nurse specialist** (CNS). Since both the American Nurses Association (2007) and the Association of Community Health Nursing Educators (ACHNE, 2007) refer to this specialized role as APPHN, this is the title that will be used in this chapter (see Nursing Tip 1). On the other hand, the advanced practice nurse in the community may be a **nurse practitioner** (NP). A nurse practitioner is generally a master's-prepared nurse who applies advanced practice nursing knowledge with physical, psychosocial, and environmental assessment skills to respond to common health and illness problems. Since about 2006, Nurse Practitioners were beginning to be prepared at the doctoral level through the Doctorate of Nursing Practice Programs (American Association of Colleges of Nursing [AACN], 1996; National Organization of Nurses Practitioner Faculties, 2006). The APPHN and NP often work in similar settings. However, their client focuses differ. The NP's client is an individual or

family, usually in a fixed setting who has the opportunity to identify individual trends in their practices. The APHN's clients may be individuals, families, groups at risk, or communities, but the ultimate goal is the health of the community as a whole (ANA/QUAD council 2007; ACHNE, 2007). The APPHN always has a population focus and obtains knowledge from nursing, social, and public health sciences to achieve goals of promoting and protecting the health of populations by creating conditions in which people can optimize their health (ACHNE, 2007; ANA, 2007). Table 39-1 compares the functions taught to the APPHN and the NP in their educational programs.

#### Nursing Tip 1 here

This chapter provides a history of the educational preparation of the advanced practice nurse. Functions in advanced practice and arenas for practice are discussed. Issues and concerns, role negotiation, and areas of role stress relative to the APHN and the NP in the community are also discussed.

### **HISTORICAL PERSPECTIVE**

Changes in the health care system and nursing have occurred in the past few decades because of a shift in societal demands and needs. Trends that have influenced the roles of the APHN and NP include a shift from institution-based health care to population-focused health care, improvements in technology, self-care, cost-containment measures, and accountability to the client, third-party reimbursement, and demands for making technology-related care more responsive to the client.

The CNS role began in the early 1960s and grew out of a need to improve client care. CNSs educate clients, communities, populations, families, and individuals; provide social and

psychological support to clients; serve as role models to other nursing staff; consult with communities, nurses and staff in other disciplines; and conduct clinical nursing research (Robertson and Baldwin, 2007).

In the United States during the 1960s, a shortage of physicians occurred, and there was an increasing tendency among physicians to specialize. The number of physicians who might have provided medical care to communities and families across the nation was reduced. As this trend continued, a serious gap in primary health care services developed. **Primary health care** includes both public health and primary care services.

The NP movement began in 1965 at the University of Colorado by Dr. Loretta Ford and Dr. Henry Silver. They determined that the morbidity among medically deprived children could be decreased by educating nurses to provide well-child care to children of all ages. Nursing practice for these pediatric nurse practitioners included the identification, assessment, and management of common acute and chronic health problems, with appropriate referral of more complex problems to physicians (Silver, Ford, and Stearly, 1967). The priorities of the nursing profession have traditionally been to care for and support the well, the worried well, and the ill, offering physical care services previously provided only by physicians. Preparing nurses as primary health care providers was not only consistent with traditional nursing but also was responsive to society's critical need for primary health care services, including health promotion and illness prevention (Hooker and McCaig, 2001).

In 1965, the physician assistant (PA) role was initiated at Duke University. This program was intended to attract former military corpsmen for training as medical extenders (Hooker and Berlin, 2002). Nurse practitioners are often combined into a single category with other nonphysician providers and are mistakenly portrayed as physician extenders. This

misinterpretation of the intended role is addressed by one of the founders, Dr. Loretta Ford (Ford, 1986).

As conceptualized, the nurse practitioner was always intended to be a nursing model focused on the promotion of health in daily living, on growth and development of children in families, and on the prevention of disease and disability. Nursing as a discipline and a profession evolved not because there was a shortage of physicians but because of societal needs. The early plans did not include preparing nurses to assume medical functions. The interests were in health promotion and disease prevention for aggregate populations in community settings, including underserved groups. These were the hallmarks of community-oriented nursing (Ford, 1986).

A report issued by the U.S. Department of Health, Education, and Welfare (now DHHS), *Extending the Scope of Nursing Practice* (1971), helped convince Congress of the value of NPs as primary health care providers. The Nurse Training Act of 1971 (PL 92-150) and the comprehensive Health Manpower Act of 1971 (PL 92-157) provided education monies for many NP and PA programs through the 1970s and into the 1980s. Similarly, in the 1970s the concept of an expanded practice role for nurses was garnering interest in Canada. Canadian nurses saw the NP role as an opportunity to expand their scope of practice and perform the role in various settings largely outside tertiary care (Bajnok and Wright, 1993). The United Kingdom has increased their advanced practice nurse programs and is continuing to explore the concept in relation to practice (Anderson, 2004).

Graduate education for nursing is still evolving. AACN (2007) is calling for the creation of a new nursing role, **clinical nurse leader** (CNL). The clinical nurse leader is defined as a nurse

who is a master's prepared generalist who functions at the micro-system level and assumes accountability for healthcare outcomes for a specific group of clients within a unit or area (AACN, 2007). Additionally, the AACN has determined that the degree for nurses seeking advanced practice should be the Doctor of Nursing Practice (DNP) (AACN, 2006). (see The Cutting Edge box)

Cutting Edge here

## **COMPETENCIES**

The Quad Council of Public Health Nursing Organizations (Quad Council, 2003) developed a set of national public health competencies specific for public health nursing practice that are based on the *Core Competencies for Public Health Professionals* authored by the Council on Linkages between Academia and Public Health Practice (2001). The core competencies were designed to serve as a starting point for academic and practice organizations to understand, assess, and meet training and workforce needs for health professionals practicing in public health; they were updated in 2009 (Council on Linkages between Academia and Public Health Practice, 2009).

The Quad Council competencies are more specific to public health nursing and were developed to assist agencies that employ public health nurses, as well as academic settings that prepare public health nurses, to facilitate education, orientation, training and lifelong learning (Quad Council, 2003). The competencies are categorized into eight domains and are applied to two levels of public health nursing practice: the staff nurse/generalist role and the manager/consultant/ CNS. The domains include core areas of analytic assessment, policy development/program planning, communication, cultural competency, community dimensions of practice, basic public health science, financial planning and management, and leadership and systems thinking skills (Quad Council, 2003). (see Link to Text Content box) The American Nurses

Association (ANA, 2007) published *Scope and Standards for Public Health Nursing Practice* that include population-focused standards of care in the following areas: assessment, diagnosis, outcome identification, planning, assurance, evaluations and standards for professional performance in quality of care, performance appraisal, education, collegiality, ethics, collaboration, research and resource utilization. This document is a collaboration between the ANA and the American Public Health Association-Public Health Nursing section's definition and role of Public Health Nursing Practice (1996).

