Roles of Advanced Practice Nurses in Oncology

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Managed care is a process of health-care management that integrates financing, cost-containment strategies, and business principles with the delivery of health care. Managed care’s rapid transformation of specialty practices,

The once identifiable hallmarks of the American entrepreneurial health-care system—access to care on demand, unrestricted provider choice, and a relatively stable delivery system—have been supplanted by a process of health-care management commonly referred to as managed care. In the broadest sense, managed care can be defined as a variety of methods to finance and organize the delivery of comprehensive health care with attempts made to control costs by limiting the provision of services.[1] This description of managed care characterizes the integration of financing, cost-containment strategies, and business principles with the delivery of health care. Or, as medical sociologist David Mechanic stated, managed care is moving health care from advocacy to allocation.[2]

A Pew Health Professions Commission Report predicts that 80% to 90% of insured Americans will move under the umbrella of managed-care systems over the next decade.[3] Recent statistics support these predictions. In 1996, Medicare enrollment into managed-care plans grew by 27% and Medicaid enrollment grew by 33%. The number of new health maintenance organization (HMO) enrollees doubled over the past 8 years to 64 million, with nearly three-quarters of American workers receiving their coverage from a variety of managed-care plans; also, 63 new HMOs were licensed, bringing the total number to 630.[4,5] The unpredictable managed-care market has been described by economists as a “buyers market,” producing not only underused hospitals but specialists who are forced to compete for the diminishing number of fee-for-service patients.[6]

Intrinsic to specialty practice is the routine use of costly diagnostic tests and the need to acquire state-of-the-art technology so as to remain competitive. There is also a general sentiment that “specialists are more expensive.”[7] Compared to the practice patterns of primary-care physicians, managed-care organizations (MCOs) view specialty practices as resource-intensive and specialists as “cost centers.”[8] This has led to the implementation of strict “gatekeeping” practices, systematic utilization management reviews, and the implementation of practice guidelines by MCOs to decrease specialty referrals.[9]

The oncology community has voiced its objections to these documented managed-care practices (eg, restricted access to specialty care, administrative challenges to professional autonomy and clinical decision-making, and reduced employment opportunities for specialists within MCOs.)[10] In response to these market changes, some physicians have formed their own health provider groups and integrated health systems. Friedman defines an integrated delivery system as having a core of physicians on salary or exclusive contract, with a common culture and a consistent product. The system is run by a single board, and offers a full array of health care services provided through capitation for a defined set of populations.[11]

Adapting to the managed-care market has also challenged another group of oncology care providers, advanced practice nurses (APNs), who are being markedly affected by the cost-containment and reengineering efforts hospitals are employing in attempts to remain competitive. In 1995, Milliman and Robertson speculated that in an optimally managed system, only 0.8 beds per 1,000 (assuming 85% occupancy) will be required as hospital occupancy levels continue to decline. This number suggests that about three out of every four hospital beds currently in use will not be needed to meet the inpatient needs of the US population.[12]

Recently released statistics by the American Hospital Association show that, between 1991 and 1995, approximately 190 facilities stopped providing inpatient acute-care services and 335 community and noncommunity facilities closed.[13] The unprecedented wave of hospital closures and the systematic increase in hospital/corporate mergers will cause the loss of 200,000 to 300,000 nursing positions. Furthermore, other industry statistics indicate that there are about 2.6 physicians (1.0 primary-care practitioners and 1.6 specialists) for every 1,000 people in the United States. In
optimally managed systems, only 0.5 primary-care physicians and 0.8 specialists are really needed per 1,000 patients.[12] These system changes have mobilized the nursing profession to assess and reexamine advanced practice nursing and, on an individual basis, are prompting APNs to remain marketable by acquiring new skills, additional administrative and professional degrees, such as mbas and jds, and advanced certifications.

Building on the preceding information, this paper will now identify who APNs are, how diverse APN roles are being implemented in oncology practice settings, the market influences affecting APN/physician relationships, and emerging roles and opportunities for APNs within oncology.

