# 5 STEP FIVE:
## Define the New Model of Care and APN Role

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**Where are you in the PEPPA Framework?**

- You are at the fifth step where you and your team define the new care delivery model and how the advance practice nursing (APN) role will support care provision in the model.

**What do you need to move forward to complete this step?**

- Prioritized goals for a new model of care.
- Identified and engaged stakeholders.

**How will this chapter help you?**

- Identify strategies for enhancing the care delivery model to meet priority patient health needs.
- Identify if the APN role is appropriate for this care delivery model.
- Understand different types of APN roles.
- Use an algorithm for making decisions about the type of APN role to introduce in a healthcare setting.
- Examine different APN job descriptions.
- Construct a logic model.

## Step Five Objectives

- Determine activities to enhance the model of care for meeting patient health needs.
- Determine the need to introduce a new health provider role and what the role will entail.

## Guiding Questions for Step Five Activities

I. What new practices and care delivery strategies (activities) can be employed to achieve identified outcomes? Are there evidence-based data to support these changes?

II. Are changes to current roles and responsibilities required to implement new care practices and care delivery strategies?

III. Is there a need for the additional expertise of a new or alternative health provider role?

IV. If so, would an APN role enhance the ability to achieve goals for meeting patient health needs? How do we know this?

V. How well does the APN role "fit" with the goals of the new model of care?

VI. What are the advantages and disadvantages of an APN role compared with alternative health provider roles?

## Key Messages

1. Continue to construct your logic model by determining the inputs, activities and outputs required to achieve goals and outcomes established in Step Four.
2. Generate a broad range of potential activities.
3. Develop a comprehensive package of activities to achieve outcomes.

## Introduction

In Step Five, we build on previous activities to determine how identified goals and outcomes for improving the model of care delivery will be achieved.[1] At the conclusion of this step, the specific details of the new model of care will be established along with the roles and responsibilities of existing and potentially new health providers.

## Logic model: Continue to build

Continued logic model construction is a helpful strategy for illustrating how specific activities and changes to the model of care are linked to achieving individual goals and outcomes. In this step, logic model development (Figure 1) focuses on identifying:

- activities or strategies to improve or modify the model of care,
- resources or inputs necessary to implement these activities, and
- outputs or the immediate results of activities that will lead to the subsequent achievement of short, intermediate and long-term outcomes.

**Figure 1 Basic components of a logic model**


Frechtling, J.A. (2007). *Logic Modeling Methods in Program Evaluation.* San Francisco: John Wiley and Sons Inc.

**Inputs** include the material and intellectual resources required to implement the new model of care.[2] Examples of inputs include: funding, in-kind contributions, office or clinic space, equipment, personnel and specific expertise.

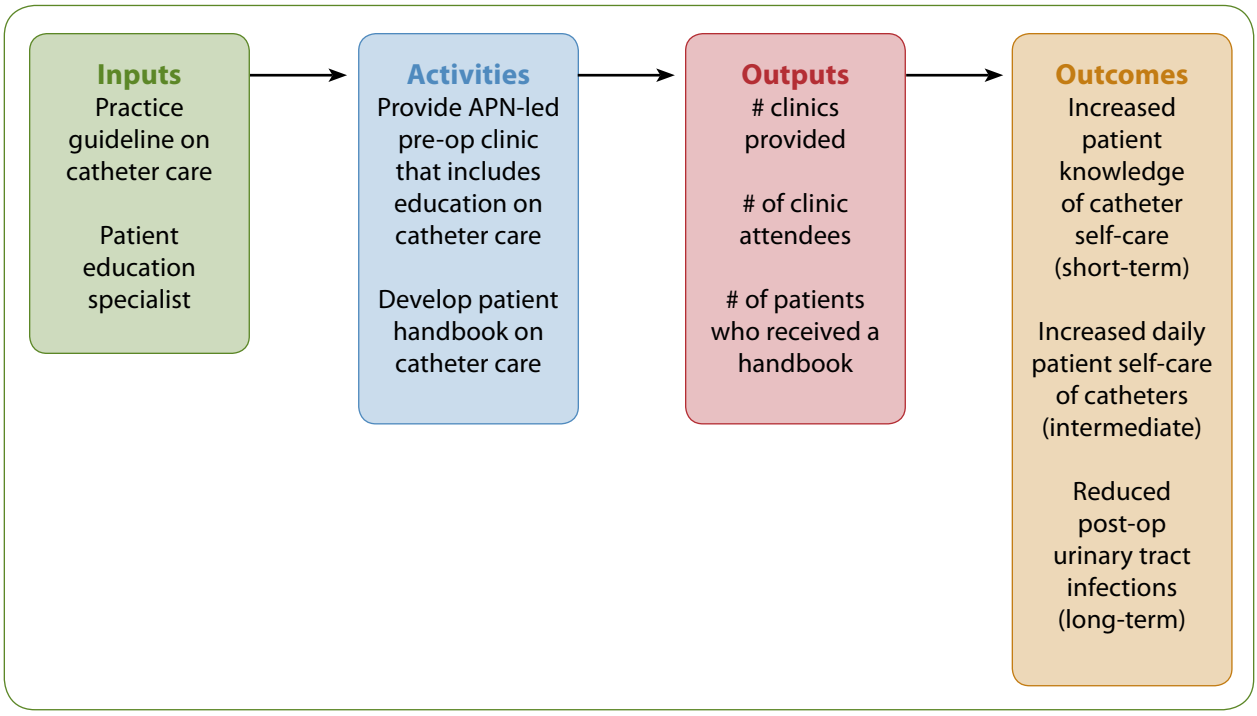
The **activity** components of the logic model essentially outline the main functions or tasks of the new or redesigned model of care. Activities should reflect actions or what the new model of care will look like and deliver. Terms that reflect activities or actions include: conduct, develop, distribute, implement, introduce, educate, teach, train, provide, offer, identify, refer, establish and/or support.[3] Examples of potential activities include the introduction of new services or programs, modifications to existing services or processes of care, changes to organization or team structures and health provider roles and the education and training of patients and/or health providers.