[Link to Text box here](#)

## **EDUCATIONAL PREPARATION**

Educational preparation for the advanced practice public health nurse includes a minimum of a master's degree and is based on a synthesis of current knowledge and research in nursing, public health, and other scientific disciplines. In addition to performing the functions of the generalist in population-focused nursing, the specialist possesses clinical experience in interdisciplinary planning, organizing, community empowerment, delivering and evaluating service, political and legislative activities, and assuming a leadership role in interventions that have a positive effect on the health of the community. ACHNE recommendations for graduate nursing education for the public health nurse specialty are guided by the IOM's 2003 report *Who will keep the public healthy?* (2003) ANA's *Public Health Nursing Scope and Standards of Practice* (2007), and AACN's *DNP essentials* (2006). They identified five role characteristics of APHN's: 1) population level health care focus 2) ecological view 3) responsibility for health outcomes for populations 4) partnership/collaboration using an interdisciplinary approach and 5) leadership in practice. The curriculum areas for the APHN that were identified are population centered nursing theory and practice, interprofessional practice, leadership, systems thinking, biostatistics,

epidemiology, environmental health sciences, health policy and management, social and behavioral sciences, public health informatics, genomics, health communication cultural competence, community-based participatory research, global health, policy and law and public health ethics (ACHNE, 2007). In addition to didactic content, graduate education for the APHN must include practicum experience that takes place at the population level, be grounded in the ecological perspective, and include the measurement of outcomes (ACHNE, 2007).

In contrast to the APHN, educational preparation of the NP has not always been at the graduate level. Early NP programs were continuing education certificate programs, and the baccalaureate degree was not always a requirement. At present, however, NPs are required to hold master's degrees and encouraged to obtain a practice doctorate (AACN, 2006). The curriculum prepares NPs to perform a wide range of professional nursing functions including assessing and diagnosing, conducting physical examinations, ordering laboratory and other diagnostic tests, developing and implementing treatment plans for some acute and chronic illnesses, prescribing medications, monitoring client status, educating and counseling clients, and consulting and collaborating with and referring to other providers (AACN, 1996). Many institutions are offering combined CNS/ NP programs. A 2006 AACN position statement calls for DNP education for advanced practice nurses and nurses seeking top systems/organizational roles. The eight foundational essentials for DNP programs are knowledge with a scientific underpinning; organizational and systems leadership; clinical scholarship; information systems; policy; collaboration; prevention and population health; and advanced nursing practice (AACN, 2006).

## **CREDENTIALING**

Certification examinations for advanced practice nurses are offered by the American Nurses Credentialing Center (ANCC). The purpose of professional certification is to confirm knowledge

and expertise and provide recognition of professional achievement in a defined area of nursing.

**Certification** is a means of assuring the public that nurses who claim to be competent at an advanced level have had their credentials verified through examination (ANCC, 2009). Although certification itself is not mandatory, many state boards of nursing require that nurses in advanced practice, particularly those in an NP role, be nationally certified to practice.

The American Nurses Association (ANA) began its certification program in 1973 and has offered NP certification examinations since 1976. The American Nurses Credentialing Center was opened in 1991 and offers certification in NP, Advanced Practice, and CNS specialty areas. Until 2009 a nurse could also be certified as a generalist or as a BSN-prepared specialist in community health. s. Since 1985, the basic qualifications for certification as an NP have been a baccalaureate degree in nursing and successful completion of a formal NP program. As of 1992, a master's or higher degree in nursing is required for NP certification through the ANCC.

Examination topics for the NP certification examination include clinical management, professional role and policy, NP and patient relationship, assessment, research, and health promotion and disease prevention (ANCC, 2010). The American Academy of Nurse Practitioners also has national competency-based certification examinations in three areas: family, adult, and gerontologic nurse practitioners (American Academy of Nurse Practitioners, 2010).

The certification examination for CNS in public/community health nursing was first offered in October 1990. Qualifications for this examination include a master's or higher degree in nursing with a specialization in community/public health nursing practice. Effective in 1998, eligibility requirements included holding a master's or higher degree in nursing with a specialization in community/public health nursing or holding a baccalaureate or higher degree in nursing and a



master's degree in public health with a specialization in community/public health nursing. In 2009, the ANCC Commission renamed the certification exam from Clinical Nurse Specialist in Public/Community Health to Advanced Public Health Nursing. Along with the name change, the eligibility criteria were expanded to accept a variety of graduate education preparation in public/community health. (see Did You Know?) Those who complete a master's degree in nursing in community/public health (which includes a minimum of 500 practicum hours), or a master's in public health degree and successfully pass the certification examination will be eligible to use the credential of Advanced Public Health Nurse- Board Certified (APHN-BC) (ANCC, 2010).

Nurses who complete a master's degree in nursing in community/public health with additional courses in advanced pathophysiology, advanced pharmacology and advanced health assessment, complete a minimum of 500 practicum hours and pass the examination, will be eligible to use the credential of Public Health Clinical Nurse Specialist- Board Certified (PHCNS-BC) (ANCC, 2010). Up until 2015, nurses who have a graduate degree in an area other than community/public health nursing and complete 2000 clinical hours of advanced practice public/ community health nursing within the last three years are also eligible to sit for this examination and use the credential of APHN-BC. Examination topics for both distinctions include foundations of advanced public/community health; application of developmental theories; epidemiology; biostatistics; research evaluation; methods and utilization; public, community and environmental health assessment; strategies to improve public/ community health; health promotion; disease prevention; risk reduction; theories and concepts of health behaviors; health screening and counseling; populations and communities education; health systems; organization and networks; and leadership concepts and professionalism (ANCC, 2010).

Certification for the APHN and NP is for 5 years. To maintain certification, the nurse must submit documentation of current RN licensure and meet a practice and continuing education requirement within the specialty area.

Did You Know here

## **ADVANCED PRACTICE ROLES**

Advanced practice nurses holding a master's degree in nursing and specializing in public health nursing, in community health nursing, or as a nurse practitioner have many roles, some of which will be described here. It should be noted that the "nursing role in the APHN is not distinguished by the sites in which the nurses practice, but rather by the perspective, knowledge base, and principals that focus on care of populations" (ACHNE, 2007, p. 16). The APHN's role characteristics include a focus on population health such as population and community assessment, advocacy and policy setting at the organizational, community, and state levels; ecological view for large-scale program planning, project management, leadership and partnership building. APHN's deliver population-focused services, programs and research (ACHNE, 2007; Robertson and Baldwin, 2007).

### ***Clinician***

Most of the differences between the roles of the APHN and the NP are seen in clinical practice. Although the APHN's practice includes nursing directed at individuals, families, and groups, the primary responsibility is to take a leadership role in the overall assessment, planning, development, coordination, and evaluation of innovative programs to meet identified community health needs. The APHN provides the direction for population-focused health care by identifying and documenting health needs and resources in a particular community and in collaborating with population-focused nurse generalists, other health professionals, and consumers (ACHNE,

2007). Practicing within the role of **clinician**, the APHN is involved in conducting community assessments; identifying needs of populations at risk; and planning, implementing, and evaluating population-focused programs to achieve health goals, including health promotion and disease prevention activities. The APHN ultimately works toward the goals of promoting and protecting the health of populations by creating conditions in which people can optimize their health (ANA, 2007).

