Advanced Practice Nursing: Reflections on the Past, Issues for the Future

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Purpose/Objectives: To provide a comprehensive historical review of advanced practice nursing, describe the development of the professional role of oncology advanced practice nurses (APNs), and document the current status of major issues.

Data Sources: Published articles, research findings, position papers and statements, conference proceedings, books, newsletters, newspaper articles, executive summaries, standards and guidelines, and personal communications.

Data Synthesis: The oncology APN role has evolved over the past 100 years in response to the healthcare needs of society and available educational opportunities. Trends in health care and education continue to influence the expansion of the professional APN role.

Conclusions: Oncology APNs are prepared to practice in a variety of roles, providing expert clinical, educational, emotional, and supportive care to patients with cancer. Several major professional issues have been identified and addressed. Oncology APNs must document the influence of expert nursing care on patient outcomes and organizational efficiency.

Key Points . . .

- The title advanced practice nurse (APN) is given to an RN who has met specific graduate degree educational requirements, has expert clinical knowledge, and provides direct care to patients. Four types of APNs are recognized: certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists (CNSs), and nurse practitioners (NPs). The term APN does not imply a blending of the CNS and NP roles but, rather, represents both as distinct roles.
- The Oncology Nursing Society (ONS) endorses the title oncology APN to designate RNs with CNS and NP roles in oncology who are prepared at a minimum of a master's degree in nursing with specialty education and experience in oncology. Oncology APNs work with patients in multiple settings and with specific populations in prevention, screening, active treatment, genetic counseling, palliative care, and hospice care.
- Over the past seven years, ONS has addressed and resolved many professional issues related to oncology nursing. Future oncology APN leaders need to collaborate with healthcare team members and negotiate with policymakers to influence practice issues and healthcare reform.

The history of advanced practice nursing provides an understanding of the origins of current practice issues. The advanced practice nurse (APN) role has evolved in response to numerous changes in the distribution of healthcare services, staffing, technology, and educational opportunities. The purpose of this article is to provide an historical perspective of the APN role and current trends in nursing education and practice. Educational preparation and role development of the oncology APN will be highlighted.

Evolution of the Role

The APN role originated in 1877, when nurses began to administer anesthesia (Bankert, 1989). The first course for nurse anesthetists was offered in the early 1900s, followed by the formation of the American Association of Nurse Anesthetists in 1931 (Bankert). The next APN position to develop was the nurse midwife, introduced to the United States in 1925 during the establishment of the Frontier Nursing Service in Kentucky. Subsequently, the American Association of Nurse-Midwives formed in 1929. These early midwives provided obstetrical and general family care and prescribed and performed procedures under medical protocols (Bear, 1995).

Today, the title of APN is given to an RN who has met specific graduate degree educational requirements, has expert clinical knowledge, and provides direct patient care. The American Nurses Association (ANA), American Association of Colleges of Nursing (AACN), and the National Council of State Boards of Nursing (NCSBN) recognize four types of APNs: certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists (CNSs), and nurse practitioners (NPs) (AACN, 1994; ANA, 1996; NCSBN, 1993). Less than 7% of RNs are APNs (ANA). Every CNS and NP specializes in a specific clinical area. In 1999, 30,000–60,000 CNSs practiced in the United States (Bigbee & Amidi-Nouri, 2001). In 2001, 81,103 NPs practiced in the United States (Pearson, 2001). About 87% of CNSs are employed in nursing; 24% practice in the role of CNS, 25% are in nursing education, and the remaining 38% are in a variety of roles and titles (Health Resources and Services Administration [HRSA],

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2000a, 2000b). A descriptive survey measuring CNS practice indicated that CNSs have increased administrative responsibilities and are performing advanced procedures that in the past were performed by physicians (Scott, 1999). Although the number of CNSs has risen only 1.6% in the past four years, this increase does not include CNSs with dual training as NPs. The number of RNs trained as NPs or CNSs increased 88% from 1996 to 2000 (National Sample Survey of Registered Nurses [NSSRN], 2001). Interestingly, only 35% of nurses with CNS position titles in this survey had formal CNS preparation (HRSA, 2000a, 2000b). The number of NPs increased 37% from 1996 to 2000; this number includes CNSs prepared as NPs. About 89% of NPs are employed in nursing, but not necessarily under the title or role of NP (NSSRN).