An important aspect to consider is the identification of the target group or audience for individual activities. In addition to patients and health providers, target audiences could include family members, volunteers, specific individuals or groups and organizations.[3]

**Outputs** are the immediate results of activities and may present in the form of quantifiable services, events or products. At times it may be difficult to distinguish outputs from outcomes. To make this distinction, it is helpful to define outputs as evidence that activities or new programs and services within the model of care have taken place.[2] Potential examples of outputs include the number of new clinics, education sessions or education resources provided and the number of attendees or recipients of these new services and/or education resources.

Establishing that an activity has occurred does not provide a measure of its effectiveness in achieving program goals or outcomes. For example, if the new service is a pre-operative patient education clinic on the self-care of urinary catheters, an output would be the number of patients who attend this clinic (Figure 2). A short-term outcome may be increased patient knowledge and skills in catheter care.

**Figure 2 Example of basic components of a logic model**




**Outcomes** are the desired changes or intended results, benefits and consequences expected to occur from the new or redesigned model of care.[2] Outcomes are the reasons why new approaches to care delivery will be implemented. Outcomes may occur sequentially over time. For example, short-term outcomes may need to occur prior to achievement of intermediate or more downstream long-term outcomes. Figure 2 provides some examples of short, intermediate and long-term outcomes.

**Short-term outcomes** are the direct results of new programs or services and provide some evidence that the underlying thinking or "logic" for introducing a new model of care will achieve ultimate long-term goals and outcomes. Changes in awareness, knowledge, attitudes and skills are common types of short-term outcomes.[3]

**Intermediate outcomes** may include changes in behaviours or the uptake of new practices that result from earlier improvements in knowledge or skill. For example, an intermediate outcome such as health provider satisfaction with the model of care may be required before long-term outcomes related to staff recruitment and retention can be achieved.

**Long-term outcomes** are the results of consistent achievement of intermediate outcomes such as uptake of new behaviours or practices. Examples of long-term patient outcomes include reduction in morbidity or mortality rates and improved health-related quality of life. Improved healthcare utilization rates and lower healthcare costs are other potential examples of long-term outcomes.

# Enhancing the Model of Care

**Determine modifications to enhance the model of care for meeting patient health needs.**

## I. What new practices and care delivery strategies (activities) can be employed to achieve identified outcomes? Are there evidence-based data to support these changes?

As the examples of problem analysis methods in Appendixes E1 through E3 illustrate, unmet patient health needs are often associated with multiple rather than singular patient, provider, treatment and/or systems problems. Therefore, generating a depth and breadth of strategies from multiple stakeholder perspectives will be important for identifying the best possible range of strategies necessary to improve the model of care and address unmet health needs. See our prostate cancer scenario on the next page which illustrates this point.

### Generating ideas about potential activities

Several strategies can be used to generate activities for achieving identified outcomes including:

- Brainstorming (see the Resources Section on Successful Brainstorming).
- Reviewing the literature for evidence about the most effective approaches (see the Resources Section on Strategies for Accessing and Evaluating the Evidence about the Effectiveness of Potential Activities).
- Contacting others who have been involved in projects related to similar patient care issues to learn from their experiences.
- Seeking input from key stakeholders who can provide important information and/or resources to support the planning and implementation of activities.

