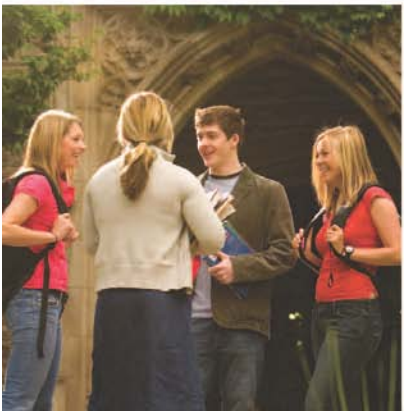




DIALOGUE
SUMMARY

ADDRESSING THE INTEGRATION
OF CLINICAL NURSE SPECIALISTS
AND NURSE PRACTITIONERS IN
ACUTE HEALTHCARE SETTINGS
IN CANADA



7 JULY 2011

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Addressing the Integration of Clinical Nurse Specialists and Nurse Practitioners
in Acute Healthcare Settings in Canada**

7 July 2011

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The author declares that he has no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the author had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants alternated between a focus on the challenges in acute healthcare that suggest the need for clinical nurse specialists and nurse practitioners, and a focus on the vulnerability of these two types of healthcare professionals (and especially clinical nurse specialists) in today's acute healthcare settings. In discussing the challenges in acute healthcare, many dialogue participants agreed that: 1) the complexity of healthcare needs is increasing; 2) effective programs and services aren't getting to all patients and the acute healthcare they do receive is often not as evidence-based as would be optimal; and 3) current health system arrangements aren't ensuring optimal quality in acute healthcare. In discussing the vulnerability of these two types of healthcare professionals, a number of dialogue participants agreed that current health system arrangements aren't ensuring: 1) consistency within and across institutions in how clinical nurse specialists and nurse practitioners are integrated into care delivery or protected when the focus turns from enhancing quality to containing costs; and 2) formalized educational requirements and standardized credentialing mechanisms for clinical nurse specialists and consistency in education, legislative provisions, scope of practice and autonomy of nurse practitioners.

Many dialogue participants agreed that a sequence of steps offered promise:

- 1) convening a national dialogue for clinical nurse specialists (and possibly a separate one for nurse practitioners) to address role clarity, the value proposition, key competencies, outcomes/metrics and educational programs;
- 2) convening a multi-stakeholder national dialogue about which health professionals are needed, in what 'doses' and using what approach to selection and training in order to meet the needs of patients and achieve the goals of the health system;
- 3) supporting a move towards credentialing and purpose-built educational programs for clinical nurse specialists, and towards addressing the distribution of specialty training programs and improving the regulatory process for nurse practitioners;
- 4) undertaking information/education campaigns focused on acute healthcare innovations that are enabling more and better care.

Two dialogue participants also argued in favour of a dedicated research strategy to address questions like which health professionals are needed and in what 'doses' at each of the unit, institution, region and provincial/territorial levels, and to develop tools that can assist local decision-makers in working through the optimal composition of teams.

A key barrier to implementation was considered to be the lack of funding for the proposed national dialogues and the limited pool of (already overstretched) leaders who can be called on to make them a success on top of the many other roles that they are already performing. One dialogue participant noted that implementation will proceed much more smoothly if decisions are made at each juncture about whether separate activities are needed for each of clinical nurse specialists and nurse practitioners working in acute healthcare settings, or whether there are sufficiently similar issues to warrant combining them.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants engaged in a frank assessment of the problem, alternating between a focus on the challenges in acute healthcare that suggest the need for clinical nurse specialists and nurse practitioners, and a focus on the vulnerability of these two types of healthcare professionals (and especially clinical nurse specialists) in today's acute healthcare settings. One dialogue participant argued that the first priority should be what is needed by patients and if the answer turns out to be, in part, clinical nurse specialists and nurse practitioners, then the next steps would involve working through how best to support them in working to their full scope of practice. Another dialogue participant agreed, noting that the focus should be on integration from the perspective of the patient and not the provider.

Starting with the challenges in acute healthcare, most dialogue participants agreed that:

- 1) the complexity of healthcare needs is increasing;
- 2) effective programs and services aren't getting to all patients, and the acute healthcare they do receive is often not as evidence-based as would be optimal; and
- 3) current health system arrangements aren't ensuring optimal quality in acute healthcare.

Many of these participants also suggested that clinical nurse specialists are underutilized in assisting with providing higher quality acute healthcare that will help patients to live well with their complex conditions, in large part by supporting nurses who aren't working to their full scope and by supporting patients and their families in navigating the different parts of the healthcare system and the different specialties and sub-specialties working in it. Likewise, many participants suggested that nurse practitioners are underutilized in assisting with providing more comprehensive acute healthcare, whether by complementing/extending the work of specialists (and thereby reaching more patients) or assisting with more complex care (e.g., pain or wound management). However, some dialogue participants noted that it was far from clear what the optimal configuration of health professionals would be to optimize both quality and comprehensiveness.