The Oncology Nursing Society (ONS) endorses the title oncology APN to designate nurses in CNS and NP oncology roles who are prepared with a minimum of a master's degree in nursing with specialty education and experience in oncology (ONS, 1995a). The title oncology APN is given to practitioners educated in CNS and NP roles. Since 1995, the Oncology Nursing Certification Corporation has offered Advanced Certified Oncology Nurse (AOCN®) certification to master's-prepared nurses with oncology experience. AOCNs® also may include administrators, educators, and researchers. Currently, 1,198 AOCNs® are certified; 267 are practicing CNSs, 267 are NPs, and the remaining 664 are working in other healthcare positions (e.g., managers, educators, supervisors, researchers, case managers, pharmaceutical representatives).

Early History of the Clinical Nurse Specialist

As the need for nursing to shift from generalized to specialized care became apparent, the concept of the APN providing expert nursing care in a specialized area was formulated. Rapid technologic advancements in psychiatry with an emphasis on interpersonal interactions with patients enhanced the development of psychiatric nursing, resulting in new roles within mental health. In the 1930s and 1940s, public recognition of mental health issues resulting from war-related psychiatric problems reinforced the need for specialized psychiatric nurses. Rutgers University in New Brunswick, NJ, offered the first master's degree-level psychiatric CNS program in 1954 (National League for Nursing, 1958). The development of several other CNS specialty programs followed. In 1965, the Nurse Training Act brought further attention to clinical specialization in graduate education and was instrumental in the development of master's-level nursing programs with clinical specialization (Bigbee & Amidi-Nouri, 2001). The Council of Clinical Nurse Specialists (CCNS) formed within ANA in 1983, and the National Association of Clinical Nurse Specialist (NACNS) was established in 1995. ANA began to offer CNS certification in the mid-1970s. Early CNSs functioned as clinicians, consultants, educators, and researchers.

After healthcare organizations established and recognized the role, CNSs were able to serve as role models and agents of change (Christman, 1991). To their credit, Georgopoulos and Christman (1970) evaluated early CNS practice and found it had a positive effect on nursing care outcomes. These early evaluative studies, which supported the importance of the CNS role in health care, launched research efforts documenting the numerous contributions of CNSs. Eventually, in the late 1980s and early 1990s, researchers began to study the effect of CNS practice on patient outcomes.

Early History of the Nurse Practitioner

Major historical events influencing the development of the NP role occurred during the early 1960s. At that time, health care experienced an uneven distribution of providers, an increase in costs, and a perceived shortage of primary care physicians. Physicians and nurses recognized that RNs potentially could provide health care that traditionally had been provided by physicians. Organized nursing was not supportive of this advanced practice role and often referred to the NPs as "physician substitutes" (Nichols, 1997). This negativity, along with insufficient funding, may have contributed to most NP programs being offered through continuing-education programs in medical schools or universities instead of through formal master's degree programs in nursing. The first NP program, offered at the University of Colorado in Denver, was created to prepare highly skilled nurses to provide pediatric public health services. NPs in this program were prepared to use critical judgment in performing health assessment and differential diagnosis and to prescribe pharmacologic treatment in the management of acute and chronic illnesses. The NPs also received training in wellness and prevention services, including screening, anticipatory guidance, patient education, and counseling. ANA defined and supported the NP role in 1974, allowing NPs to become primary care providers for pediatric and adult populations. Eventually, NP programs moved into graduate schools of nursing. A literature review found several studies during the 1980s that documented the competence, cost-effectiveness, and patient and physician satisfaction with NP services. These studies further legitimized the NP role. Currently, the American Nurses Credentialing Center offers certification in family, adult, pediatric, geriatric, school nurse, and acute care services. The National Certification Corporation offers certification in women's health.

The primary care role of the NP has remained viable. On February 7, 1997, the *Wall Street Journal* reported that Oxford Health Plans Inc. and Columbia Presbyterian Medical Center in New York had launched a pilot program that gave 20 NPs the autonomy to be primary care providers (Winslow, 1997). As primary care providers, NPs had the power to refer patients to specialists or emergency care services, authorize hospital admissions, and write patient prescriptions. NPs in the program were reimbursed at the same rate as primary care physicians, thus sending the message to the public that primary care providers offer health care equally across the board. The results of this pilot program were expected to demonstrate cost savings resulting from the NPs' emphasis on disease prevention and health promotion (Winslow).