## Prostate Cancer Scenario

In a hypothetical needs assessment of patients with prostate cancer undergoing radical prostatectomy, the identified health goal is to prevent post-operative urinary sepsis (see the Goal Statement in the logic model example found in Appendix F1). Addressing this issue is deemed a priority by the healthcare planning team.

The higher than expected rate of urinary sepsis and delayed post-operative recovery and patient return to optimal health had downstream affects on healthcare utilization with increased hospital re-admissions and the cancellation of other surgeries due to lack of beds.

A number of factors have contributed to this unmet health need including:

- Lack of pre and post operative patient education about the self-care of urinary catheters,
- The increased age of patients who are at higher risk for complications,
- Lack of standardized approaches to assess patient readiness for discharge, and
- Delays in homecare services due to shortages of healthcare providers (See the Problem Statement in the logic model example in Appendix F1).

Implementing only one strategy such as pre-operative education, may limit the extent to which urinary sepsis can be prevented because other contributing factors have not been addressed. The logic model in Appendix F1 provides an example of how multiple activities related to patient education, healthcare provider assessment and management and home care management can lead to the achievement of short, intermediate and long-term goals to prevent urinary sepsis.


To generate the broadest range of innovative and creative solutions, focus first on the generation of possible activities and avoid getting stuck on feasibility or implementation issues.

Initially, it is helpful to focus simply on the generation of possible activities and to avoid getting stuck in discussions about the feasibility of implementation. These issues will be analyzed and considered during the final decision-making process.

Research has shown that APN roles are most effective when they provide a comprehensive package of interventions or services that address patient health needs and gaps in care delivery.[4-7] For this reason, the identification of activities should consider biological, psychological and social interventions relevant to unmet patient health needs and identified goals.

The healthcare setting (e.g., inpatient, outpatient, community and/or home) where interventions may take place is also an important consideration. While new services may need to be introduced, the identification of activities should also consider ways to augment or improve patient access to existing services and resources.

TIP

To generate a range of activities relevant to APN roles and expertise, consider a variety of clinical practice, education, organizational leadership, research and scholarly activities to achieve desired outcomes.

Clinical practice or the direct delivery of patient care is a core feature of APN roles. However, goals to improve oncology nursing practice also require the support of other APN role activities including:

- Education,
- Organizational leadership,
- Research, and
- Professional development and scholarly work.

To identify a full range of strategies that may be relevant to APN roles and expertise, consider how education, leadership, research and professional development/scholarly activities may also contribute to the achievement of identified outcomes.

TIP

To develop a comprehensive package of services and interventions, categorize potential activities into related themes or categories.

Once a broad range of options have been generated, determine if some activities are related to similar themes or categories and potential target groups. For example, in the logic model in Appendix F1, categories or themes of related activities were identified for patient education, healthcare provider assessment, and home management. Patients and/or health providers were the target groups for these activities in outpatient clinics, the hospital and home care settings. Categorizing activities may help to develop a well-defined and comprehensive package of services and interventions.

## Determine the need to introduce a new health provider role

In this section, we focus on determining specific inputs related to the expertise and personnel for implementing selected activities by answering the following questions:

- Are changes to current roles and responsibilities required to implement new care practices and care delivery strategies?
- Is there a need for the additional expertise of a new or alternative health provider role?
- If so, would an APN role enhance the ability to achieve goals for meeting patient health needs? How do we know this?
- How well does the APN role "fit" with the goals of the new model of care?
- What are the advantages and disadvantages of an APN role compared with alternative health provider roles?

To answer all of the above questions requires understanding the scope of practice and the roles and responsibilities of existing and potentially new health providers within the model of care.

## Understanding scopes of practice

Scope of practice is a term used by licensing authorities for various health professions that define the procedures, actions, and processes permitted by licensed practitioners. In Ontario, the scopes of practice for 23 health professions are legislated and regulated by the Regulated Health Professions Act (RHPA).[8] The licensing authority or college for each health profession enforces the RHPA.[9]

Scopes of practice are designed to promote safe, ethical and high quality care by specifying the accountability, responsibility and authority each health provider assumes for the outcome of his or her practice.[10]

To fully understand scope of practice, it is important to review the Scope of Practice Statement and authorized controlled acts for individual health professions. The RHPA identifies 13 controlled acts that may only be performed by qualified practitioners (see Appendix F2). Confusion arises because there is overlap in practice, with some professions authorized to perform the same or some parts of the same controlled acts.[11] However, not all health professions can perform controlled acts. In addition, other legislation such as the Nurses Act, provide some exceptional conditions in which providers can perform controlled acts.[8-12]

Unregulated health providers may also have roles within the existing model of care. These providers include support workers, healthcare aides, home support workers and homemakers. Unregulated health providers assist patients with activities of daily living and may provide basic nursing care such as bathing, dressing, feeding and assisting with medications.[13] The RHPA provides exceptions when unregulated health providers may provide controlled acts.[8]

## II. Are changes to current roles and responsibilities required to implement new care practices and care delivery strategies?