Defining Advanced Nursing Practice

Nursing can trace the term “specialist” back to the turn of the century, when postgraduate courses were offered by hospitals. The first issue of the American Journal of Nursing, published in 1900, included an article entitled “specialists in Nursing” that addressed the development of specialized clinical practice. By 1980, the American Nurses Association affirmed that “specialization is a mark of the advancement of the nursing profession.” Nevertheless, it is important to distinguish between specialization in nursing and advanced nursing practice. Specialization involves concentration in a selected clinical area within the field of nursing.[14] Advancement, as described by Cronenwett, involves both specialization and expansion. Expansion refers to the acquisition of new practice, knowledge and skills, including the knowledge and skills that legitimize role autonomy within areas of practice that overlap the traditional boundaries of medical practice. The term “expanded role” has been used throughout the nurse practitioner literature.[15]

Within the nursing community, there is no clear definition of advanced nursing practice. Calkin has proposed a conceptual definition,[16] and other authors have defined advanced nursing practice in terms of particular roles. To offset this lack of consensus, specialty organizations, such as the Oncology Nursing Society (ONS), have developed a core definition of advanced practice for their specialties. In 1990, the ONS defined advanced nursing practice as “expert competency and leadership in the provision of care to individuals with actual or potential diagnosis of cancer.”[17] Advanced practice nurses generally function as licensed registered nurses who have met advanced educational and practice requirements and are prepared at the graduate level. The defining characteristics of advanced nursing practice, as described by Hamric et al, include three primary criteria and eight core competencies. The three primary criteria are graduate education, certification, and a practice focused on patient and family. The eight core competencies include clinical practice expertise, expert guidance and coaching, consultation, research skills, clinical professional leadership, collaboration, change agent skills, and ethical decision-making skills.[14]

These competencies encompass all roles and cross all practice settings.

Advanced Practice Nursing Statistics

Of the 2.2 million registered nurses in the United States, about 100,000 are APNs.[18] There are four established advanced practice roles: nurse practitioners (NPs), nurse anesthetists (CRNAs), nurse midwives (CNMs), and clinical nurse specialists (CNSs). There are also many abbreviations used in state legislatures to describe APNs (see box on page 00). Of these four groups, approximately 25,000 are nurse practitioners; 40,000 are clinical nurse specialists; 5,000 are certified nurse midwives; and 20,000 are certified registered nurse anesthetists.[19]

On a state-by-state basis, many legal and regulatory inconsistencies exist both between and within APN roles. Variations also exist among states regarding titles, scope of practice, collaborative protocols, practice agreements, and prescriptive authority.[20] Advanced nursing practice varies among institutions and practice settings, but there are marketable leadership skills common to all APN roles. These include mastering change, systems thinking, shared vision, continuous quality improvement, redefining health care, and service to the community. These leadership qualities are incorporated into the oncology roles of the CNS and NP. The focus of this paper will be a discussion of these established functions and the emergence of case managers, acute care nurse practitioners (ACNPs), and blended CNS/NP roles.

Oncology Clinical Nurse Specialist

The clinical nurse specialists role was established by nursing leaders to improve both the quality of care provided to patients and the clinical practice of professional nurses in acute care. Unlike the distinct and clearly defined purposes of the certified registered nurse anesthetist, certified nurse
midwife, and nurse practitioner, which lend support to public health or physician needs, the function of the clinical nurse specialist is more broadly defined and encompasses many specialties such as oncology.

The first CNS specialty emerged at the turn of the century in the field of psychiatry, and its success paved the way for other specialized nurses’ roles. In the mid-1970s, the ONS and the Association of Pediatric Oncology Nurses were founded, and oncology nursing as a specialty developed. Compared to other ANP specialties, oncology clinical nurse specialists (OCNSs) have been incorporated into the health-care system with relative ease. As key members of multidisciplinary care teams, OCNSs provide acute services in predominantly hospital-based settings. Other common practice settings include ambulatory clinics, office practices, hospices, and radiation oncology centers.

Within the managed-care arena, OCNSs are members of integrated delivery systems and staff model HMOs and oncology health-care companies. Their primary responsibilities are: managing a specific caseload of patients with complex needs, directing patient care activities, and collaborating with physicians in patient care management. Additional functions include coordinating an ongoing multidisciplinary plan of care and systems for patients and families, developing and implementing educational programs, creating an environment that promotes quality patient care, and advocating for the needs of patients and families. While caring for specific oncology populations, the OCNS demonstrates any or all of the following competencies: direct caregiver, coordinator, consultant, educator, researcher, and administrator. Because these functions are not used at all times or in all settings, they have generated some confusion and mixed expectations among patients, staff, and administrators.

When the CNS role was conceived, its primary focus was to provide consultation and quality patient care. Today’s market-driven initiatives have forced administrators to reexamine and reallocate their need for CNS services. Some hospitals have downsized OCNS services and are increasingly delegating inappropriate tasks to assistant personnel, which compromises the oncology patient’s condition and care outcomes. Oncology nurse specialists are responding to these organizational and administrative decisions by redesigning their roles and implementing new cost-effective models of care to achieve the desired outcomes. For example, the CNS has branched out into utilization review, identifying and correcting systems problems, and establishing institutional quality control programs.