In the late 1980s and early 1990s, a house staff physician shortage and a perceived "over supply" of physician specialists existed. As a result, educators (Silver & McAtee, 1988), hospitals, and ANA recommended and implemented the NP role as house staff substitutes in acute care settings so that residents could focus on more complex care demands. Subsequently, the acute care NP position developed, blending the dimensions of nursing and medicine into collaborative practice. Articulating this transition, Anne Keane, EdD, RN, FAAN, testified on behalf of the acute care NP role to the Physician Payment Review Committee in December 1992. Keane stated that "APNs are educated to provide high-tech care in the acute care setting . . . the literature and education of advanced practice nurses demonstrate that they are well

qualified to meet hospital service needs and are able to function in an environment with complex cases" (A. Keane, personal communication, April 4, 2001). ANA recommended that U.S. hospitals develop financial mechanisms for this new role. Clinically, acute care NPs practice within a medical practice model and perform procedures that in the past only had been performed by physicians (e.g., lumbar punctures, chest tube insertions, bone marrow biopsies, thoracentesis, paracentesis, writing inpatient medical orders). The American College of Physicians Task Force on Physician Supply examined the expanded NP role. Following this review, the American College of Physicians developed a policy position paper that supported expanded roles for NPs as substitutes for physician house staff within collaborative systems and hospital and ambulatory settings (American College of Physicians, 1994). This support empowered NPs and encouraged administrators to create new positions in the acute care setting. NPs provided direct patient care, including assessing admission histories, administering physicals, identifying problems, formulating treatment plans, ordering diagnostic tests and medications, educating and counseling patients and family members, performing procedures, and establishing discharge plans. NPs then started working in nonteaching hospitals in collaborative practice with physicians.

Trends Influencing Clinical Nurse Specialist and Nurse Practitioner Practice

In the late 1980s, the economic drive to reduce healthcare costs through the more efficient use of resources influenced the growth of managed care systems across the United States. The goal to reduce costs and improve care initiated the development of utilization management, critical pathways, patient care guidelines, outcome measures, and case management. Healthcare providers implemented the case management role to improve the quality of care and reduce the cost and length of hospital stays. The Case Management Society of America (CMSA) defined interdisciplinary case management as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet individual healthcare needs through communication, use of available resources, and promotion of quality, cost-effective outcomes (CMSA, 1994). Congruent with this broad interdisciplinary definition, case managers often are RNs, APNs, or social workers, depending on the institution and patient population. An exploration of the clinical, systematic, and fiscal components of the case manager position found that it shared many similarities with the CNS role, especially regarding complex patient populations. The traditional CNS role, involving clinical practice, consultation, education, and research, is congruent with the case management model of practice. About 4% of CNSs are in case management positions (HRSA, 2000a, 2000b). APNs specifically influence care at a systems level through disease management strategies, health promotion, disease prevention, and complication management programs across the continuum of healthcare services. APN case managers hold graduate degrees in nursing with expertise in a clinical specialty and are accountable for managing high-risk, clinically complex, or resource-intensive patients to optimize clinical, functional, and cost outcomes. They establish programs and improvements within healthcare systems and are accountable for evaluating the cost and quality outcomes associated with case manager intervention (Mahn & Zazworsky, 2000). ANA has not yet formally recognized the roles of case managers as advanced nursing practice.

The process of analyzing the case management model of nursing care highlights the commonalties of NPs and CNSs and may account for increasing awareness of their overlapping roles. In 1990, CCNS and the Council of Primary Health Care Nurse Practitioners elected to become one entity based on the ANA joint council conference's conclusion that the two scopes of practice have significant commonalties with variations determined by practice setting and patient population (Schroer, 1991). CNSs typically focus on case management activities, whereas NPs tend to be primary care providers performing direct patient care (Ray & Hardin, 1995). The difference is not as apparent in the subroles but is evident in the amount of time dedicated to each area of focus. Currently, NP and CNS commonalties are accepted, and the focus is not on blending but strengthening each role and recognizing the unique contributions of both.