A thorough accounting and assessment of existing roles and responsibilities may assist in determining if changes to the complement and mix of team members are required to implement the new model of care. Goals of this review would be to ensure that the new model of care utilizes current roles to their maximum potential and that interactions among roles are efficient and as productive as possible. Strategies to improve quality of work-life and reduce role strain are also important goals. Table 1 provides a checklist of possible activities to conduct this assessment.

TABLE 1

**Checklist for understanding current roles and responsibilities in the model of care**

| Strategies | Methods or Approaches | Tips |
|---|---|---|
| Document existing roles | Environmental scan to identify all existing roles | Be sure to consider the broadest range of health provider, support, volunteer, clerical, technical, communication and administrative roles.<br><br>Review the care map developed in Step Two to identify the types of roles involved in the delivery of health services. |
| Describe and understand how roles currently operate | Collect and review job descriptions<br><br>Meet with staff individually or in groups | Compare job descriptions with actual role implementation to assess:<br>• If roles are being utilized to their fullest potential,<br>• Needs and opportunities for role development or expansion, and<br>• Role strain due to excessive workload or gaps in knowledge and skills. |
| Identify and compare scopes of practice for regulated health providers | Access the most recent legislation and regulatory guidelines for relevant health provider roles.[14] See http://www.hprac.org/en/keylegislation/keylegislation.asp[15] | Identify where there are role differences or overlap among scopes of practice.<br><br>Assess if roles are operating at their full scope of practice.<br><br>Assess if roles are operating beyond their scope of practice. |
| Examine role competencies, standards of practice and credentialing requirements | Access the most recent legislation and regulatory guidelines for relevant health provider roles.[14] See http://www.hprac.org/en/keylegislation/keylegislation.asp[15]<br><br>Review role recommendations and guidelines of provincial, national and international professional associations | Determine if current job descriptions and role requirements are consistent with legislation and published recommendations.<br><br>Determine if there are opportunities for role expansion.<br><br>Assess if existing staff have the recommended educational preparation and experience for their roles. |

In your review of existing roles consider the following:

- Which roles provide the scope of practice, knowledge and skills to implement planned changes?
- Could individuals in existing roles take on activities with appropriate training, support and/or supervision?
- Would these new activities be an addition to, or replacement of, current role responsibilities?
- Can additional activities be assumed by the existing numbers of staff in the roles or are increased numbers of staff required?
- How do changes in processes of care delivery (sequencing, timing, provider) impact on interactions and communication among team members? Do these changes minimize unnecessary duplication or overlap in role responsibilities?

## III. Is there a need for the additional expertise of a new or alternative health provider role?

If the above assessment identifies the need for additional expertise, which types of roles can provide this expertise? Think broadly about the types of clinical and non-clinical expertise that would be assets for implementing planned changes.

Other roles that may strengthen the skill mix within the team include: volunteers, health planners, support services, information and computer technologists, information management specialists, educators and those with learning technology expertise, researchers, research assistants, graduate students, program evaluation experts, clerical staff, managers and administrators. Other community agencies and organizations that already provide services and have staff with specific expertise may be willing to partner or collaborate in the new model of care.

TIP

Think broadly about the types of clinical and non-clinical expertise that may complement and strengthen human resources within the new model of care.

## IV. If additional expertise is required, would an APN role enhance the ability to achieve goals for meeting patient health needs? How do we know this?

If alternate health provider roles are being considered, APN roles should be included in this examination. To minimize role conflict and confusion and to maximize the use of APN expertise, it is important to clarify stakeholder perceptions about the purpose and multiple dimensions of APN roles.

The mandate of APN roles is to maximize, maintain or restore patient health through innovation in nursing practice and in the delivery of health services.[15-17] A core feature of all APN roles is involvement in the direct delivery of comprehensive patient care.

According to the Canadian Association of Nurses in Oncology (CANO), APNs enhance nursing practice and cancer care delivery through the integration of knowledge and skills across five role dimensions including direct clinical and comprehensive care, research, education, organizational leadership and professional and scholarly development.[18]

A defining feature distinguishing APN roles from other types of nursing roles is that, in addition to clinical care, they have multiple responsibilities for practice improvement and innovation at several levels including patients, the profession of nursing, health providers, cancer care organizations and the broader healthcare system.[15-19]

TIP

A defining feature that distinguishes APN roles from other types of nursing roles, is the integration of multiple role responsibilities for nursing practice and health systems improvement through:

- The provision of direct clinical care,
- Education,
- Research,
- Leadership, and
- Professional development and scholarly activities.

