A Perfect Storm or the Butterfly Effect: Strategically Innovating Nurse Practitioner Education (With Response)

To the Editor:

In “A Perfect Storm: A Window of Opportunity for Revolution in Nurse Practitioner Education,” Clabo et al. (2012) proposed a change in clinical education models for advanced practice registered nurses (APRNs). We agree that ongoing evaluation and reform of clinical education models are necessary to ensure the preparation of highly qualified nurse practitioner (NP) and APRN workforces. The authors raise good points and offer valuable suggestions; however, we take issue with some of the authors’ challenges.

Clabo et al. (2012) frequently interchanged the terms nurse practitioner and advanced practice registered nurses. APRN is a broader term that includes clinical nurse specialists, certified nurse-midwives, and certified RN-anesthetists, in addition to certified NPs (APRN, 2008). It is not accurate to generalize that the Criteria for Evaluation of Nurse Practitioner Programs (National Organization of Nurse Practitioner Faculties [NONPF], 2012) provides guidelines for anything different than NP educational programs.

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Clabo et al. (2012) criticized the apprentice model for NP clinical education that uses volunteer preceptors and the ratios described in the evaluation criteria. They referred to a one-to-one preceptor model, yet they overlooked the fact that this ratio applies only to faculty who are themselves providing direct care to patients. Faculty members who may be balancing a significant teaching workload in addition to maintaining clinical practice would not be able to take on more than one student for direct supervision at a time in a specific precepted experience. Criterion IV.B.1 (NONPF, 2012) describes faculty–student ratios for indirect supervision, but this criterion does not stipulate a preceptor–student ratio for direct supervision. As written, this criterion would accommodate interprofessional clinical experiences and creative clinical education models.

Clabo et al. also urged a move away from a prescribed number of clinical education hours for achievement of competencies. NONPF is on record for making this same recommendation. However, NONPF endorses the Criteria for Evaluation of Nurse Practitioner Programs and supports its retention of a base number of clinical hours. The latest edition (NONPF, 2012) of these criteria acknowledges that NP education must move away from a prescribed number of hours toward a measurement of competencies, but it recognizes some of the current limitations. At a time of continued external criticisms of NP education, a base minimum of hours across programs is useful.

We concur with Clabo et al. (2012) that we face a crisis in NP clinical education. The competition for preceptors and clinical education sites, as well as other resource challenges, is significant. Increased availability of academic nurse-managed health centers is one strategy in clinical education to foster NPs’ role development, as well as to provide students with diverse and interprofessional experiences. However, other models are needed as well. As the leader in NP education, NONPF has a strategic priority to promote and explore the development of new models. We look forward to working with Clabo et al. and our members in this endeavor.

References


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The authors have disclosed no potential conflicts of interest, financial or otherwise.

Response:

The authors thank Dr. Barksdale and Ms. Werner for their response to our editorial, and we welcome the opportunity to respond to their comments. We recognize that the universe of advanced practice registered nurses (APRN) practice includes many advance practice roles, as described by Barksdale and Werner, but we deliberately chose to focus our attention on the system of clinical education as it relates to the preparation of nurse practitioners (NPs), specifically NPs being prepared to provide primary care.

The premise of our editorial was—and remains—that there currently exist a set of forces that call for the expansion of the pool of talented NP graduates prepared to provide high-quality, cost-effective primary care. This set of forces (an aging population with multiple comorbidities, expanded health care coverage provided by the Affordable Care Act (2010), and the force of the Institute of Medicine’s (2011) report on the Future of Nursing, which recommends calling for nurses to practice to the full extent of their preparation, as well as for an expanded scope of practice for NPs) requires all stakeholders involved in the education of NPs to develop new models of clinical education that are effective, resource efficient, and of high quality to meet the demand for NPs in primary care. The current system of clinical education is essentially identical to that developed more than 40 years ago, and it neglects both the opportunities presented by advances in our understanding of clinical education and the pressing demands of current health care practice.
Specifically, we challenge the assertion by Barksdale and Werner that a requirement for a minimum number of clinical practice hours is a necessity. Completion of a specified number of clinical hours is not a measure of quality education, and we reiterate our call for a move to a focus on demonstration of competencies, many of which may be achieved through alternate forms of education.

Finally, at no point did we infer that the National Task Force criteria stipulate a one-to-one model for volunteer preceptors. Rather, we asserted that this is the structure for the vast majority of clinical education for NP practice and that this model is no longer sustainable. We also assert that seasoned faculty, who are providing direct care, are fully capable of supervising more than one student, which is similar to models used in the education of other health care professionals.

We are pleased to see that NONPF leadership acknowledges the current crisis in clinical education, and we look forward to working with them and other thought leaders to rapidly develop, implement, and test new models of clinical education. We share with them the common goal of producing exceptionally well-prepared NPs in sufficient numbers capable of both responding to the demands of the forces of the perfect storm and improving the health of all Americans.

References


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The authors have disclosed no potential conflicts of interest, financial or otherwise.

doi:10.3928/01484834-20121119-04