It is up to the organizations to grant CNSs the authority to effect these changes. As health-care delivery continues to move out of acute care settings into home and community, oncologists will be keenly challenged to meet the increasingly complex needs of patients and families. Because of their advanced training and skill competency, OCNSs are prepared to assist physicians in procuring and coordinating the care and services of oncology patients. One clinical system that provides coordinated care through different models, such as payment sources (hospitals), location (community based), discipline (clinical) or time frame (episode or continuum-based), is case management.

Oncology Clinical Nurse Specialist/Case Manager

The shift of financial risk from payors to providers and the integration of payors and providers into one delivery system are defining new practice models and delivery systems. Case management is increasingly regarded as an essential component of managed care, and case managers are the facilitators and coordinators of its process. Although the concept of case management is simple, the process of case management is quite complex. Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources that promote quality cost-effective outcomes.[21]

There are five essential features to case management: the focus on patients and families with complex needs, negotiation and procurement of needed services, development and maintenance of essential networks, use of expert clinical reasoning, and focus on the episode and/or continuum of care. Health maintenance organizations usually incorporate some aspects of case management into the process when designing programs, but the development of oncology outcome management programs at comprehensive cancer centers remains a relatively new phenomenon.

The following are two examples that incorporate features of case management into oncology care. The program developed at UT M. D. Anderson Cancer Center focuses on reducing practice variability while increasing quality. It identifies case managers as participants in utilization management and discharge planning while also ensuring that the treatment being provided is congruent with the care contract. The clinical management of patients is the responsibility of the entire team, but it is the clinical practice coordinators, APNs, who develop and implement collaborative care paths and ensure that patients follow the pathways outlined by the medical team.[22]
Memorial Sloan-Kettering Cancer Center has selected disease management as the strategy by which to define the quality and cost of cancer treatment and create a competitive advantage within the managed-care market. Disease management is a comprehensive, integrated approach to care and reimbursement based on the natural course of the disease.[23] Essentially, disease management is a population-based, outcomes-oriented, patient-centered paradigm that incorporates a team approach and proactive delivery of care.[24] Throughout the development and ongoing implementation of this care delivery model, APNs have helped develop treatment pathways, standard orders, patient education materials, and spreadsheets that identify the direct costs of care. Case management has been identified as a component of the disease management program that focuses on the coordination of care and services for patients who either require a high intensity of service or have complex care needs.

A series of telephone conversations with nursing leaders at selected comprehensive cancer centers revealed that OCNSs exhibit the core behaviors necessary to adapt to case manager roles.[personal communications] Included among these are strong interpersonal and communication skills, a systems approach to problem solving, flexibility, negotiation and conflict management skills, and a focus on promoting patient/family autonomy. This “big picture” approach to care meets patient and provider needs and fulfills organizational requirements to streamline the process of care by coordinating both the timely delivery of services and the appropriate use of resources. Ultimately, the OCNS/case manager will be held accountable for the 24-hour care of each caseload of patients and will have to ensure that the overall plan of care meets expected patient and administration goals.

Historically, the focus of CNSs was to bring specialty nursing expertise and quality care to the patient’s bedside. Today, the emphasis is on strengthening assessment skills and primary-care management techniques.[25]

**Nurse Practitioner**

Another advanced nursing practice role, nurse practitioner, is also evolving from a primary health model of providing one-to-one holistic comprehensive care to one that encompasses a broad range of specialties and the management of target populations, such as oncology. Nurse practitioners evolved in primary care in the late 1950s and ’60s. The first NP program was established in pediatrics in 1965 at the University of Colorado. In the following decades, the role of NP expanded to address public health needs and advance community-based continuity of care.

During this time, medical specialization was becoming a trend that increased the numbers of physicians in specialty roles and decreased those in primary care. This gap in care was filled by NPs, who addressed consumer demands for accessible, affordable health care and a health-care environment that viewed the NP as a physician substitute in a climate of physician shortage.[26] Support from federal and private agencies allowed the educational development of NPs, envisioning the many practice sites where they would be employed: schools, clinics, health departments, and private practice offices. Nurse practitioners also provide needed access to care in geographic areas where there has been an undersupply of primary care physicians. This was recognized by state legislatures, enabling nursing boards to expand the role of advanced practitioner nurses; eg, Oregon and Delaware passed laws granting hospital privileges to NPs and South Dakota allows APNs to form professional service corporations.[20]