Professional practice leaders, managers, educators and/or researchers may have responsibilities for leading, developing, implementing, teaching or evaluating the effectiveness of new oncology nursing practices. However, unlike APNs, they are not involved in the direct provision of patient care. Similarly, very experienced registered nurses in non-advanced roles may have specialized oncology nursing knowledge and skills in the delivery of direct patient care but do not have leadership, education, research and professional/scholarly responsibilities for practice improvement.

APN roles are also designed to be flexible and responsive to changes in patient, health provider, organization and health systems needs. As a result, there is wide variation in how APNs implement their roles even within the same organization or for similar patient populations. Individual APN roles also evolve over time in response to changing needs. These dynamic features can make it difficult for stakeholders to fully understand and develop appropriate expectations of APN roles.

## Strategies for clarifying and understanding APN roles

A frequently reported barrier to the successful implementation of APN roles is stakeholder confusion about the purpose of these roles.[19,20] Some stakeholders may come to the healthcare planning team with pre-conceived perceptions and attitudes about APN roles that may or may not be accurate or complete. For this reason, it may be useful to have a group discussion about individual perceptions and experiences with APN roles. How these views and levels of understanding compare with current provincial and national policies could also be assessed. Through this discussion, team learning needs and strategies for establishing an up-to-date and a mutually shared understanding of APN roles can be identified.

**TIP**

To promote effective healthcare planning team decision-making about the use of APN roles within the model of care, establish a mutually shared understanding of these roles that is consistent with current provincial and national policies.

While some APN roles, such as Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP), have been in practice for over the last 40 years, the overall development of the APN role in Canada is relatively new. Provincial, national and specialty organizations such as the College of Nurses of Ontario (CNO), the Canadian Nurses Association (CNA), the Canadian Association of APN's (CAAPN) and the Canadian Association of Nurses in Oncology (CANO), are continually updating their policies about role definitions, standards of practice, role competencies, educational preparation and the regulation and licensing of APN roles. Representatives of these organizations are important stakeholders who can assist the healthcare planning team to better understand APN roles and to make informed decisions about how these roles could be implemented to meet goals for improving the model of care. Other potential strategies for promoting healthcare planning team understanding of APN roles are summarized in Table 2.

TABLE 2

**Strategies for clarifying and understanding APN roles**

- Review published literature and provincial and national policies on APN scope of practice, role competencies, educational preparation, credentials and regulatory and licensing requirements.
- Identify the information needs of healthcare team planning members by comparing their understanding and perceptions of APN roles with provincial and national policies.
- Promote shared understanding of APN roles within the healthcare planning team through group discussions and learning activities.
- Invite representatives from nursing organizations and associations to participate in the healthcare planning team and/or to provide education and resources to improve team member understanding of APN roles.
- Invite a panel of expert APNs to a team meeting to share experiences on how they have implemented their roles.
- Conduct site visits to see how other organizations have implemented APN roles for similar patient populations.

## Understanding the types of APN roles in Ontario

While we are working toward national consensus about APN roles, regulatory authority for all nursing roles occurs at the provincial level and thus may vary by jurisidiction. Appendix F3 provides a summary of the similarities and differences among APN roles in Ontario. Ontario has three types of APN roles: Clinical Nurse Specialist (CNS), Primary Healthcare Nurse Practitioner (PHCNP) and Acute Care Nurse Practitioner (ACNP) roles.

CNSs provide specialized acute and chronic disease management for patients and families affected by cancer who have complex health needs.[21] In oncology, CNSs may specialize in areas defined by type of cancer (i.e., breast or prostate cancer), type of care (i.e., palliative or wound care), type of treatment (i.e., bone marrow transplantation, radiation therapy) and/or patient age (young adults, geriatrics). CNSs work most often in hospitals, outpatient and long-term care settings. CNSs have the same scope of practice as registered nurses and thus do not require additional legislation or authority to practice.

PHCNPs provide health promotion and disease prevention services, episodic care for minor injuries and illnesses and ongoing management for patients with chronic illness.[21] In oncology, PHCNPs may have a role in cancer prevention and screening, chronic disease management, surveillance and in palliative care. They work most often in family practice, outpatient, emergency department and community settings.

An ACNP may also be known as NP-Pediatric or NP-Adult. ACNPs provide acute and chronic disease management for patient populations with specialized needs.[21] They work most often in hospital and outpatient settings in a variety of speciality areas of cancer care similar to that of CNSs.