The NP applies advanced practice nursing knowledge and physical, psychosocial, and environmental assessment skills to manage common health and illness problems of clients of all ages and both sexes. The NP's primary client is the individual and family. In the direct role of clinician, the NP assesses health risks and health and illness status, as well as the response to illness of individuals and families. The NP also diagnoses actual or potential health problems; decides on treatment plans jointly with clients; intervenes to promote health, to protect against disease, to treat illness, to manage chronic disease, and to limit disability; and evaluates with the client and other primary care team members about how effective and comprehensive the nursing intervention may be in providing continuity of care (AACN, 1996; NONPF, 2006). Despite the setting of the advanced practice nurse practitioner, the practice can be population-focused. These interventions often include community assessment and analysis, case finding, an emphasis on prevention, and participation in public policy. An advanced practice nurse in the community may work in an agency or setting where the caseload consists of individuals who present themselves for services. The APHN goal would be to identify others in the community who may be at risk and in need of the services. Outreach activities can accomplish this while also trying to accomplish the goals and objectives of Healthy People 2020, see Box 39-1.

Box 39-1 here

The ability of NPs to diagnose and treat has increased the provision of health care, teaching, and client compliance with treatment plans. The amount of physician involvement in the NP's practice is generally directed through state legislation (Phillips, 2010). Frequently, the NP will use **protocols** or algorithms that have been previously agreed on by the physician and the NP. These documents, required by some states, serve as standing orders for the management of certain illnesses. As of 2010, all states have passed legislation, either partial or full, granting NP's supervisory, collaborative, or independent authority to practice. Each state has differing regulatory and legislative mandates in regards to NP areas of practice authority, reimbursement and prescriptive authority. Work is progressing on a Consensus Model for APRN Regulation that includes standardized regulatory language intended to improve access to patient care by eliminating practice barriers across states (Phillips, 2010).

An important area for both APHNs and NPs to include in their advanced practice is health promotion/disease prevention. Within the past several decades, there has been a growing belief that the most effective way of dealing with major health problems is through prevention. This requires refocusing the health care system, identifying aggregates (populations) at risk, introducing risk reduction interventions, teaching people that they control their own health, and encouraging health promotion and disease prevention behaviors. It has been predicted that there will be an even greater emphasis on population-focused care and that nursing will increasingly be viewed as the way to address many of the health care problems that plague society in this new millennium (ACHNE, 2007; ANA, 2007). The US Department of Health and Human Services (USDHHS, 2010) develops national objectives for promoting health and preventing disease. Since 1997, this initiative, called Healthy People, has set and monitored national health objectives to meet a broad range of health needs, encourage collaboration across sectors, guide

individuals toward making informed health decisions as well as measure the impact of prevention activities. This campaign is essential for APHNs and NPs working toward the goal of a healthier nation. Nurses and advanced practice nurses may also use the resource: *The Guide to Clinical Preventative Services* to address health promotion and disease prevention (USDHHS/ AHRQ/ USPSTF, 2009). NPs and APHNs are especially involved in helping to meet the proposed objectives in the access to health services, educational and community-based programs and public health infrastructure domains.

### **Population-focused Intervention**

The following example illustrates a population-focused intervention. An APHN was recently hired at a community hospital in the hospital's community health department. Traditionally, this department provided excellent health education and screening programs to individuals in the surrounding communities. However, outreach activities did not occur. After reviewing the data on attendance at community health events, the APHN developed and implemented a needs assessment in three neighboring communities not attending the events. In one neighborhood, consisting of 1800 apartments, 85% of the population were middle-income African Americans of all ages. The needs assessment revealed a strong interest in health promotion and disease prevention but nevertheless a lack of participation. The APHN developed a collaborative relationship with churches and community groups in the neighborhood. Health fairs and events were initiated (see Levels of Prevention box).

Levels of Prevention box here

### ***Educator***

Nurses in advanced practice function in several indirect nursing care roles. The **educator** role of the APHN and NP includes health education within a nursing framework (as opposed to health

educators who may not have a nursing background) and professional nurse educator (faculty) roles.

The APHN identifies groups at risk within a community and implements, for example, health education interventions. The APHN and NP increase wellness and contribute to maintaining and promoting health by teaching the importance of good nutrition, physical exercise, stress management, and a healthy lifestyle. They provide education about disease processes and the importance of following treatment regimens. In addition, they provide anticipatory guidance and educate clients on the use of medications, diet, birth control methods, and other therapeutic procedures (ACHNE, 2007; Logan, 2005; NONPF, 2006). They also counsel clients, families, groups, and the community on the importance of assuming responsibility for their own health. This education may occur on an individual, family, or group level, in an institutional, ambulatory, or home setting, or it may occur in the community with vulnerable at-risk populations.

As professional nurse educators, the APHN and NP provide formal and informal teaching of staff nurses and undergraduate and graduate students in nursing and other disciplines (Figure 39-1). They also serve as role models by instructing (or being a preceptor to) students in advanced practice in the clinical setting.

Figure 39-1 here

### ***Administrator***

The APHN and NP may function in administrative roles. As a health **administrator**, they may be responsible for all administrative matters within an agency setting. They may be responsible for and have direct or indirect authority and supervision over the organization's staff and client care. In this capacity, nurses in advanced practice serve as decision makers and problem solvers.

They may also be involved in other business and management aspects such as supporting and managing personnel; budgeting; establishing quality control mechanisms; and program planning and influencing policies, public relations, and marketing (ACHNE, 2007; Logan, 2005).

### ***Consultant***

Consultation is an important part of practice for APHNs and NPs. Consultation involves problem solving with an individual, family, or community to improve health care delivery. Steps of the consultation process include assessing the problem, determining the availability and feasibility of resources, proposing solutions, and assisting with implementing a solution, if appropriate (AACN, 1996; NONPF, 2006) (see Chapter XX). The APHN and NP may serve as a formal or informal **consultant** to other nurses, providing them with information on improving client care. They may also consult with physicians and other health care providers or with organizations or schools to improve the health care of clients. For example, nurse consultants are often used at the district or state level of public health departments. APHNs and NPs work closely with nurse supervisors, other nurse practitioners, and staff public health nurses to develop programs and improve the services provided to clients at clinics and in the home. Nurse consultants in the public health arena may work with all other public health nurses or may work in departments as members of an interdisciplinary team such as maternal–child health, chronic diseases, or family planning.

### ***Researcher***

Improvement in nursing practice depends on the commitment of nurses to developing and refining knowledge through research. Practicing APHNs and NPs are in ideal positions to identify researchable nursing problems related to the communities they serve. They can apply their research findings to the community health practice setting.

