A Perfect Storm: A Window of Opportunity for Revolution in Nurse Practitioner Education

The national landscape surrounding advanced practice nursing roles is undergoing significant change. A "perfect storm" of forces is converging that presents a unique window of opportunity for advanced practice registered nurses (APRNs) to realize their full potential for the provision of high-quality, cost-effective care that will improve the health of families, communities, and the nation. In particular, three of these converging forces are driving the demand for APRNs:

- Increased incidence of complex, multimorbid conditions among the aging American population, placing a significant strain on an already overburdened primary care system.
- Enhanced access to care made possible by the Patient Protection and Affordable Care Act, projected to add 32 million Americans to the rosters of the insured (Dower & O'Neil, 2011), further increasing the demand for primary care services.
- The Institute of Medicine's (IOM, 2011) report on the *Future of Nursing* that calls for less restrictive and more nationally uniform descriptions of the scope of practice for nurse practitioners, which appears to be gaining momentum as a number of state regulatory bodies reexamine their respective scopes of practice for nurse practitioners.

The effect of these converging forces serves to highlight the need for an expanded APRN workforce, especially those prepared to deliver primary care. Currently, there are approximately 155,000 licensed nurse practitioners in the United States, 88% of who practice in primary care settings (American Academy of Nurse Practitioners [AANP], 2012). Although estimates of future demand vary, there is a broad consensus that the current rate of production is insufficient to meet future needs.

With the looming increased demand for primary care services, it is logical to assume that schools of nursing would seek to fill this void by increasing the number of applicants they admit. Although the annual number of graduates from U.S. nurse practitioner programs has increased substantially over the past decade from approximately 6,400 per year in 2004 to 11,000 in 2011 (AANP, 2012), many programs have reached their capacity for expansion. This is evidenced by the fact that more than 13,000 qualified applications were turned away from graduate programs in 2011 (American Association of Colleges of Nursing [AACN], 2012). This limitation in capacity, in part, is a result of the well-documented nursing faculty shortage. However, a greater threat is another less frequently cited, but equally troubling, stricture in the APRN pipeline—namely, the current method of APRN clinical education.

Nationally, there have been important changes to the didactic portions of APRN curricula. The *Consensus Model for APRN Regulation* (Advanced Practice Nursing Consensus Work Group, 2008), the revised *Essentials of Master's Education in Nursing* (AACN, 2011), and *Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) have provided much needed clarity and standardization of both the role of and the population focus for APRN education programs. These models have sparked stimulating dialogue and curricular innovation in many programs in the United States, resulting in an evolution in didactic education and including an expanded scope that now prepares graduates to function in a broader, more collaborative interprofessional role for the health care system of the future. However, this change, although important and necessary, is not in and of itself sufficient to address the impending perfect storm.

Without a corresponding focus and similar effort to address the model of clinical education for advanced practice nursing, the profession simply will not be able to educate the number of APRNs needed to respond effectively and proactively. Currently, the vast majority of APRN programs still include clinical education models that were designed and implemented by the original nurse practitioner programs established nearly a half-century ago. This "apprentice" model, in which students work under the direct (and more often than not, one-to-one) supervision of volunteer preceptors and are overseen by a member of the nursing faculty, cannot be a viable option for ensuring that even a portion of the number of APRNs needed in the future will be available. Preserving the clinical education model as it currently exists, especially in this time of health care reform and cost containment, will mean that we will have to continue to limit enrollments in advanced practice programs (AACN, 2012; IOM, 2011) and never achieve an

increasingly diverse public's need for greater access to primary care. The current model is further constrained by the fact that schools of nursing also compete for both clinical sites and preceptors with other educational programs, including undergraduate and graduate medical education and physician assistant programs.

In addition, despite the growing recognition of the value of interprofessional collaborative practice and calls for interprofessional education opportunities (Culliton & Russell, 2010; Interprofessional Education Collaborative, 2011; IOM, 2011), most APRN clinical education still occurs in silos. This represents a missed opportunity for students in advanced practice nursing roles to learn with and from students in other health disciplines and to form the basis for a truly collaborative team practice that builds on shared learning and role socialization. Even the recently released update from the National Organization of Nurse Practitioner Faculties, *Criteria for the Evaluation of Nurse Practitioner Programs* (2012), the valuable work of a number of stakeholder organizations committed to advanced practice nursing education, offers only an incremental approach to changing clinical education and not the type of radical reform called for by the *Future of Nursing* report (IOM, 2011) and the Carnegie report on nursing education (Benner, Sutphen, Leonard, & Day, 2009) and demanded by the brewing set of perfect storm forces.

Why does the one-to-one preceptor model persist—especially at a time of diminished resources, severe faculty shortages, and limited and heavy competition for clinical sites and preceptors? The nation is in great need of nurse practitioners, especially those who will practice in primary care settings. This perfect storm provides a window of opportunity for nursing to dramatically improve the nation's health care system by increasing access to primary care services provided by a cadre of APRNs. To take advantage of this opportunity, a new and innovative model of APRN clinical education must be designed and implemented, in relatively short order. Such a model must provide quality, resource-efficient education that prepares graduates for primary care delivery in an increasingly complex health care system.

The avenues available to consider in the design of new models are many and begin with a fundamental shift in our thinking from a focus on a prescribed number of hours to the achievement of measurable competencies. We must take maximum advantage of emerging modalities to support clinical education, including the range of low- to high-fidelity simulation and the use of standardized patients. Nurse-managed centers may serve as clinical sites for small groups of advanced practice students under the supervision of experienced APRN faculty. We should learn from and build on the concept of dedicated education units to adapt and expand their use for advanced practice students. Although there will always be a role for one-to-one preceptorship, we suggest that this model should be reserved for those experiences where it is essential, including intensive immersion capstone clinical experiences.

We are aware that the challenges of clinical education for advanced practice nursing are being discussed every day in schools and practice settings across the country. What has not yet occurred are coordinated local or national initiatives designed to address the state of clinical education models for advanced practice. Established coalitions, including local and regional associations of academic and practice leaders and the Regional Action Coalitions of the Robert Wood Johnson Foundation's Future of Nursing Campaign for Action (Robert Wood Johnson Foundation, 2010) are well positioned as potentially powerful facilitators of change.

The current system of clinical education is unsustainable at best, broken at worst. As Tanner (2012) challenged earlier this year, "We are approaching a crisis in both the cost of clinical education and the insufficient supply of suitable clinical sites if we continue to use traditional approaches to clinical education" (p. 419). We no longer are afforded the luxury of time to pursue small-scale incremental change. Our ability to respond to the demands of the perfect storm and to ensure that APRNs are available and well prepared to function in a reformed, cost-constrained health care system is dependent on our ability to make bold reforms to the current model of clinical education, and to do so now. The type of radical transformation required to meet the demands of the perfect storm will require collaboration between academic and practice settings and across the health professions to design, test, and quickly implement new models of clinical education. This collaboration may release our dependence on the current model of one-to-one preceptorships and allow us to expand enrollments to meet the looming societal demand for access to safe, affordable, high-quality primary care.

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