PHCNPs and ACNPs have an extended scope of practice that permits functions normally confined to physicians.[22] An extended class (EC) license gives NPs the authority to diagnose, prescribe and treat common medical conditions. NPs are required to successfully complete an exam for NP-Primary Healthcare, NP-Adult or NP-Pediatric. Completion of this exam provides them with an EC license and authorization to use the title, NP. While the EC license provides NPs with diagnostic and prescriptive authority, there are restrictions on these activities.[22] Appendix F4 provides some examples of these restrictions and information on how to access current guidelines. In 2010, new legislation will reduce some of the current restrictions on NP practice.

Credentials include certificates, degrees or diplomas awarded by educational institutions.[20] Appendix F5 summarizes national documents and position statements about APN roles in Canada. There is national and international agreement that completion of a graduate degree in nursing is the optimal level of preparation for CNS and NP roles.[23,24]

NPs must complete an approved NP program offered at an undergraduate or graduate level for PHCNPs or graduate level for ACNPs.

Clinical nursing practice is the primary core function of CNS roles. For this reason, the CNA recommends that CNSs complete a gradute degree in nursing and have clinical experience in a specialty area of practice.[25] Therefore graduate degrees in other disciplines such as education, business or psychology are not recommended as the basis for CNS practice. Unlike NPs, there are no CNS specific graduate eduction programs. CNSs complete a generic advanced practice nursing or graduate nursing education program.

Canada currently does not have a graduate program in oncology nursing, although some universities provide a single cancer specific course. Colleges and universities may also provide introductory level oncology nursing certificate programs for basic but not advanced levels of practice. Therefore most APNs develop specialized oncology knowledge and skills through practice experience.[20]

CANO recommends advanced certification in oncology as a requisite for all APN roles.[18] In Canada, nursing certification in areas of specialized practice is only available through the Canadian Nurses Association at the basic but not advanced levels. Advanced level certification exams in oncology nursing are available through the Oncology Nursing Society in the United States.

CANO distinguishes the oncology APN from the generalist and specialized oncology nurse.[18] The generalist nurse may care for cancer patients within an assigned caseload and is prepared at the basic educational level. The specialized nurse is a registered nurse whose primary focus is cancer care. This nurse has enhanced specialty knowledge and skill and practices in an environment where most individuals have a diagnosis of cancer or are at risk of developing cancer.

## V. How well does the APN role "fit" with the goals of the new model of care?

Previous research has demonstrated that there is often a disconnect between why and how APN roles are implemented and the underlying goals and scope of these roles.[19] This lack of "fit" contributes to the underutilization of APN expertise and provider-versus-patient focused roles. Lack of "fit" can lead to APN roles that replace or support rather than complement existing provider roles and may contribute to role conflict, poor role acceptance, and poor APN job satisfaction. Table 3 provides some indicators for assessing the fit between goals for improving the model of care and oncology APN roles.

Appendix F6 also provides some evidence-based examples of different models or ways in which oncology APN roles have been implemented and evaluated. In each of these examples, oncology APN roles were found to be effective in achieving positive patient, provider and health systems outcomes.

TABLE 3

**Indicators of fit between goals for model of care improvement and oncology APN**

- The ultimate goal is to promote, maintain or restore the health of patients at risk for/or affected by cancer.
- New care processes and interventions improve the delivery of continuous, coordinated and patient-centred care.
- There is flexibility for the APN role to transition with the patient who has complex, specialized and intensive healthcare needs across practice settings (e.g., inpatient, outpatient, home).
- Responsibilities in all 5 dimensions of the oncology APN role (direct patient care, education, research, organizational leadership and professional/scholarly development) can be identified and linked to activities in the logic model illustrating the new model of care.
- APN activities are innovative; they complement rather than replace or overlap with existing health provider roles.
- The delivery of nursing care is the predominate component of the clinical practice role and is within the RN or RN(EC) scope of practice.
- APN clinical activities involve the delivery of a comprehensive and holistic package of nursing services and interventions to address the biological, psychological and social health needs of patients and families.
- The logic model identifies activities for improving nursing practice that are linked to the APN role and the organization's strategic plan.
- Logic model activities illustrate the roles and responsibilities of the interprofessional healthcare team (in which the APN is a member) for achieving goals.

## VI. What are the advantages and disadvantages of an APN role compared with alternative health provider roles?

The decision to introduce an APN role should include discussion about the potential advantages and disadvantages of the APN role compared to alternate health provider roles. Possible factors to consider are the extent to which comparison roles have the level of educational preparation, scope of practice, knowledge, skills and expertise to implement activities and achieve outcomes outlined in the logic model.[1]

Appendix F7 provides an algorithm or questions to consider when making a decision about whether to introduce an APN role or other types of nursing or health provider roles. The algorithm also provides some suggestions for how to determine which type of APN role (i.e., CNS or NP) should be introduced.