All APHNs and most NPs are trained in the research process and, as **researchers**, can conduct their own investigations and collaborate with doctorate-prepared nurses, answering questions related to nursing practice and primary health care. The acts of identifying, defining, and investigating clinical nursing problems and reporting findings encourages peer relationships with other professions and contributes to health care policy and decision making (Logan, 2005; Harne-Britner and Schafer, 2009). For example, APHNs in administrative, consultant, or practitioner roles daily encounter situations that need further investigating (e.g., noncompliance with certain public health regimens or immunization schedules). They may, anecdotally or through needs assessments, identify a trend that, if examined, could be dealt with through population based strategies (see Evidence Based Practice Box). APHNs and NPs may collaborate with population-focused nurses at all levels to develop the research design, collect and analyze the data, and determine the implications for further use of nursing interventions identified. APHN's play a critical role in ensuring that evidence based research is shared and integrated into health care practice (Harne-Britner and Schafer, 2009).

Evidence based practice box here

## **ARENAS FOR PRACTICE**

Regardless of where public health nurses work (e.g., schools, homes, clinics, jails, shelters, or mobile vans) the core interventions to accomplish the goals of promoting and protecting the health of populations is similar across all practice arenas. An Intervention Wheel model was developed to define the scope of public health nursing practice by type of intervention and level of practice (see Chapter 9). Interventions are actions that the public health nurse takes on behalf of individuals, families, systems and communities (Minnesota Department of Health, 2001). Positions for NPs and APHNs vary greatly in terms of scope of practice, degree of responsibility,



power and authority, working conditions, creativity, and reward structure (Logan, 2005; Robertson and Baldwin, 2007). These factors and the effects on practice are influenced by nurse practice acts and other legislation (e.g., reimbursement and prescriptive privileges) that govern the legal practice in each state (Phillips, 2010). The following areas include traditional as well as alternative practice settings for APHNs and NPs.

### ***Primary Care***

Research indicates that the opportunities for APNs in primary care settings increased throughout the past decades and this trend is expected to continue (Laurant, Reeves, Braspenning, and Sibbald, 2009). Evidence has supported that appropriately trained nurses in primary care can produce the same high quality care and achieve equally positive health outcomes for patients as physicians. In general, preliminary research found no appreciable differences between physicians and nurses in health outcomes for patients, process of care, resource utilization, or cost (Laurant, Reeves, Braspenning, and Sibbald, 2009).

### **Independent Practice**

Nurses form an **independent practice** for several reasons, including personal or professional desire to break new ground for nursing and to meet health care needs within a community. It is important to investigate the state's nurse practice act to determine the limitations and the laws related to this arrangement. For example, NPs may provide a more comprehensive array of health services in states where they have legislative authority to prescribe drugs. Nurses in many states have successfully lobbied for **third-party reimbursement** for all RNs who provide direct care services to individual clients (Phillips, 2010). The independent practice option is more likely to be chosen by NPs and APHNs in states that have established legislation to provide for this nursing practice.

Another option for NPs and APHNs interested in independent practice is to contract with physicians or organizations to provide certain services for their clients or staff. Nurses need to define a service package and market it attractively. An example is providing a home visit to new parents after 2 weeks to assess the newborn, respond to parental concerns, and provide counseling and anticipatory guidance about nutrition, development, and immunization needs. This service may be marketed to pediatricians and family practice physicians who would offer or recommend the service to their clients as an option. An NP may negotiate with a local school board to provide preschool children with health examinations or physical assessments before the children participate in sports. Under a contract, APHNs may develop and implement health and safety programs on accident prevention and health promotion activities for small companies.

### **Nursing Centers**

**Nursing centers** or clinics, a type of joint practice developed by advanced practice nurses, provide opportunities for collaborative relationships for APHNs, NPs, baccalaureate-prepared nurses, other health care professionals, and community members (Anderko, Lundeen, and Bartz, 2006; Paterson, Duffett-Leger, and Cruttenden, 2009). Primary health services may be provided by NPs, depending on state legislation. Community APHNs, along with nurses and nursing students, may identify aggregates at risk and work in partnership with the community to implement risk reduction activities (Anderko, Lundeen, and Bartz, 2006). A central mission of nurse managed clinics is community development such as health care accessibility and resources; public involvement; interprofessional practice; and health promotion and disease prevention supported by the principals of primary health care (Paterson, Duffett-Leger, and Cruttenden, 2009). Nursing center models are discussed in more detail in Chapter 21.

## **Faith Community Nursing/ Parish Nursing**

Faith **community nursing**, also known as **parish nursing**, is a concept that began in the late 1960s in the United States when increasing numbers of churches employed registered nurses to provide holistic, preventive health care to congregation members. Faith community nursing is a model of care that uses nurses based within faith communities such as churches and synagogues to provide health services to the members of those communities. The faith community/ parish nurse functions as health educator, counselor, group facilitator, client advocate, and liaison to community resources (Health Ministries Association, 2005, McGinnis and Zoske, 2008).

Because these activities are complementary to the population-focused practice of APHNs, faith community nurses either have a strong public health background or work directly with both baccalaureate-prepared nurses and APHNs (see Nursing Tip 2 box). Faith community nurses positively affect client outcomes by providing health services in health promotion and disease prevention, chronic disease management, and culturally sensitive services (McGinnis and Zoske, 2008). See Chapter 45 for further discussion about faith community/ parish nursing.

Nursing tip 2 here

## ***Institutional Settings***

### **Ambulatory/Outpatient Clinics**

NPs and APHNs may be employed in the primary care unit of an institution (e.g., the ambulatory center or outpatient clinic). These centers/clinics generally provide hospital referral, hospital follow-up care, and health maintenance and management for non-emergent problems. The population served is usually more culturally and economically diverse and represents a larger geographic area than that served by private practices. In these outpatient settings, NPs typically practice jointly with physicians to provide acute and chronic primary care. Hospital acute care

outpatient services may include clinics for general medicine or family practice, or specialty-oriented clinics, such as pediatric, obstetric-gynecologic, and ear-nose-and-throat clinics.

Outpatient clinics organized for chronic care may be problem-oriented (e.g., hypertension, diabetes, or acquired immunodeficiency syndrome [AIDS] clinics).

### **Emergency Departments**

Persons without access to health care, such as the medically uninsured and the homeless, often do not seek health care services until they become ill. Hospital emergency departments (EDs) are increasingly used for non-emergent primary care. Although this is an inappropriate use of expensive health services, it is a result of the current system, which limits access to routine and preventive health care. Emergency department care is one of the most expensive services offered in health care today (Wood, Wettlaufer, Shaha, and Lillis, 2010).

Emergency services often require long waits for persons who have nonemergency problems. Fast-track/nonemergency sections of ERs have become commonplace to accommodate these situations. NPs in these settings see clients with non-emergent problems and provide the necessary treatment and appropriate counseling (Campo, McNulty, Sabatini, and Fitzpatrick, 2008). APHNs may also help educate clients on the importance of health care and how to gain access to the preventive health care system. APHNs, with their knowledge of community health resources, can help ensure that psychosocial needs are assessed and met. APHNs can act as liaisons or go-betweens for community programs that serve the needs of special populations (Hooker, Cipher, Cawley, Herrmann, and Melson, 2008).

