Innovative Intraprofessional Clinical Training for Clinical Nurse Specialists and Nurse Practitioner Students

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ABSTRACT

Background: Most graduate nursing education curricula naturally segregate students by role as they move into their role-specific coursework and clinical experiences. Segregation diminishes the opportunity for students to form important intraprofessional relationships. Intraprofessional collaboration can potentiate the influence of advanced practice nurses on individual patients, patient populations, and larger health care systems. Method: This pilot program paired clinical nurse specialists and nurse practitioner students in immersion clinical practicum experiences aimed to increase their understanding of each other’s role and potential avenues for collaboration in future practice. Results: Students report increased levels of understanding of each other’s roles and scope of practice. Pairing students in immersion experiences broadens their clinical reach and potentializes their influence on vulnerable patient populations. Conclusion: Findings indicate that this pilot program can be sustained. Benefits to early and focused intraprofessional educational experiences include increased awareness of advanced practice roles, scope of practice, and potential avenues for future collaboration. [J Nurs Educ. 2017;56(12):748-751.]

The complex needs of today’s patients require innovative best practice models and disruption of the traditional methods of preparing health care professionals. In 2001, The Institute of Medicine (IOM) recommended that health care providers work in interprofessional teams to address the complex and challenging needs of systems of care in the U.S. professional health care education programs have answered the call for interprofessional education (IPE) and are embedding IPE course content and clinical experiences into their curricula. However, little has been written about intraprofessional collaboration and how to facilitate this within schools of nursing. Advanced practice nurses (APNs), nurse practitioners (NP), clinical nurse specialists (CNS), nurse anesthetists, and nurse midwives often work separately rather than teams. Traditional graduate nursing education segregates students as they move into role-specific course work and clinical practicum experiences. To better prepare APNs to work in an interprofessional environment, their education should mirror this setting.

Nurses, especially CNS and NP students, enrolled in traditional graduate programs experience clinical education in separate role-specific clinical practicum courses and clinical sites. Each program has different and distinct objectives for their clinical training. Beyond the initial shared APN curricular content of the “3-Ps” (Advanced Pharmacology, Pathophysiology, and Physical Assessment), which are taken early in the curricula and before the formation of any professional identity, the roles have very little interaction and few academic intraprofessional collaborative opportunities. To add to this divide, many graduate nursing programs are offered via an online or hybrid format, further decreasing opportunities for student groups to interact and develop an understanding and appreciation of one another’s role, responsibilities, and scope of practice.

Little has been written about an intraprofessional collaborative model for the CNS and NP role in clinical practice (McNamara, Lepage, & Boileau, 2011). A literature review resulted in even fewer studies that examined a collaborative clinical education and learning experience for the two advanced practice roles. Plager, Conger, and Craig (2003) discussed how to develop curricula in which the two tracks shared blended content. However, students were not placed together in a clinical setting. Although this type of preparation provides the opportunity for exposure within the classroom, it does not prepare these two integral advanced practice roles for collaborative practice. Too often, these roles have functioned in parallel, or even direct
competition, with one another rather than working together in a collaborative fashion, resulting in inefficient and costly patient care models (McNamara et al., 2011). Lack of understanding of the CNS role among both health care team and community members adds to the divide. This article describes a pilot clinical experience designed to build a collaborative intraprofessional experience between CNS and NP students.

**Differences Between CNS and NP**

The focus of the CNS and NP roles are distinct, with different purposes and outcomes. Both strive to improve the health of the populations for which they provide care. The NP is an expert provider of direct primary or specialty care for both patients and families and is prepared to fill the void of qualified primary care providers in rural and medically underserved areas (National Conference of State Legislators, 2016). They are trained in conducting assessments, ordering and interpreting diagnostic tests, diagnosing, and initiating and managing treatment plans to include the prescription of medications (American Association of Nurse Practitioners, 2010). NPs also promote health management and disease prevention through patient-centered education and counseling. In contrast, the CNS is prepared as a clinical expert for specialty populations, a systems thinker, and an expert in communication, collaboration, and team building. They also have special skills and expertise in identifying gaps in health care delivery, designing and implementing programs, and assessing and evaluating health care interventions to improve health care delivery and outcomes (National Association of Clinical Nurse Specialists, 2015). Although the NP focus is typically at the patient level, the CNS focus is on population health and systems.