## Developing the APN job description

As Appendix F3 and F5 suggest, various nursing organizations and professional associations define APN standards of practice or the dimensions of these roles differently. For NP roles, the CNO[22] identifies standards and role competencies specific to the clinical practice dimension of the role (e.g., interprofessional care; communicating a diagnosis; prescribing; order lab, x-rays and diagnostic tests (Appendix F3).

In addition, the Canadian NP Core Competency Framework[26] identifies role competencies in four areas: health assessment; health-care management and therapeutic intervention; health promotion and prevention of illness and injury and complications; and professional and role responsibility. To some extent, specific competencies related to education, research and organizational leadership are integrated within these four areas (Appendix F5).

In contrast, the CNA[25] and CANO[18] identify standards and role competencies for five role dimensions for the CNS and the advanced oncology nurse respectively (Appendix F5). Both of these organizations identify similar role dimensions including clinical practice, education, research and leadership. For the CNS, the CNA has established a separate standard and competencies for consultation.[25] CANO[18] includes competencies related to consultation across all role dimensions and places a stronger emphasis on scholarly practice and the professional development of oncology nursing.

Competencies outlined in the CNPI Core Competency Framework[26] are also more consistent with NP roles in primary healthcare rather than acute specialty care settings. Competencies for the NP-Adult or NP-Pediatric are also generic and do not address specialty practice competencies for these roles. To date, the CANO[18] is the only organization to define specialty-based competencies for the APN (Appendix F5). These competencies are useful for informing the development of CNS and NP roles. The lack of consistent use of terms and identification of role competencies contributes to stakeholder confusion about APN roles. There are also a wide number of international models of advanced nursing practice that place different emphasis on certain aspects of these roles.[17] Differences between role competencies highlight the greater emphasis on clinical practice responsibilities and transfer of some medical functions for the NP role compared to the greater emphasis on education, research, and organizational leadership for the CNS role (Figure 3).

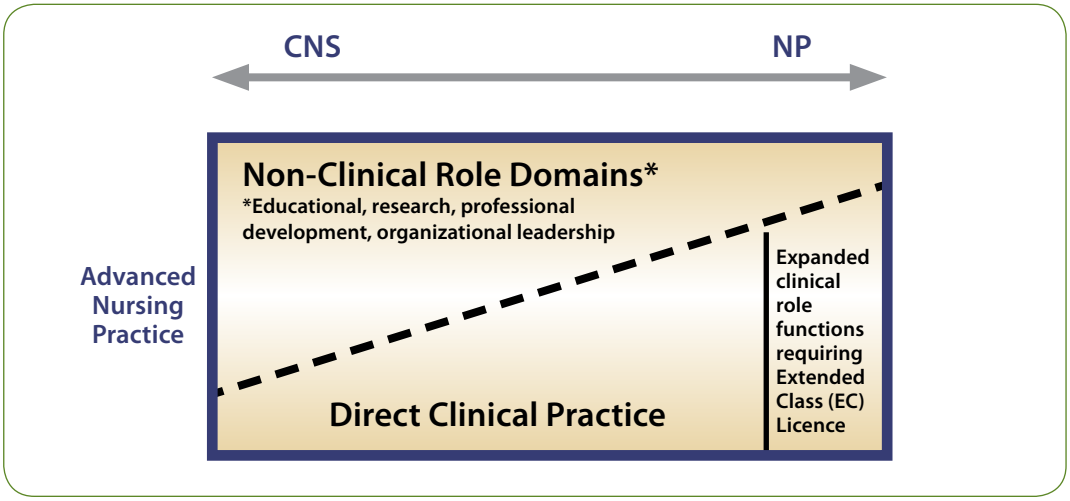
However, as Figure 3 illustrates, APN roles occur along a continuum in terms of their focus on various role dimensions. But regardless of the type, all APN roles must include both direct clinical care and non-clinical role dimensions. There is national and international agreement that what make APN roles "advanced" is not the expansion of medical funcations to the role, but the integration of clinical practice, education, research, leadership and professional development activities that lead to innovation in nursing practice and health systems improvement.[18,19,23,24]

At one end of the continuum are CNSs who generally have greater responsibilities and a higher proportion of role time allocated to non-clinical care activities related to research, education, organizational leadership and

professional development and less time allocated to direct clinical care. At the opposite end of the continuum are NPs who usually have increased responsibility and greater role time providing direct clinical care and less time related to other role dimensions. NPs also have an expaned scope of practice that permits them to perform clinical functions that in the past were restricted to physicians.