In today’s health-care market, NPs are represented in a variety of clinical specialties and practice sites, such as long-term care facilities, chemotherapy and symptom management clinics, managed-care corporations, women’s health clinics, and private sector industries. The legal authorities defining scope of practice, reimbursement practices, and prescriptive authority for NPs differ throughout the United States. Pearson’s 1997 annual update on legislative issues reports that NPs can practice independently in 26 states and can independently prescribe drugs, including controlled substances, in 17 states. Thirty-three states permit prescription writing with varying degrees of physician involvement or delegation.[20]

The focus of NP practice has been on ambulatory and family-centered care, emphasizing health promotion and disease prevention and the management of stable chronic and common acute conditions. The care that NPs provide demands accurate and timely problem identification that may include diagnosis, treatment plan development, and patient/family educational components. The NP is usually a member of an interdisciplinary team and participates in consultation with other health-care providers. Nurse practitioners are direct caregivers who tend to focus on wellness. As Mundinger stated, “It seems that NPs care for patients while they’re standing up and CNSs care for...
patients when they’re lying down. This perception is changing, however. The acute care setting is one area in which the role of the NP is emerging, although not without controversy.

**Acute Care Nurse Practitioner**

The acute care nurse practitioner meets clinical and administrative needs while promoting self-management of the patient’s disease. The decreasing availability of house staff, state-mandated reductions in physician working hours, and the continuing pressure to enhance quality care have once again placed NPs in an adaptive and controversial spotlight. For example, in February 1997, Oxford Health Plans and Columbia Presbyterian Medical Center in New York City struck a groundbreaking deal permitting patients to choose an NP instead of a doctor as their principal primary-care provider. In this pilot program, primary-care status, usually reserved for physicians, will be assigned to NPs, giving them broad authority, increasing their share of clinical responsibilities, and placing them on financial parity with physicians.

This model may challenge the historically successful primary-care collaborative practice model that has existed between NPs and physicians. It is now being translated into integrative practice models that address complicated medical and nursing problems in patients with acute care needs. The advanced practice skills and increased levels of autonomy that NPs bring to both primary and acute care encompass not only diagnosis and management of physical conditions but also the assessment and management of psychosocial needs, coordination of resources, and provision of comprehensive services with the goal of providing seamless care. As in the past, NPs fill physician (house staff) supply gaps in care, thus creating opportunities in acute care settings.

The ACNP, like the CNS, must be an expert with advanced clinical decision-making and diagnostic-reasoning skills in a defined specialty, such as oncology. Oncology ACNPs practice in collaboration with clinical service fellows and attending physicians, providing continuity and consistency for patients who are undergoing chemotherapy treatments, symptom management, surgery, and procedures, such as autologous bone marrow transplantation. The characteristics of the caseload of the ACNP are complex, unstable, and chronic. The professional and cost-effective care that the ACNP provides is viewed by oncologists as adjunctive care that extends the practice of the specialty physician. The quality of this care, both on an inpatient and ambulatory basis, far surpasses that routinely supplied by a system that mandates the perpetual rotation of house staff and results in discontinuous care and decreased patient satisfaction.

**Clinical Nurse Specialist Plus Nurse Practitioner: A Blended Role for Advanced Practice**

As APNs adapt to administrative demands and market changes, there is the potential of creating new divisions or segments in the role of APNs. One of the most enduring debates in the nursing community is whether or not to blend the NP and CNS role. In the search for job satisfaction and security, many CNSs are completing post-master's certificate programs that will meld their specialty expertise with NP physical assessment and advanced pharmaceutical knowledge. This integrated role is also seeking its place in the new advanced nursing practice market.

The topic of merging the roles of CNS and NP has divided the nursing community into opposing camps. Many nurses continue to debate the pros and cons of combining these roles, but for many practicing APNs, that combined role is already very much a reality.

The instability of the marketplace, cost of specialized personnel, and hospital workforce reductions have compelled CNSs to advance their education so that they qualify as NPs. As traditional hospital settings shrink and length of stay decreases, CNSs, with a view toward expanding professional employment opportunities, are creating a role that is being perceived as a technically/clinically competent, flexible in collaborating effectively across disciplines and specialties, and highly
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In 1994, the Pew Health Professionals Commission Report predicted that, to meet the needs of the underserved urban and rural populations, the need for NPs would double by the year 2000.[33]

Over the last decade, position papers, surveys, and supporting statements from various nursing councils and organizations have been published that describe the commonalities and differences between these roles. As more information became available, the concept of role convergence gained support when the National League for Nursing published a position statement recommending the blending of advanced clinical practice and role preparation for CNS/NP graduates.[34] In 1992, the National Council of State Boards of Nursing and the American Nurses Association also recommended merging the roles. The overriding concept was that blending the preparation and practice modalities of the NP and the CNS into the APN would create benefits for nursing, consumers, and providers. The blended role has the potential for maximizing the expertise that both the CNS and NP bring to advanced nursing practice, enabling each specialty to manage its combined clinical assets as valued resources rather than solitary practices.