Specialty practice (e.g., oncology) is directing APN functions toward market initiatives that value the design of case management systems. Currently, ONS membership includes 675 nurses who identify themselves as case managers; 42 are prepared at the master's degree level (M. Vrabel, personal communication, April 4, 2001). The role of case management is growing among APNs. A case management program for patients receiving chemotherapy (diagnostic related grouping 410) tested by Haddock, Johnson, Cavanaugh, and Stewart (1997) demonstrated a reduction in length of stay and chemotherapy side effects. Patient satisfaction increased significantly six months after implementation of a CNS case management program at the University of South Carolina in Columbia (Sherman & Johnson, 1994).

The Advanced Practice Nurse Role in Oncology

APNs provide integrated care across the continuum of cancer in specialized areas such as palliative and hospice care. Weggel (1997) emphasized the advantages of APN leadership in these areas and cited a need for the establishment of the APN role in palliative care. Great Britain has moved toward the APN model to provide direct and indirect care to the dying. APNs provide direct care by implementing interventions for problems and planning prebereavement and bereavement services. Indirect APN care includes providing consultation and education services and empowering primary care nurses. Scott (1995) suggested using a similar model to complement current hospice care in the United States. The Memorial Sloan-Kettering Cancer Center Supportive Care Program currently uses an APN model in which APNs are responsible for the day-to-day management of health care and are assigned to care for patients identified as high risk for pain and other symptoms (Coyle, 1995).

The genetic revolution of the late 1990s and early 21st century has created a potential need for presymptomatic genetic diagnoses and risk assessment of developing diseases, such as cancer. The complexity and expansion of genetic research has created the need for oncology APNs to become active in genetic counseling and testing. Oncology APNs are the ideal healthcare professionals to assess for genetic pre-

disposition (i.e., pedigree construction), educate patients and families about genetics, and order appropriate cancer surveillance tests. Oncology APNs with a subspecialty in genetics are highly qualified to provide genetic counseling and testing, interpret cancer predisposition test results, and develop and coordinate cancer genetic programs and services (Greco, 2000). Additionally, these specialists provide consultation and translate genetic information to other healthcare providers.

Currently, oncology APNs work in multiple settings, such as hospitals, clinics, hospice, home, and long-term care facilities and with specific populations in cancer prevention, screening, active treatment, and palliative care. Oncology APNs may function in a variety of roles, including serving as healthcare providers for patients undergoing active treatment, providing follow-up care to cancer survivors, managing care in the acute care setting, acting as case managers, working in industry, operating research studies, and providing palliative, hospice, and bereavement care. Although the APN role has expanded over the past decade and encompasses numerous responsibilities, the focus continues to revolve around helping patients and families to cope with the cancer experience. The number of CNSs providing cancer care in the United States and throughout Great Britain has increased steadily over the past several years (Hill, 2000).

Historical Perspective of Advanced Practice Nurse Education

The GI Bill influenced the evolution of advanced education for RNs and the development of the Professional Nurse Traineeship Program, which gave nurses who had served in World War II the opportunity to return to school. During the postwar period, healthcare needs concentrated mainly on inpatient hospital care, and the need for nursing leadership was recognized. During this time, universities, colleges, and certificate programs initiated postgraduate programs focusing on specialty care areas, administration, and education. The opportunity for advanced education continued in the 1960s with the Nurse Training Act, which provided additional sources of funding (Kalisch & Kalisch, 1986).

Clinical Nurse Specialist Education

Early CNS graduate programs were in psychiatric nursing, including the first graduate nursing program, developed at Rutgers University in 1954. Master's degree programs rapidly developed across the country, offering training in a variety of specialties, including adult health and medical-surgical nursing. Nursing program curricula were based on nursing models, and the goal was to train nurses to care for a population of patients in a specific specialty (e.g., clinical practice, education, consultation, research). As early as 1965, ANA stated in a position paper that the CNS title should be used only by nurses with a master's degree in nursing (Belcher & Shurpin, 1995). In the mid-1990s, when the need for primary care NP programs increased, the number of CNS programs declined and many programs began to develop combined NP and CNS curricula. By the late 1990s, the literature began reporting the demand for and shortage of CNSs across the country. Currently, a rise in patient acuity and complex health issues is resulting in a growing demand for CNSs. In response to this growing demand, for example, the School of Nursing at the University of Pittsburgh in Pennsylvania reinstated its master's degree CNS program in the fall of 2001 ("Pitt," 2001).