### **Long-Term Care Facilities**

The elderly age group represents the fastest growing population (especially those over 85 years of age) in the United States (Administration on Aging, 2009). The data reveal a long anticipated

trend that we are living longer resulting in higher percentages of elderly Americans. By 2030, it is projected that one in five people will be aged 65 or older (or 70 million people). Statistics reveal a shortage of advanced practice nurses specializing in gerontological nursing to care for the growing older adult population (Thronlow, Auerhahn, and Stanley, 2006).

Gerontology is an increasingly important field of study, and many courses are available on health needs of older adults. NPs and APHNs with an interest in geriatrics need to continue their education in this area to increase their knowledge and skills specific to this at-risk aggregate (Thronlow, Auerhahn, and Stanley, 2006). Many NPs and APHNs view long-term care facilities as exciting areas for practice and a way of increasing quality of care while containing costs for older adults and the disabled. United States federal legislation provides reimbursement for NPs and APHNs to provide care to clients in Medicare-certified nursing homes and to recertify eligible clients for continued Medicare coverage. In long-term care facilities where clients are not ambulatory, NPs and APHNs may make regular nursing home rounds, assess the health status of clients, and provide care and counseling as appropriate. In long-term care facilities in which the residents are more ambulatory, NPs and APHNs also may provide health maintenance and other primary health care services to the nursing home clients.

### **Industry/ Occupational Health**

The Healthy People 2020 (USDHHS, 2010) objectives include a section on occupational health and safety with goals to reduce work-related injuries and deaths. Thousands of new cases of disease and death occur each year from occupational exposures.

APHNs and NPs are increasingly useful in occupational health programs as business and industry seek ways to control their health care costs and to provide preventive and primary on-site care services. These services help reduce absences from work and increase productivity of

workers. The APHN in an industrial/ occupational setting assesses the health needs of the organization on the basis of claims data, cost–benefit health research, results of employee health screening, and the perceived needs of employee groups (Mellor and St. John, 2007). With their advanced administrative and clinical skills, APHNs plan, implement, and evaluate companywide health programs.

NPs in occupational settings generally practice independently, with physician consultation as needed. The health and welfare of the worker is the major concern. Responsibilities for maintaining employee health include direct nursing care for on-the-job injuries. Often clinical responsibility extends to monitoring work-related illnesses such as diabetes and hypertension. Employees may elect to see the NP for common problems and see a physician for more complicated problems. The role of the occupational health nurse is discussed in Chapter 43.

### ***Government***

#### **U.S. Public Health Service**

The U.S. Public Health Service operates the National Health Service Corps, which places health providers in federally designated areas with shortages of health workers, and the Indian Health Service, which provides health services to Native Americans.

During the 1970s, both the Corps and the Indian Health Service offered to pay to educate RNs to become nurse practitioners if they would promise to work for a designated period of time with the Public Health Service. These programs were discontinued during the 1980s when more emphasis was placed on physician recruitment. In 1988, Congress reauthorized two loan repayment programs for NPs' education—one with the Corps and one with the Indian Health Service. More recently in 2009, the American Recovery and Reinvestment Act invests an additional \$300 million into the Health Corps hoping to double its field strength by providing

more scholarships and loan repayment options for healthcare providers. Depending on the needs of the area, an NP employed by the Public Health Service may be the only health care provider in the setting or may practice with a group of providers to serve a rural, an urban underserved, or a Native American population. (National Health Service Corps, 2010)

### Armed Services

The increased availability of physicians reduced the active recruitment of nurses to advanced degree programs by the armed forces during the 1980s. NPs are used in ambulatory clinics serving active duty and retired personnel and their dependents. APHNs use their skills with needs assessment and program planning/evaluation to develop programs aimed at improving the health of the aggregate military population (US Department of Defense/ Today's Military, 2010).

### Public Health Departments

Public health departments are increasingly employing advanced practice nurses with master's degrees. These APHNs and NPs have administrative and clinical skills to work collaboratively with physicians and to manage and implement clinical services provided by the health departments. Home care and hospice services are nursing sections in many public health departments and require the services of population-oriented nurse clinical specialists.

Health departments also provide primary care services in well-child clinics, family planning clinics, and general adult primary health care clinics. A public health department may use NPs and APHNs, depending on the size of the department, the department's health priorities in the community, and financial constraints.

APHNs should possess basic competencies for responding to disasters whether the health threats are natural, intentional, or technological (mass causality incidents, unfolding infectious disease outbreaks, bioterrorism or evolving environmental disasters). APHNs are well positioned to

collaborate with leaders of the community to develop and implement systems level preparedness and response plans for populations before, during, and after an event (ACHNE, 2008; Kuntz, Frable, Qureshik, and Strong, 2008; Jakeway, LaRosa, Cary, and Schoenfisch, 2008).

### **Schools**

School health nursing, discussed in Chapter 42, involves comprehensive assessment and management of care, with particular emphasis on health education, to promote healthy behaviors in children and their families. Innovative practice occurs in school nursing (Nelson, 2009).

APHNs and NPs may be employed as school health nurses by school boards or county health departments to provide specific services to schools such as confirming that immunization status is current; performing hearing and vision screening; and providing many organizational, community assessment, and political functions. School-based health services may be staffed by APHNs and/or nurses prepared as school, pediatric, or family nurse practitioners. Services provided by these advanced nurse practitioners include not only basic health screening but also monitoring of children with chronic health problems and finding health care for children with limited access to medical care. These nurses work collaboratively with parents, community leaders, educators, and physicians to ensure that each child within the school community receives needed services. APHNs and NPs may be well suited to manage school health services if they meet specific criteria developed by individual states.

### ***Other Arenas***

#### **Home Health Agencies**

Major legislative changes in Medicare and third-party reimbursement for hospital services resulted in unprecedented growth in the home health care industry through the 1990s. Home health care is less expensive than extended hospital care and thus is an attractive option for third-



party payers (Madigan and Vanderboom, 2005; Schober, 2007). Additionally, equipment and drug companies are developing products for home use, physicians and hospitals are exploring the development of home services, and consumers are demanding more services. Advanced practice nurses have traditionally been involved in home care in many capacities. Because of their knowledge and skills in the following areas, NPs and APHNs are well-qualified to provide home health care that yields positive outcomes for clients and their families. Home health APNs engage in holistic health assessments and coordinate services with an interdisciplinary team for clients with complex health needs; are involved in coaching, consultation, evaluating and utilizing research findings; provide leadership in both the clinical and professional arenas; and collaborate interprofessionally to accomplish client goals and outcomes (Barrett, Latham, and Levermore, 2007).

Many APNs today are practicing in telehealth environments. (see What Do You Think? box.) Telehealth is the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data and education using interactive video, visual, audio and data telecommunication (Varghese and Phillips, 2009).

What do you think box here

### **Correctional Institutions**

Residents of prisons and jails are a population with health needs that can be met by APHNs and NPs. APHNs are an asset within prison systems, planning and implementing coordinated health programs that include health education as well as health services. Where personnel resources are limited, APHNs provide health education and counseling for inmates and/or their families to prepare prison clients for going back into the community upon their release. NPs often practice

in on-site health clinics at correctional institutions, providing both primary care services and health education programs (Ferszt and Erickson-Owens, 2008; Walsh and Freshwater, 2006).