**Potential Benefits of CNS and NP Collaboration**

A collaborative model between the CNS and NP has not been researched in great detail. Nonetheless, it is evident that CNS and NP collaborative practice can provide significant potential for improving outcomes for patients and populations. Although they have distinct roles, they share common goals. A collaborative practice model allows the NP to focus on providing necessary individualized primary care, although their CNS partner focuses on the coordination and transition of care. Patients with multiple chronic diseases requiring complex care coordination could benefit from the expertise of the NP and CNS paired to provide detailed and tailored education and coaching. The CNS is able to develop clinical pathways and quality indicators that streamline care while also increasing quality and decreasing cost for the already burdened rural and medically underserved community clinics. In addition, the CNS can develop data retrieval and monitoring processes necessary to track outcomes and efficiencies in today’s changing health care environment. Together, these roles could ensure that rural and medically underserved health clinics are providing patient-centered, culturally sensitive, quality care.

**Collaborative Models of Care for Rural and Underserved Clients**

The U.S. health care system has been plagued with limited access for patients and inefficient and ineffective systems of care. Patients in rural and medically underserved areas are particularly vulnerable. Not only do they have limited access, but they also lack the continuity of care necessary to achieve improved outcomes and decreased cost (National Rural Health Association, 2016). Although the Triple Aim calls for an integration and coordination of client focused care that bridges acute and community care settings (Berwick, Nolan & Whitting, 2008), this type of care is difficult to achieve in rural communities. APNs are uniquely prepared to provide necessary care to meet the needs of these vulnerable populations; however, educational programs have not historically prepared them to work together using a collaborative model to improve health care systems and population health. Collaborative models, where APNs work side by side on an integrated team, can potentiate the level of comprehensive care that they are able to deliver, eclipsing what they can achieve in traditional siloed roles. To accomplish this type of interprofessional collaboration, CNSs and NPs must understand and respect one another’s unique preparation, scope of practice, and professional role. Practicing this type of collaborative care model should begin while in training. Educational programs not only have the responsibility of preparing APNs for independent practice, but also fostering the development of collaborative relationships between APN roles, thus ensuring that APNs are better equipped to meet the needs of rural and medically underserved populations.

**Intraprofessional Pilot Clinical Practicum Site and Experience**

Under the direction of the Graduate Program Director and supported by a Health Resources and Services Administration grant, CNS and NP faculty developed a program for training and support of APN preceptors in rural and medically underserved areas, thereby increasing graduate nursing student placements in these community settings and improving APN preceptor skill. Although NP students had typically been placed in rural and medically underserved areas for some of their clinical training, the CNS students had completed most, if not all, of their clinical hours in traditional urban acute care hospital settings. The pilot intraprofessional clinical experience was designed as a 1-week immersion training experience during which an NP and CNS student team was paired for a clinical experience in a rural community-based clinic. Two student volunteers, one from the Family NP program and one from the Adult-Gerontology CNS program, were selected. Each student had completed one full semester of clinical training within their traditional clinical setting (NP - primary care community practice, CNS - Acute Care Hospital setting). It is important to note that students enrolled in the Adult-Gerontology CNS program are dually prepared as nurse educators, enhancing their ability to formulate patient program outcomes and recognize how institutional, social, and economic factors may impact the work of the IPE team.

The first goal of the intraprofessional clinical experience was to expose the students to an innovative model of care in a rural and medically underserved community-based clinic. The initial clinical site was a dynamic community-based medical home initiated by two NPs with deep ties to the community. In addition to a traditional brick-and-mortar community-based clinic, the
clinical site included a mobile health wagon with sophisticated diagnostic equipment prepared to take health care to vulnerable members of the community who may be place bound and otherwise disenfranchised. The second goal was to challenge the NP and CNS student team to collaborate using a new model of care where they work together to identify patient and population needs and develop innovative solutions to improve patient care and patient care outcomes. The intraprofessional student team was expected to assess and develop one sustainable quality improvement project to meet the needs of the clinic’s population that could be followed longitudinally by future student teams to include rapid cycle evaluation and improvement with each student team immersion experience. Future NP and CNS student teams would follow at various intervals, with the goal being at least one team each semester. Once a team’s project is initiated, the new dyad would identify further potential projects to develop through a similar process.

The Student Experience

While the 8-hour drive across the state to the clinic was not intended to be part of the learning experience, the student team reported engaging in rich dialogue that could not have been replicated in a classroom or discussion forum. They took this time to not only get to know each other but also to explain the unique preparation, competencies, and responsibilities of their roles. Despite the students’ years of experience as practicing RNs at the bedside, the NP student was not fully aware of the CNS competencies and preparation. By the time they had arrived at the clinic, the students reported that they were able to identify the different, yet complimentary, skills of the CNS and NP. The NP quickly began, under the tutelage of the clinical preceptor, providing high-level patient care focusing on diagnosis, treatment, health promotion, and health management. In contrast, the CNS student began an analysis of not only the clinic, but also the community and population that the clinic serves.