Nurse Practitioner Education

The University of Colorado in Denver developed the first NP program in 1965 (Ford & Silver, 1967). These early NP programs were offered as continuing education or certificate programs in medical or nursing schools until 1975, when specialized NP master's in nursing degree programs became available. In 1992, the American Nurses Credentialing Center required a master's degree for NP certification (Galassi & Wheeler, 1994). Although early programs all were based on a medical model, the goal of the programs was to train nurses to serve in expanded roles as practitioners of nursing and provide medical services to people in underserved regions. The curricula typically was focused on pharmacology, primary care, physical assessment, history taking, health promotion, and nutrition.

Oncology Advanced Practice Nurse Programs

As early as 1968, the University of Pittsburgh offered an oncology tract in the medical-surgical master's degree program in nursing. The first oncology graduate program in nursing, however, was not offered until 1974 at Rush University in Chicago, IL. Oncology graduate nursing programs vary in curricula and presentation of content. In 1990, 44 nurses graduated from CNS programs in oncology nursing (Hinds, 1990). Currently, 35 U.S. institutions offer master's degree programs with an oncology concentration; 26 are CNS programs, and 9 are NP programs (Peterson's Guides, 2000). In addition, two separate oncology-focused programs have developed, one offering a master's in pain and palliative care at New York University in New York, NY (Sherman, 1999) and one in palliative care at the Breen School of Nursing at Ursuline College in Pepper Pike, OH (Sheehan, 2001). In 1978, the American Cancer Society (ACS) published a curriculum guideline for a master's degree in nursing with a specialization in oncology. The current edition of this guideline (ACS, 1994) has broadened the course content to include CNS and NP education in clinical practice, education, consultation, collaboration, systems management, role competency, research, outcome evaluation, program development, and leadership. The ONS Education Committee published *Standards of Oncology Nursing Education: Generalist and Advanced Practice Levels* (ONS, 1995b), a document containing recommendations for developing standardized oncology nursing education programs that reflect the current state of knowledge and practice.

Past Recommendations and Current Status of Major Oncology Advanced Practice Nurse Issues

In 1994, ONS conducted a state-of-the-knowledge conference on oncology advanced practice nursing to identify specific issues and make recommendations for APNs. The participants of this conference wrote and forwarded recommendations to the ONS Board of Directors (Hawkins, 1995). Table 1 includes the conference's 10 global recommendations. Some of the issues have been addressed and resolved; others continue to be problematic.