Turning to the vulnerability of these two types of healthcare professionals, a number of dialogue participants agreed that current health system arrangements aren't ensuring:

- 1) consistency within and across institutions in how clinical nurse specialists and nurse practitioners are

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Canada;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of an approach (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
- 10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

integrated into care delivery (or supporting excellence in care delivery) or protected when the focus turns from enhancing quality to containing costs (particularly in settings where specialists are paid on a fee-for-service basis and their hospitals can hire physician assistants/clinical associates to work with them, and in some cases contribute to their billings, and where nurse practitioners are paid through hospital global budgets, which can be easily cut back in tight budgetary periods such as the current one, or can admit and discharge their own patients, which introduces a competitive dynamic with physicians); or

- 2) formalized educational requirements and standardized regulatory and credentialing mechanisms for clinical nurse specialists, and consistency in education, legislative provisions, scope of practice and autonomy of nurse practitioners working in acute healthcare settings.

One dialogue participant cautioned against assuming a reduction in demand for these two roles given the persistent shortages in some medical specialties, the growing number of women in medicine, and the reduction in the number of hours that residents can be on call. This individual argued that many helpful conversations could happen at the specialty level before convening a national dialogue.

One dialogue participant noted that an additional challenge with education is that it's not sufficiently well integrated with the system in which graduates will work in several ways, including alignments of supply and demand, how well prepared graduates are for the types of work they will be called upon to do, and how well 'socialized' they are once they start work. A second dialogue participant noted that medical education tends to produce physicians with a 'sense of entitlement' rather than with a good understanding of what it means to be an effective team player alongside clinical nurse specialists and nurse practitioners, among others. A third dialogue participant noted that the lack of credentialing of clinical nurse specialists means that any nurse can self-identify as one despite significant heterogeneity in their education and clinical experience. This individual described how one institution had 'cleaned up' this job title by re-writing the job description to focus on 'driving evidence-informed practice across teams,' re-classifying the job as management, and 'de-listing' a number of individuals who didn't have an advanced degree or a clinical practice domain.

Several dialogue participants noted that acute healthcare settings in many parts of the country are not separate from the broader healthcare system, and that clinical nurse specialists and nurse practitioners need to work across parts of the system and across specialties working in the system. One dialogue participant added that clinical nurse specialists are no longer being judged by how well patients are cared for while in their own institutions, but by how well they're being cared for by the entire healthcare system. Another dialogue participant noted that the nature of the role of these two types of healthcare providers may be very different in large academic centres compared to in smaller hospitals. A third dialogue participant argued that these roles are often not planned thoughtfully or communicated effectively. A fourth dialogue participant observed that employing clinical nurse specialists tends to be an employer decision that is 'imposed' on acute healthcare settings, whereas bringing on board a nurse practitioner tends to be a team decision, based on a business case where issues like cost and effects on outcomes have been examined (and compared to alternatives, such as hospitalists), and accompanied by a working through of many issues such as work distribution (before a nurse practitioner starts work). A fifth dialogue participant said that the only two examples in the local community of clinical nurse specialists working with nurse practitioners were in neonatal intensive care and pediatric hematology.

A number of dialogue participants kept returning to the lack of clarity about the outcomes to which clinical nurse specialists and nurse practitioners can contribute to achieving, and the metrics that can be used to measure their achievement. One dialogue participant noted that cost savings can be one metric, with improvements achieved by greater attention to resource use in acute healthcare settings, shorter lengths of stay and fewer readmissions. Another noted that safety and quality should ideally be the focus of other metrics. One dialogue participant noted the importance of clinical nurse specialists taking particular care to 'leave a footprint' when they undertake activities like consulting on a patient with a wound, so that their contribution to achieving outcomes can be noted. Several dialogue participants noted that this lack of clarity about outcomes contributed to the lack of a value proposition for clinical nurse specialists and nurse practitioners.

Several dialogue participants noted the importance of learning more from clinical nurse specialists and nurse practitioners about what they are doing now and where the opportunities lie. One dialogue participant noted that a Canada-wide survey of clinical nurse specialists has just been completed and results will soon be available.

DELIBERATION ABOUT ELEMENTS OF AN APPROACH FOR ADDRESSING THE PROBLEM

Dialogue participants discussed three elements of an approach that had been previously endorsed by a broad-based group of key stakeholders and that had been examined in the issue brief. Many dialogue participants agreed that parts of each of the three elements held promise, typically with some element of re-framing to ensure that the focus begins with patient needs and then moves to who is best positioned to meet this need. A number of dialogue participants also noted that the three elements are logically sequenced, at least for clinical nurse specialists, such that element 1 should be pursued before element 2, and element 2 before element 3.