The NP student realized the need for extended teaching regarding diabetes management and healthy living. Most patients traveled over 1 hour “off of the mountain” to come to the clinic and were unable to make frequent visits to the clinic. Although medications and necessary supplies to manage a patient’s diabetes were provided by the clinic, these patients were unable to access healthy fruits and vegetables. The closest grocery store for most residents was at least a 1-hour driving distance from their homes. The staff felt that the CNS student should lead a diabetes education program, beginning with initiation of telephone contact with patients to schedule their education session. Of 150 community members who were identified to participate in the education, the CNS student was only able to reach seven who were able to come into the clinic at the scheduled time. After discussing these findings with the CNS faculty mentor, the student began conducting an informal survey to determine why the community members could not attend. Common themes included the need to care for a family member, lack of transportation, and conflicting work schedules. In collaboration, the CNS and NP student team identified the typical wait time for each patient to see the NP as an opportunity for the CNS to begin educating the patient on disease management, healthy living, and community resources. This tag-team approach worked well. Not only was the CNS able to assist the patient, but she was also able to gather valuable concise information during the educational session and provide this to the NP, aiding in the facilitation of a successful and efficient appointment.

Student Outcomes

The students reported that their experience at this rural clinic was invaluable. Although it was not glamorous, it exposed them to brokenness and great needs that exist within their own state, of which they were not fully aware prior to the clinical emersion experience. Each student felt a calling to return to the clinic or similar settings upon graduation on a volunteer basis. Prior to this experience, the CNS student had not considered returning to the rural community in which she had been raised. She articulated a new desire to practice in a rural community setting, as opposed to her original plan to work in the urban acute care setting.

Following this experience, with faculty support, the students submitted an application to the institutional review board of their university to return to the area during a remote area medical mission weekend to collect demographic data and information on how the population would prefer to receive health information related to needs articulated by the members of the community. The original two students, joined by another CNS and NP student and an interprofessional faculty led team, returned to collect data on more than 220 patients. Although a preliminary data analysis has been completed, final data analysis is still underway. Findings will be used by the next student team to tailor an educational program that fits the needs of the population based on interest and availability. In addition, the intraprofessional student team and faculty wrote and published an article about their experience in the state nursing association’s quarterly newsletter.

Conclusion

Students and faculty alike realized that the richness of the experience and outcomes could not have occurred without an intraprofessional partnership. Health care needs to embrace new models of care and intraprofessional work is essential. The CNS and NP partnership can provide a powerful vehicle for this change.

Since this experience, additional community based settings have been located and secured in rural areas. Faculty met with each site to discuss outcomes expected of student CNS and NP teams. It will be the expectation that each student has a partnering experience at least once before graduation. The goal is to have a deliverable for each site. Future student teams can enhance and further develop the deliverables or address new needs identified during their own experiences. For example, during this particular rural experience, the team worked on enhancing the current teaching related to diabetes management. Other students can use this information to tailor a project to meet these needs. After the blueprint for identifying a problem, developing solutions, and implementing rapid cycle improvement has been put into action at the different sites, each subsequent student team can move the project forward and develop a new project. Work product will be driven by community identified needs. Preliminary data from the summer remote area medical survey showed that most individuals preferred written material they
could take home to review versus a classroom or online program. The next pair of students will continue this work.

Although this pilot study was funded through a Health Resources and Services Administration grant, it is a sustainable model for intraprofessional advanced practice clinical education and one that could easily be replicated by other schools. With an increasing focus on IPE in all health care professions, the lessons learned regarding roles and responsibilities, respect, effective communication, and team building in an intraprofessional clinical education model for CNS and NP students can lay the foundation for their collaborative work within interprofessional teams in their future practice.

Clinical sites must have a clear understanding of each APN role. Many rural community-based clinical sites do not have a CNS preceptor. Most are unaware of what the role is and how it will benefit the clinic. Faculty must invest time in visiting these sites either face-to-face or virtually to ensure preceptor colleagues are aware of the potential roles for the NP/CNS team in their setting. Further, as each NP/CNS team travels to a new site, the roles of each APN can be modeled by the students, further educating our providers in the community.

Finally, although this pilot IPE experience was designed to include a CNS/NP dyad, future teams may be expanded to include other APN student roles, including midwives, nurse anesthetists, and nursing administrators. The population of the clinic and needs of patients can help direct the development of appropriate intraprofessional advanced practice nursing team members.

References