## ISSUES AND CONCERNS

### *Legal Status*

The legal authority of nurses in advanced practice is determined by each state's nurse practice act and, in some states, by additional rules and regulations for practice (Phillips, 2010). (see Table 39-1) In the 1970s, regulations for the direct care role performed by NPs, including diagnosis and treatment, were less defined in state nursing laws than they are today, and the legal statutes of NPs were being questioned. Since 1971, when Idaho revised its nurse practice act to include the practice of NPs, other states have amended their nurse practice acts or revised their definitions of nursing to reflect the new nursing roles. NPs are regulated by their state boards of nursing through specific regulations (Phillips, 2010). Legislative authority to prescribe has changed dramatically in the last several years. By 2002, NPs in all states (including the District of Columbia) had **prescriptive authority**, some with independent authority to prescribe and some dependent on physician collaboration (Phillips, 2010). Although legal problems and unresolved disputes still exist in a few states, tremendous gains have been made because of nurses' active involvement in the political and policy-making arenas (Phillips, 2010).

Table 39-1 here

### *Reimbursement*

The third-party reimbursement system in the United States, both public and private, is complicated. To practice independently or work collaboratively with physicians, NPs need to be reimbursed adequately. Because states regulate the insurance industry, available third-party

private reimbursement depends in large part on state statute. Advanced practice nurses want direct access to third-party payers. The most common mechanism through which NPs get access to direct payment is through benefits-required laws. Laws also include the right to practice without being discriminated against by another provider or a health care agency (Phillips, 2010). The Rural Health Clinic Services Act of 1977 (PL 95-210) was the first breakthrough in third-party reimbursement for nurses in primary care roles (Table 39-2). The law authorized Medicare and Medicaid reimbursement to qualified rural clinics for services provided by NPs and PAs, regardless of the presence of a physician (Wasem, 1990). The intent of the act was to improve access to health care in some of the nation's underserved rural areas; however, its use from state to state has varied dramatically. Recent legislative changes to include the coverage of services by certified nurse midwives, clinical psychologists, and social workers, have improved the effectiveness of the Rural Health Clinic Services Act for reimbursement options.

In 1989, Congress mandated reimbursement for services furnished to needy Medicaid clients by a certified family nurse practitioner or certified pediatric nurse practitioner whether or not under the supervision of a physician. With the 1997 passing of the national reconciliation spending bill, NPs could be directly reimbursed, regardless of geographic setting, at 85% of what a physician would have been paid (if the service is covered under Medicare part B) (Pearson, 1998) Effective January 1, 2003, individuals applying for Medicare provider numbers as NPs must possess a master's degree from an NP program, as well as national certification and state licensure. Once an NP has a provider number, he or she submits bills using the standard government form to the local Medicare insurance carrier agency for each visit or procedure.

### ***Institutional Privileges***

Because of their direct care role, NPs in the community are more concerned than APHNs about **institutional privileges**. Traditionally it has been difficult for NPs to obtain hospital privileges within institutions where their clients are admitted. However, with the broadening scope of practice and professional responsibilities, more nurse practitioners are obtaining hospital privileges (often referred to as credentialing). An application process is generally required and reviewed by a group of physicians in the department of medicine. The criteria for nurse practitioners wishing to obtain hospital privileges vary by hospital and state; however, most hospitals require that nurse practitioners have national certification.

### ***Employment and Role Negotiation***

For NPs and APHNs to collaboratively provide comprehensive primary health care, they must understand and develop negotiating skills. Positive working relationships with health professionals, organizations, and clients require role negotiation, particularly when few guidelines exist for a role or a role is new and undeveloped. NPs and APHNs need to assess the internal politics of the organization as part of their role negotiation. Networking is another necessary skill. Forums, joint conferences, collaborative practice, and research provide opportunities to expand their functions.

Because in some locations NPs and APHNs often seek employment, as opposed to being sought by employers, assertiveness is needed. Increased financial constraints and new health care legislation have reduced the number of job opportunities. NPs and APHNs should feel comfortable about marketing their skills. Marketing strategies should be designed to project an image that shows a nurse's individual achievement. In assessing and analyzing the needs of

target markets, nurses must consider professional, institutional, and the target client groups' goals.

Methods of obtaining positions and negotiating future roles include providing portfolios of credentialed documents and samples of professional accomplishments such as audiovisual materials, program plans and evaluations conducted, client education packets, and history and physical assessment tools developed. **Portfolios** are folders that contain all of these documents to showcase the nurse's abilities. NPs and APHNs should keep current portfolios containing examples of their professional activities. Names, addresses, and telephone numbers of professional and personal references should be furnished in the portfolios (but only after the referring persons have granted permission). A new application that can assist in keeping current portfolios is an electronic portfolio or e-portfolio where information is housed on the internet that can be easily updated and shared/ transmitted to employers and others. There are many web sites that provide e-portfolio management and services, an example is Decision Critical ([http://www.decisioncritical.com/Critical\\_Portfolio.asp](http://www.decisioncritical.com/Critical_Portfolio.asp)).

## **ROLE STRESS**

Factors causing stress for advanced practice nurses include legal issues (as discussed previously), professional isolation, liability, collaborative practice, conflicting expectations, and professional responsibilities. NPs and APHNs will want to identify self-care strategies to cope with predictable stressors, some of which are discussed here.

### ***Professional Isolation***

**Professional isolation** is a source of conflict for NPs and APHNs. Because they practice across all age-groups, NPs and APHNs are likely to be hired in remote practice employment sites. Rural communities unable to support a physician, for example, may find the NP an affordable and

logical alternative for primary care services. The autonomy of practice in these sites attracts many NPs and APHNs, who may fail to consider the disadvantages of isolated practice. Long drives, long hours, lack of social and cultural activities, and lack of opportunity for professional development are often experienced by these rural practitioners. These sources of stress, which could lead to job dissatisfaction, can be reduced or eliminated by negotiating the employment contract to include educational and personal leaves.

### ***Liability***

All nurses are liable for their actions. Because more legal action is appearing in the judicial system, specifically concerning NPs, the importance of **liability** and/or malpractice insurance cannot be overemphasized (American College of Nurse Practitioners, 2010). Although malpractice insurance may not be required to function as an NP or an APHN, most nurses carry their own liability insurance. It is in the best interest of NPs and APHNs to thoroughly investigate the coverage offered by different companies rather than to assume that the coverage is adequate. Practitioners who function without a physician on site are particularly vulnerable. The scope of the NP's and APHN's authority determines the liability standards applied. The limits of each practitioner's authority are legislated by individual states (Phillips, 2010).