Element 1 - Launch a multi-stakeholder strategic-planning initiative

Many dialogue participants supported the participation of clinical nurse specialists and nurse practitioners in a multi-stakeholder national dialogue about which health professionals are needed, in what ‘doses’, and using what approach to selection and training in order to meet the needs of patients and their families and achieve the goals of the health system. Several dialogue participants emphasized that an essential category of participants at this dialogue would be employers, which can include executives working in regional health authorities, acute hospitals, and long-term care institutions, among others. One dialogue participant noted that the national Advisory Committee on Health Delivery and Human Resources might be quite interested in such a conversation as long as the dialogue engaged all health professionals and not just nurses and physicians. Another noted that a dialogue has already been started by the Canadian Nurses Association’s National Expert Commission, which was launched in May 2011.

For clinical nurse specialists, several dialogue participants argued that preparatory work should be undertaken, possibly through a separate national dialogue focused on clinical nurse specialists (and not acute healthcare more generally or clinical nurse specialists in acute healthcare settings specifically). The focus of this preparatory work would be:

- 1) addressing role clarity (or for those who believed that there is clarity already, communicating about the role more effectively);
- 2) articulating the value proposition for clinical nurse specialist (e.g., filling gaps such as supporting system navigation by patients and achieving defined outcomes);
- 3) describing the key competencies of clinical nurse specialists, the outcomes that they can contribute to achieving and the metrics that can be used to measure their achievement; and
- 4) planning educational programs to ensure a sustainable supply of clinical nurse specialists.

One dialogue participant questioned whether the first area of focus should be the identification of key competencies, and only then should the discussion move to role clarity, the value proposition and educational programs. Several dialogue participants noted that clinical nurse specialists are a group that is often missed in discussions within the nursing profession, and that a national dialogue focused exclusively on them might be particularly important. One dialogue participant noted that she was grateful for the opportunity to put clinical nurse specialists back in a context that could be related to, and that the national dialogue could help both to think this through further and to assist with ‘re-branding’ the role. Another dialogue participant noted that the dialogue should ideally include the full spectrum of organizations (e.g., the full range of hospitals from

small community hospitals to large teaching hospitals, and from acute hospitals to long-term care institutions to rehabilitation institutions, as well as home care providers). A third dialogue participant noted that the discussion of role clarity needed to address the full range of potentially related roles (e.g., international medical graduates who work as hospitalists are what some nurse practitioners are compared against in terms of expected costs and outcomes).

For nurse practitioners, dialogue participants saw value in a similar preparatory process, however, discussions about role clarity could be undertaken in conjunction with clinical nurse specialists (recognizing that this conflicts with the idea that the latter need dedicated focus on their own), discussions about outcomes could profitably be expanded to include questions about workload and productivity, and discussions about funding might need to take place first at the provincial/territorial level.

Element 2 - Support consistency in standards, requirements and processes

For clinical nurse specialists, a number of dialogue participants supported a move towards credentialing (based on defined competencies and accommodating existing clinical nurse specialists through some form of ‘grandfathering’ clause) and purpose-built educational programs (given none exist now). A few dialogue participants wondered whether a national commission (as described in element 1 above) might be the optimal way to undertake this work. Several dialogue participants noted that title protection would be hard to secure (or justify securing) given that the prescribing authority used to secure title protection in those U.S. states that have it is not really necessary for clinical nurse specialists. One dialogue participant cautioned that the emphasis with education should be establishing educational standards, but not a tightly standardized education, which would ‘kill local flexibility.’ Another dialogue participant affirmed this point of view, arguing that clinical nurse specialists needed a broad education so that they can move between content areas and then specific clinical training (often provided by their employer) so that they can add value in a given content area where there’s a large need. A third dialogue participant pointed out that despite the ‘glamour’ associated with specialization, broad education programs are much easier to secure funding for and to sustain with local expertise. A fourth dialogue participant introduced the idea of a national mentorship program to provide the specialty perspective to those clinical nurse specialists moving into new roles.

For nurse practitioners, some dialogue participants prioritized addressing the distribution of specialty training programs across Canada (given that most programs are generalist educational programs and that specialized training programs can be hard to sustain given the small pool of expertise in any given centre) and improving the Canadian Nurses Association exam for nurse practitioners (given the exam is targeted at the basic level and its broad groupings of specialty categories may not align with specific forms of practice, such as a nurse practitioner working in a hospital-based HIV clinic who may draw on both primary healthcare and acute healthcare training). Although nurse practitioners are a group for whom title protection is no longer an issue, one dialogue participant noted that there is some cross-national variation in how the role is regulated (e.g., Quebec’s regulations have much more specificity to them), and another pointed out that there is no national mechanism to ensure each nurse practitioner has the right education for their role (e.g., a nurse practitioner working in primary healthcare could only write the adult examination even though they will inevitably see pediatric patients). A third dialogue participant noted that there is substantial cross-institutional variation (and even within-institutional variation) in nurse practitioners’ roles.