Some within the profession see the blending of roles as detracting from the distinct contributions that each role makes. Cukr states that, in 1993, a separatist movement defined the NP as a unique role in advanced nursing and strongly suggested that it remain so.[35] Acknowledged differences in state legislative, legal, and regulatory requirements affect scope of practice, board promulgated rules, and protocol development.

Although these and other acknowledged barriers serve to marginalize the ability of APNs, managed-care markets will not distinguish between these titles as long as the right care is being provided in the right place for the right price. The outcomes of health-care interventions will determine who is the right provider and what value-added dimensions enhance the practice and patient care.

Value-Added Characteristics of the Advanced Practice Nurses

In the world of business and marketing, value-added means that the data generated or products delivered must be valued enough so that consumers can differentiate or choose one product or service over another. The concept of value-added has also found its way into the vocabulary of the health-care industry. The term is often used by administrators and managers to determine the efficacy of products, personnel, or services. The purchasers of health-care services view the skills/knowledge of APNs as marketable commodities that can produce quantifiable outcomes. By achieving the needed outcomes, such as better quality of care and patient satisfaction, both important factors in renegotiating MCO contracts, the APN is able to document the importance of the role in the delivery, management, and economics of patient care.

The following attributes were identified by administrators, nursing leaders, and physicians, when asked what characteristics they determined to be the value-added components of the APN role. They listed a strong clinical expertise that bridged financial knowledge and information systems technology skills; a detailed orientation to patient safety that encompassed the coordination of resource-appropriate services and integrated delivery systems; an enhanced tie-back to nursing staff, as house officers are reduced and APNs take on more clinical and educational responsibilities; and implementation of care/case manager roles that stress the evaluation and improvement of care. The ability to demonstrate and document outcomes that improve the health status of patients, assist patients to become self-reliant in their own care, and develop and implement tools that can standardize care and reduce variations in practice also enhance the role of the APN.

Advanced practice nurses in oncology will have to use all of their skills and resources to demonstrate their added value in a patient encounter while meeting the demands of a delivery system that is not yet fully defined. The pressures to effectively manage pain and/or symptoms, develop care plans to meet complex home care needs, and address the long-term care questions of patients and families will require collaboration and cooperation from all members of the care team. The prospect of advanced practice nurses functioning independently or making decisions unilaterally is neither feasible nor practical in today’s market. The organization of seamless patient care activities can be accomplished only through a multidisciplinary team structure that acknowledges the relationship of interdependence and the recognition of complementary roles. Mundinger has identified the incentives that promote physician/APN collaboration: an increase in comprehensive services, an increase in home and community connections, an increase in family support, and ultimately a decrease in costs of care. These factors enhance collaborative teams and promote their marketability within a capitated environment.[36]
Future Directions

In the past, APN roles were shaped by population and physician needs, consumer education requirements, market demands, and political/legal forces. These functions defined and shaped the professional characteristics of advanced nursing practice. As health-care systems continue to merge and managed care stresses the cost-effectiveness of resources, APNs will expand their practice skills and identify and implement new functions within highly complex environments. The redirection of classical nursing functions toward market initiatives that value the design of care/case management systems, the participation in innovative primary-care models within managed-care organizations, and the implementation of multidisciplinary care teams are expanding the advanced nursing practice landscape.

Unlike the past, APN roles will be defined and shaped by health-care markets with aggressive HMO enrollments and administrators who bargain for lower case rates and premium rollbacks. The focus of hospitals is now the business of health care as much as it is the provision of health care. The practice of oncology managed care stresses proactive care planning, disease management modeling, a more flexible system for patients, enhanced quality, and achievable outcomes through data acquisition and analysis. The management of these components requires a comprehensive approach built around professional partnerships. To successfully move oncology care into the 21st century, physicians and APNs must identify shared opportunities and provide innovative solutions within the economic realities of the marketplace. Combining the clinical expertise of all of the health-care team members creates a stronger foundation for providing quality oncology care. In the final analysis, that is what patients and the public expects.

References:


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