### ***Interprofessional Collaborative Practice***

The future of NPs and APHNs depends on whether they make a recognized difference in the health of families and communities, and on their ability to practice collaboratively with physicians. **Interprofessional collaborative practice** defines a peer relationship with mutual trust and respect. Working out a collaborative practice takes a considerable amount of time and energy. Until such practice relationships evolve within joint practice situations, the quality health care that nursing and medicine can collaboratively provide will not be achieved. The

arrangement demands the professional maturity to work together without territorial disputes, and the structure and philosophy of the organization must support joint practice as a mechanism for health care delivery. The growing pains of establishing such a practice produce stress for all involved; however, the results and benefits to clients and professionals are worth the effort. Interprofessional collaborative practice for APHNs and NPs involves more disciplines than just medicine. Advanced practice nurses work with baccalaureate-prepared nurses and other nurses, social workers, public health professionals, nutritionists, occupational and physical therapists, community leaders and members to meet their goals for the health of individuals, families, groups, and communities. To work toward the Healthy People 2020 objectives, collaboration of multidisciplinary groups is essential. APHNs, NPs, and baccalaureate-prepared nurses can provide leadership in attaining this collaborative effort.

### ***Conflicting Expectations***

Services provided by NPs and APHNs in health promotion and maintenance are often more time consuming and complex than just the management of clients' health problems. NPs and APHNs frequently experience conflict between their practice goals in health promotion and the need to see the number of clients required to maintain the clinic's financial goals. The problem becomes worse when the clinic administrator or physician views NPs and APHNs only as medical extenders and limits reimbursement to the nurse. A practice model that can assist nurses in including health promotion and maintenance activities as well as medical case management into each client visit uses (1) flexible scheduling, (2) health maintenance flow sheets, and (3) problem-oriented recording with nursing goals and plans prominently displayed in the health record. For APHNs, program planning and evaluation based on systematic needs assessments conducted with communities are methods to show the needs and benefits of health

promotion/disease prevention. Being an educator and role model in carrying out Healthy People 2020 objectives will emphasize the importance of health promotion and disease prevention in the health care system.

### ***Professional Responsibilities***

Professional responsibilities contribute to role stress. Most states require NPs and APHNs in expanded roles to be nationally certified and to maintain certification. Recertification requires documentation of continuing education hours. Because there may not be many nurse practitioners in an area, continuing education may not be locally available and may require travel and lodging expenses in addition to time away from the practice site. Anticipating professional responsibilities and travel expenses in financial planning decreases these concerns. Negotiating with the employer for educational leave and expenses should be part of any contract.

Quality of client care, however, cannot be measured or ensured by continuing education or the nurse's credentials. Professional responsibility includes monitoring one's own practice according to standards established by the profession and protocols, if used, and a personal feeling of responsibility to the community. Continuous quality improvement is another professional responsibility for NPs and APHNs. This process should evaluate need, cost, and effectiveness of care in relation to client outcomes (Austin, Luker, and Martin, 2006).

### **TRENDS IN ADVANCED PRACTICE NURSING**

On the basis of data provided by state board of nursing authorities in 2009, there were 131,285 NPs; 12,227 CNSs; 7257 certified nurse midwives; and 37,550 certified registered nurse anesthetists in the United States (Phillips, 2010). These data show a continued increase in NPs and a decrease in CNSs. The loss of CNS positions in hospitals has occurred in financially stressed health care systems. Quality and cost of care have been adversely affected. Academics



tended to emphasize NP programs as a result of the change. However, the need for NPs and APHNs is increasing, especially in light of health care reform, social changes, and complex specialized health problems of the 21<sup>st</sup> century (ANA, 2007).

APHNs and NPs in collaboration with nurses, community agencies and members, and other disciplines have the potential to make an impact on health promotion and disease prevention at the individual, family, group, and community levels. Population-focused APHNs and NPs are in excellent positions to use the Healthy People 2020 National Health Promotion and Disease Prevention objectives and the Healthy People in Healthy Communities model in planning their advanced practice nursing interventions.

## CHAPTER REVIEW

### Practice Application

#### CASE 1: APHN

Martha Corley is an APHN who coordinates the after-care services for a community hospital's early discharge clients. Martha has worked with the nursing staff to develop a nursing history form to identify family and social supports available to clients who are likely to need nursing or supportive care for a limited time after discharge. With this and additional information from head nurses, Martha visits selected clients to begin discharge planning. She consults with each client and family to validate assessed needs. The physician is also consulted about medical therapies to be continued at home. Martha has access to nurses and other resources throughout the community that accept cases on contract. She outlines the initial care plan with nurse case managers assigned to the client and receives regular progress reports. An essential aspect of her practice is to evaluate outcomes of her interventions.

Which of the following is the best example of evaluation of Martha's nursing care?

- A. Assessment of client and family satisfaction of her services
- B. Reported medical complications of her caseload
- C. Review of related literature about home care programs
- D. Collected data on hospital readmissions of her clients

#### CASE 2: FAMILY NURSE PRACTITIONER

Julie Andrews is an NP who practices with two board-certified family practice physicians in an urban office. Julie has her own appointment schedule and sees 12 to 20 adults and children on an average day. Although she sees some acutely ill clients, most of her appointments are for routine health maintenance visits. The two physicians also refer clients to Julie for management of stable

chronic health problems such as hypertension and diabetes. She has received a number of referrals from Martha Corley (see case 1) of clients with hypertension and diabetes. Assignment of these clients to Julie by the physicians did not begin until Julie had been with the practice for about a year. During the first months of practice, Julie assessed the numbers and types of client problems seen in a typical week. She found that hypertension was the most frequent chronic problem. Julie reviewed a sample of records of clients with hypertension and found that many had recorded blood pressures indicating uncontrolled hypertension.

On the basis of this information, what advanced practice nursing intervention could Julie provide?

- A. Continue to see the clients referred to her through the physicians and Martha.
- B. Conduct an in-service education on the hypertension for the staff in the office.
- C. Provide nurse practitioner visits for hypertensive clients and compare the outcomes to hypertension clients seen by the physicians in the office.
- D. Provide care for all hypertensive clients in the office.

**Answers are in the back of the book.**

**Key Points**

- Changes in the health care system and nursing have occurred in the past few decades because of a shift in society's demands and needs.
- Trends such as a shift of health care from institution-based sites to the community, an increase in technology, self-care, cost-containment measures, accountability, third-party reimbursement, and demands for humanizing technical care have influenced the new roles of the APHN and NP.
- Educational preparation of the APHN has always been at the graduate level, whereas this has not been true of the NP; however, there are implications that both the NP and APHN educational preparation may be at the doctorate of nursing practice level.
- Specialty certification began through the ANA in 1976 for NPs, and through the ANCC in 1990 for APHN.
- The major role functions of the NP and APHN in community health are clinician, consultant, administrator, researcher, and educator; typically, the NP spends a greater amount of time in direct care clinical activities and less time in indirect activities than the APHN.
- Major arenas for practice for NPs and APHNs in community health include primary care practice, institutional settings, industry, government, public health agencies, schools, home health, correctional health, nursing centers, and health ministry settings.
- Legal status, reimbursement, institutional privileges, and role negotiation are important issues and concerns to nurses who practice in an advanced role in public health nursing.
- Major stressors for NPs and APHNs include professional isolation, liability, collaborative practice, conflicting expectations, and professional responsibilities.

- The use of Healthy People 2020 objectives is important in emphasizing health promotion and disease prevention in advanced practice nursing and in improving the health of the nation.