One dialogue participant proposed a national commission on nursing education, however, another dialogue participant argued against the need for and value of such a commission. Another dialogue participant proposed a more radical approach, namely to establish a national education-certifying body for all specialty providers, not just physicians, which could be particularly helpful for clinical nurse specialists. A dialogue participant noted that there could be interest in this approach if the one existing national certifying body (the Royal College of Physicians and Surgeons) re-organized itself as a truly cross-professional certifying body.

Element 3 - Launch an information/education campaign

A number of dialogue participants supported the idea of information/education campaigns focused on acute healthcare innovations that are enabling more and better care. One dialogue participant noted that the Canadian Nurses Association is already starting to do this with the National Expert Commission's work on the role and contribution of nursing. Several dialogue participants argued that the public should be a prime target audience for this campaign, and not just professionals and employers. One dialogue participant noted that HIV patients in her institution are particularly articulate spokespeople for how nurse practitioners ensure that they receive high quality care. Another dialogue participant argued that a national commission on education (element 2) should precede element 3 for clinical nurse specialists, given they are typically not 'part of the conversation' and can be 'hard to engage.'

Considering the full array of options

Given that the greater focus in the deliberations about element 1 was the national preparatory meetings for each of clinical nurse specialists and nurse practitioners, several dialogue participants returned to the issue of a multi-stakeholder national dialogue about which health professionals are needed, in what 'doses', and using what approach to selection and training in order to meet the needs of patients and their families and achieve the goals of the health system. One dialogue participant said that this dialogue will be essential to confirm whether these roles are needed and, if so, what is the vision for their roles over the next 20 years, which is the planning horizon for many educational programs. Several dialogue participants indicated that there would be strong interest among employers in participating in such a forum. One dialogue participant noted that there would be many interested partners in such a forum if the conversation were truly cross-professional. The partners could include the Canadian Healthcare Association (an association of employers), Canadian Alliance for Sustainable Health Care (an association of private companies supporting the work of the Conference Board of Canada on the sustainability of the healthcare system), Canadian Life and Health Insurance Association (an association of life and health insurance companies) and Health Human Resources Research Network (a network of researchers), as well as Health Action Lobby (a coalition of 35 national health organizations).

Two dialogue participants argued for a dedicated research strategy to address questions like which health professionals are needed and in what 'doses' at each of the unit, institution, region and provincial/territorial levels to inform both very local decisions about what is optimal and larger-scale decisions that support planning based on these local decisions. Other dialogue participants supplemented this with a call for the development of tools that can assist local decision-makers in working through the optimal composition of teams.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

A key barrier to implementation was considered to be the lack of funding for the proposed national dialogues and the limited pool of (already overstretched) leaders who can be called on to make them a success on top of the many other roles that they are already performing. Regarding the lack of funding, one dialogue participant noted that there would likely be little government appetite for such national dialogues.

One dialogue participant noted that the Canada-wide survey of clinical nurse specialists will provide helpful information to support the implementation of all three of the elements. A second dialogue participant noted that implementation will proceed much more smoothly if decisions are made at each juncture about whether

separate activities are needed for each of clinical nurse specialists and nurse practitioners, or whether there are sufficiently similar issues to warrant combining them.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Dialogue participants affirmed the idea that the elements as they were introduced were logically sequenced so that an optimal set of next steps would mean:

- 1) convening a national dialogue for clinical nurse specialists (and possibly a separate one for nurse practitioners) to address role clarity, the value proposition, key competencies, outcomes/metrics and educational programs (in preparation for the next step);
- 2) convening a multi-stakeholder national dialogue about which health professionals are needed, in what 'doses', and using what approach to selection and training in order to meet the needs of patients and their families and achieve the goals of the health system;
- 3) supporting a move towards credentialing and purpose-built educational programs for clinical nurse specialists and towards addressing the distribution of specialty training programs and improving the licensing process for nurse practitioners;
- 4) undertaking information/education campaigns focused on acute healthcare innovations that are enabling more and better care (possibly in conjunction with the work already being undertaken by the Canadian Nurses Association).

An additional element of an approach could be the creation of a dedicated research strategy to address questions like which health professionals are needed and in what 'doses' at each of the unit, institution, region and provincial/territorial levels, and to develop tools that can assist local decision-makers in working through the optimal composition of teams. However, the timing of this element was not discussed explicitly in relation to the above-noted elements.