In Figure 3, the diagonal line is broken, to reflect the flexible nature of APN roles and that the portion of time CNSs and NPs spend on clinical and non-clinical activities can vary in response to the changing needs of patients and practice settings.

**Figure 3 Continuum of APN Roles**




(Bryant-Lukosius, D. 2002-2008, unpublished work)

A common barrier to the implementation of APN roles is that clinical practice often supersedes the uptake of non-clinical responsibilities. Lack of priority and goal setting for non-clinical role responsibilities, conflicting role expectations and poor time management contribute to the incomplete development and implementation of APN roles and expertise. A particular strength for using the CANO[18] competencies to develop an APN job description is the process of documenting responsibility and accountability for implementing both clinical and non-clinical dimensions of the role.

Developing an APN job description must also take into account the organization's philosophy, values and beliefs about nursing. If there are existing APN roles in other programs or departments of the organization, there should also be a strategy to ensure consistency in how APN roles are defined and implemented. For example, APNs at the University Health Network in Toronto have developed their own model of advanced nursing practice with five core competencies related to clinical practice, education, research, collaboration and change agent to reflect the nursing values and beliefs of that organization.[27] The APN Committee at Winnipeg Health Sciences Centre has also adapted an existing model of advanced nursing practice for roles in their organization.[28]

In Ontario, about 30% of oncology roles are generically titled as advanced practice nurse or are classified as an advanced practice nurse but are called by other titles, such as Clinical Leader, that have been created by the organization.[20] In these situations failure to use consistent and recognized role titles and to clearly identify the specific type of APN role (i.e., CNS or NP), contributes to stakeholder role confusion.

Recruitment of qualified APNs with oncology expertise who have completed a graduate nursing program may also be a challenge.[20] The "grow-your-own" oncology APN model with opportunities for APN internship positions may also need to be considered. For example, Hamilton Health Sciences has an APN internship program where nurses without requisite APN credentials are expected to achieve the required education and licensing conditions for the role over a pre-determined length of time.

Table 4 provides some suggestions to consider when developing an APN job description and Appendix F8 provides some sample job descriptions for CNS and NP roles.

TABLE 4

**Checklist for developing an APN job description**

- Be clear on the specific type and title of the APN role to be introduced (i.e., CNS, NP-Adult, NP-Pediatric, NP-PHC).
- Identify educational, licensing and credentialing requirements relevant to the specific type of APN role (Appendix F4).
- Select a model of advanced nursing practice that outlines role competencies that are consistent with the values and beliefs about nursing practice within the organization.
- Include responsibilities that are relevant to or consistent with recognized role competencies for the advanced oncology nurse (clinical practice, education, research, organizational leadership and professional development).
- Clearly outline scope of practice and responsibilities for initiating and performing specific controlled acts (Appendix F2) along with the needs for Medical Advisory Committee approval and collaborative practice agreements for implementing medical directives. (Appendix F2 ).
- Outline responsibilities for communicating, collaborating and interacting with other health providers.
- Clearly identify the patient populations for and the practice settings in which the role will operate.
- Link APN role responsibilities to organizational structures and strategic goals through defined membership or leadership in specific committees.
- Promote the implementation of professional and scholarly practice role responsibilities and access to academic resources and research supports by requiring a faculty cross appointment to an affiliated university school of nursing.

Stakeholder consensus on APN role responsibilities and activities may also be important for obtaining necessary role acceptance and support.[19,29] This is particularly important when APN role responsibilities are reliant on the cooperation of other health providers in the coordination and provision of clinical care. Stakeholder agreement on role priorities and how work time should be allocated to various responsibilities is important for effective APN time management and to avoid role strain associated with conflicting role expectations.

Consensus strategies such as brainstorming techniques, Delphi survey or nominal group process techniques outlined in the Resources Section of this toolkit can be used to identify stakeholder preferences in defining the specific activities and responsibilities of the APN role.

**TIP**

Establish stakeholder consensus on APN role responsibilities and priorities in order to promote role acceptance and support, minimize role conflicts and role strain and to promote effective time management.

## Next Step

In Step Six of the PEPPA Framework, a detailed plan for implementing and evaluating changes to the care delivery model and the introduction of the APN will be finalized. Step Six will provide guidance on strategies to achieve implementation and evaluation milestones.

# Implementation Pointers

Involve or collaborate with academic partners, graduate students and researchers to ensure you have support for implementing proposed changes to the model of care.

Previously conducted literature reviews or published systematic reviews are important and time saving sources of evidence.

Use toolkits on developing logic models if you need more support in creating a logic model for your care delivery model and its implementation. If your organizational members have no previous experience with logic models, you may want to advocate for a more formal workshop.

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