**Clinical Decision-Making Activities**

1. Explore the development of the NP and APHN in the community. Give details about the differences in the roles.
2. Investigate graduate programs in public health in the state or region to determine the requirements for admission, the type of degree awarded, and whether or not NP and/or APHN preparation is available. Do the similarities and differences make sense to you? Why?
3. Review your state's nurse practice act and any rules and regulations governing advanced practice roles. Are rules different for NPs and APHNs? Give examples.
4. Negotiate a clinical observation experience with an NP and an APHN in community and public health, and compare and contrast their roles. Discuss the roles as you see them with the NP and APHN. When you consider your thoughts about the roles, have you considered what the APHN and NP have told you about their roles? How has their input changed your views?

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**Table 39-1 Similarities and Differences in Functions Taught to Advanced Practice Public Health Nurses (APHN) and Nurse Practitioners (NP)**

FUNCTION	NP PROGRAM	APHN PROGRAM
Comprehensive assessment	Always	Often
Physiology and pharmacology	Almost always	Often
Diagnosis and management	Always	Often
Systems	Individual/family focus	More systems focused
Leadership	Usually	Almost always
Program planning and evaluation	Less often	Always in community and public health
Research	Generally	Generally

**Table 39-2 Landmark U.S. Legislation for Advanced Practice Nurses**

1977	Rural Health Clinic Services Act authorized NP and PA services to be directly reimbursed when provided in a rural area.
1989	As part of Omnibus Budget Reconciliation Act (OBRA), Congress recognized NPs as direct providers of services to residents of nursing homes.
1990	Congress established a new Medicare benefit through the Federally Qualified Health Centers where services of NPs are directly reimbursed when provided in these centers.
1997	Passage of the national reconciliation spending bill. NPs can now be directly reimbursed, regardless of geographic setting, at 85% of what the physician would have been paid (if the service is covered under Medicare part B).
2003	Individuals applying for Medicare provider numbers, such as NPs, must possess a master's degree from a NP program, as well as national certification and state licensure.

**Figure 39-1** An advanced practice public health nurse leads a training session for a group of congregational nurses.

(same picture as in last edition, p. 921)

**Nursing Tip 1**

Advanced Public Health Nurses generally view the community as their client even when caring for individuals, families, and groups.



**The Cutting Edge**

The AACN has determined that the preferred preparation for specialty advanced practice nursing should be the Doctor of Nursing Practice (DNP) which is defined by specialty nursing practices that focus on either advanced practice nursing (nurse practitioner) or on aggregates, systems or organizations (APHN) (ACHNE, 2007, AACN, 2006). The latter designation includes Advanced Public Health Nursing (ACHNE, 2007).

**Link to Text Box**

In this chapter, emphasis is placed on the role of the advanced public health nurse in the community. The Quad Council's Domains of Public Health Nursing Practice (2003) are categorized into two levels of public health nursing practice: the generalist/ staff role and the manager/ Clinical Nurse Specialist/ consultant/ executive role. The latter role includes a higher level mastery of skills and competencies. Their fifth domain, Community Dimensions of Practice Skills, lists the competencies as: establishes and maintains linkages with key stakeholders; utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships; collaborates with community partners to promote the health of the population; identifies how public and private organizations operate within a community; accomplishes effective community engagements; identifies community assets and available resources; develops, implements and evaluates a community public health assessment; and describes the role of government in the delivery of community health services. These skills are clearly consistent with the APHN role and are at an advanced mastery level. This is in contrast with the generalist/staff public health nurse where the expected level of performance mastery for this domain is at the knowledge level. Thus, if an agency planned to conduct health education programs within a community, the APHN would take leadership roles in developing, implementing and evaluating a needs assessment and interacting with community stakeholders to assist with conducting the health education programs that would be most relevant and accessible to the community.

**Did you know?**

There are 2 distinctions for APHN certification. The first is for those who complete a master's degree in nursing in community/public health, which includes a minimum of 500 practicum hours, or a master's degree in public health, and successfully pass the certification examination. They will be eligible to use the credential of Advanced Public Health Nurse-Board Certified (APHN-BC). The second is for those nurses who complete a master's degree in nursing in community/public health with additional courses in advanced pathophysiology, advanced pharmacology and advanced health assessment, complete a minimum of 500 practicum and pass the examination. They will be eligible to use the credential of Public Health Clinical Nurse Specialist-Board Certified (PHCNS-BC) (ANCC, 2010).

**Box 39-1 Example of a Healthy People 2020 Objective and Selected Advanced Practice****Nursing Activities****OBJECTIVE**

Under Mental Health (objective 18-1): Reduce suicide rate to no more than six suicide deaths per 100,000 people.

**ACTIVITIES**

- Review recent literature and epidemiology of suicide.
- Provide in-service education programs to groups of health professionals related to groups at risk for suicide and related assessment and screening tools for early detection and treatment of depression.
- Become active in legislation activities related to firearm access.
- Assess individual clients for depression and suicide risk.

## **Levels of Prevention Related to Population-focused APHN Activities**

### **PRIMARY PREVENTION**

Flu immunizations at churches; classes on breast self-examination; education on the need for early detection of breast cancer.

### **SECONDARY PREVENTION**

“Men’s Night Out” event with screenings for blood pressure, cholesterol (at neighborhood site); health fair at neighborhood sites with screenings

### **TERTIARY PREVENTION**

Identified need and follow-up at clinics for groups with chronic diseases (diabetes, cancer, hypertension)

### **Evidence-Based Practice**

Based on results of a needs assessment survey of ten questions that addressed the background and needs of ninth and tenth grade students at a local high school, a youth violence prevention program was implemented and evaluated by an advanced public health nurse. Results of the needs assessment showed that 88% (n=53) of the students personally had been exposed to some form of violence, such as gun violence, hitting, and stabbings and 72% (n=43) reported committing acts of violence. In addition, 68% (n=41) of the students reported associating with individuals who commit various acts of violence, and 63% (n=50) reported seeing a gun, while four students (7%) reported using a gun. Thirty-six students (60%) reported that they never had a class on violence-related topics. Content of the program developed and implemented by the APPHN included material on gun and gang violence, dating violence, and anger management/conflict resolution. Teaching strategies were role-playing, group activities, and a field trip to a trauma program for youths at a local hospital. A pre-test was conducted prior to the program and again in one month at the end of the program. A one-way t-test identified an increase in knowledge and skills in several areas after program implementation. Skills acquired included therapeutically resolving violent disputes and methods to prevent different types of dating violence. This program provides a blueprint of an adolescent violence prevention program that could be replicated in other communities/settings.

Regan ME: Implementation and evaluation of a youth violence prevention program for adolescents, *J of School Nurs* 25(1):27-33, 2009.

**Nursing Tip 2**

The faith community nurse role, also known as parish nursing, has been integrated into some nurses' volunteer activities.

**What do you think?**

As telehealth moves into the mainstream of our present health care system, nurses must provide innovative ways to convey caring in their practices. What do you think are some solutions of incorporating the core nursing concept of *caring* while using telehealth technologies?