Table 1. Current Status of 1994 Recommendations

Recommendations	Developments and Current Status
1. Officially adopt the use of the term advanced practice nurse (APN) as a single umbrella designation for clinical nurse specialists (CNSs) and nurse practitioners (NPs).	The Oncology Nursing Society (ONS), American Nurses Association, American Association of Colleges of Nursing, and the National Council of State Boards of Nursing recognize four types of APNs: certified registered nurse anesthetists, certified nurse midwives, CNSs, and NPs. The standard and professionally accepted terminology in the literature concurs with this definition (Pearson, 2001). *ONS Position on the Role of the Advanced Practice Nurse in Oncology Care* (ONS, 2001) endorsed the title APN to designate CNS or NP roles in oncology nursing but does not infer the merger of these two roles. The ONS position defined the oncology APN as a nurse prepared with a minimum of a master's degree in nursing who has education in the specialty of oncology and precepted clinical oncology experience.
2. Explore the ramifications of second licensure for advanced practice in states that have implemented this legislation.	Each state has its own summary of APN legislation for title protection, legal authority for scope of practice, and prescriptive authority. All state laws and rules have an impact on scope of practice. Second licensure is not prevalent; state laws are not uniform in scope of practice; and prescriptive authority rules vary and continue to prohibit APNs from practicing to their full capacity. The ONS position is that all states should recognize the advanced oncology certified nurse (AOCN®) certification as an indication of competence that should be included in the criteria for a practice licensure or recognition. Nineteen states accept AOCN® certification as meeting requirements for advanced oncology nursing licensure or recognition (ONS, 2001).
3. Develop a model core curriculum for APN oncology graduate programs.	Each university has its own oncology curriculum for oncology APN education in a CNS or NP track. The American Cancer Society (ACS) published a guide to include CNS and NP clinical education in master's degree programs (ACS, 1994), and ONS developed a document for standard oncology nursing education at the advanced level (ONS, 1995b).
4. Support increased funding and access opportunities for postgraduate education.	Section 822 of Title VIII of the Public Health Service Act has continued to be the major federal source of support for NP programs. Grant award monies for the funding of NP programs increased from $2 million to $11 million between 1976 and 1996. Federally supported projects continue to provide funding for about 15% of NP programs committed to underserved populations. Section 821 of Title VIII increased funding of CNS programs from $2 million to $17 million between 1976 and 1989. The amount provided for CNS training during the 1990s was about $12 million (Health Resources and Services Administration, 2000a). The ONS Foundation has awarded 14 postmaster's scholarships since 1996 (B. Revo, personal communication, July 10, 2001).
5. Open the AOCN® examination administered by the Oncology Nursing Certification Corporation (ONCC) only to master's prepared RNs.	The current requirement is a master's degree in nursing.
6. Explore the feasibility and ramifications of joint APN certification examinations with other organizations.	ONCC offered the first AOCN® examination in 1995. ONCC has explored joint certification examinations with other organizations and has determined that the current AOCN® certification meets the needs of ONS constituents. Nineteen states recognize the AOCN® credential, and numerous states currently are considering recognition. (C. Miller-Murphy, personal communication, July 6, 2001).
7. Increase opportunities to expand the knowledge and involvement of APNs in the regulatory and legislative process.	The *Oncology Nursing Forum, Clinical Journal of Oncology Nursing, ONS News,* ONS Online, and the ONS special interest group newsletters provide a mechanism for reporting legislative updates and issues. In 2002, ONS will offer a session on the regulatory process and legislative issues prior to the ONS 27th Annual Congress in Washington, DC. The session will include a trip to the U.S. Capitol, and attendees will be encouraged to discuss major nursing issues with their Congressional representatives. In 2001, ONS encouraged members to serve as state health policy liaisons (SHPLs) and is supporting SHPL attendance at the 2002 annual Nurse in Washington Internship Program. ONS developed a comprehensive legislative agenda for the 107th Congress focusing on four key areas: ensuring access to quality care, preventing and reducing suffering from cancer, advancing tobacco control, and bolstering the practice of oncology nursing. ONS is a participant in One Voice Against Cancer, a coalition of cancer-related organizations that lobbies for increased funding for cancer programs by meeting with Congress and lobbying to elevate cancer concerns in legislature (Halpern & Waters, 2001).

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Table 1. Current Status of 1994 Recommendations *(Continued)*

Recommendations	Developments and Current Status
8. Revise the *Standards of Advanced Practice in Oncology Nursing* (ONS, 1990) to more accurately reflect current and future practice.	ONS published *Statement on the Scope and Standards of Advanced Practice in Oncology Nursing* in 1997. In February 2001, ONS developed *ONS Position on the Role of the Advanced Practice Nurse in Oncology Care,* which provided a comprehensive description of professional practice.
9. Incorporate APN outcomes into the research priorities of ONS.	The ONS Research Priority Survey 2000 included "outcome of cancer care" in the questionnaire. Survey results will be published in 2002. The APN retreat in 2000 addressed outcome measurements, and the 2001 retreat participants were committed to working on evidence-based and outcome measurement projects.
10. Encourage APNs to seek out opportunities for involvement in healthcare setting decision-making groups.	ONS has supported the nomination of ONS members to the following key decision-making committees: the National Cancer Advisory Board, the President's Cancer Council, and the National Cancer Institute Board of Scientific Advisors. ONS members have been appointed with the support and encouragement of ONS to positions on National Cancer Institute Progress Review Group Committees, the American College of Surgeons Commission on Cancer (ONS Board seat), and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Professional Technical Advisory Committees, and ONS supported the nomination of an ONS member to JCAHO (L. Fennimore, personal communication, July 6, 2001).

Conclusion

As our population ages and the number of oncologists declines, the demand for oncology APNs to provide expert clinical, educational, emotional, and supportive care will intensify. APNs must continue to practice in a wide variety of roles, providing direct care to patients and families and working with healthcare systems and policy issues. Experienced APNs have a comprehensive perspective of the current healthcare delivery system and can communicate the effectiveness of expert nursing care as it relates to patient outcomes and organizational efficiency. The importance of APNs must be documented and communicated to healthcare policy decision makers. APNs provide advice on the appropriate distribution and restructuring of healthcare systems, application of technology, and interpretation and utilization of research. Future APN leaders will need to collaborate with physicians and administrators and negotiate with business and financial policymakers to help shape the ongoing design of healthcare reform.

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