Bridging the Gap Between Acute Care Nurse Practitioner Education and Practice: The Need for Postgraduate Residency Programs

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ABSTRACT

The dearth of specialty training in graduate programs for acute care nurse practitioners (ACNPs) has created a gap between education and practice. The demand in hospitals for ACNPs has risen dramatically across the board. Concerns for patient safety and lowered overall satisfaction with care have led many hospitals to use ACNPs as a solution to the reduction of house staff. However, a lack of specialized training could jeopardize the ability of ACNPs to embrace this opportunity. Postgraduate residency programs could provide formal, mentored, and specialized training over the course of a year, preparing ACNPs to step up to the challenge.

Keywords: Acute care, education, mentoring, nurse practitioners, postgraduate residency

The need for nurse practitioners (NPs) in the acute care setting has increased dramatically over the last 10 years. One of the highest demands for acute care nurse practitioners (ACNPs) has been in specialty services within the hospital setting. The inpatient hospital setting has historically been staffed by resident house staff; however, with the reduction in work hours for residents and decreases in Medicare funding, hospital administrators have been looking for alternatives for providing patient care. They are quickly realizing that well-trained and seasoned ACNPs can provide consistent care that improves outcomes and patient satisfaction scores in the hospital setting.[1] ACNPs take ownership of their units and have a stake in patient outcomes over the long haul, which makes them extremely valuable members of the health care team.

The current curriculum in many adult ACNP programs does not provide new graduates with specialized training in any particular area; rather, the focus is on acute processes across the life span. Specialty training has been delegated to professional organizations.[2] The acute care track at one time had its roots in educating NP students to care for patients with complex, high-acuity needs and in critical care settings. However, as part of the APRN Consensus,[2] the track now covers all patients with an acute process. Additional educational needs using postgraduate residency programs may be necessary to bridge the gap between the generalist model of NP curricula and the needs of the acute care setting. This momentum is further being accelerated through ongoing changes in medicine. The purpose of this article was to generate a dialectic discussion surrounding the need for postgraduate residency programs for ACNPs and to foster interest in clinicians and academicians to promote the concept in their institution.

PROBLEM IDENTIFICATION IN ACUTE CARE

Historically, hospital administrators have relied on the abundance of a resident workforce to staff the wards 24/7. However, there is currently a shortage of resident house staff in the hospital setting because of the reduction of work hours mandated by the

Accreditation Council for Graduate Medical Education.[3] Hospitalists have been used to supplement the lack of the resident workforce; however, this model is cost prohibitive for many hospital systems. In addition, there has been a stagnant growth of students choosing medicine as a discipline.[4] There are multiple reasons for this, such as increased costs of obtaining a medical degree coupled with projected decreases in salary and other options that allow individuals to have more time for themselves and their families. The lack of residents and hospitalists to adequately cover hospital inpatients and the costs to maintain that model are simply not feasible.[5,6] Furthermore, hospital administrators are now acutely aware of the costs of suboptimal care because Medicare is refusing to pay for certain adverse outcomes associated with poor quality care. According to The Leapfrog Group,[7] a coalition of private and public businesses that advocate for quality and safety in hospitals, poor staffing contributes to medical errors and adverse events.

This situation has led many hospitals to transition to using ACNPs in place of physicians and house staff to provide quality care in the hospital with promising results.[8-11] A typical scenario encouraging hospitals to look to ACNPs is during the expansion of a specialty, such as critical care. Lineberry[12] reported the experience of Memorial Sloan Kettering Cancer Center, which wanted to expand the medical intensive care unit. The idea surfaced to use advanced practitioners (ACNPs and physician assistants [PAs]) in lieu of intensivists. Lineberry reported that the implementation of advanced practitioners was so successful that other units in the hospital wanted to convert to a similar model. As more units and hospitals turn to this type of model using advanced practitioners, the need for experienced ACNPs will increase.

ACNPs are in a position to step into the acute care setting and make a difference in patient outcomes. However, the change of ACNP program curricula to reflect care across the life span instead of a focus on a specialty has created a gap, which needs to be addressed through education.

BACKGROUND ON ACNPS

In 2008, the National Council of State Boards of Nursing published the document "Uniformity in APRN Roles" to address the proliferation of NP specialties offered by schools of nursing.[2] State boards of nursing were unable to maintain their ability to license and certify NPs in such a diverse setting of specialties. As a result, the consensus statement declared that there was only 1 NP role with 6 population foci that could be successfully licensed and certified. The National Council of State Boards made it clear that advanced practice registered nurses (APRNs) could specialize in addition to attaining the core competencies of practice across the life span in 1 of the 6 population foci, but they could not be licensed by the State Board of Nursing within a specialty. "Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education."[2(p6)] Competency in the skills, ability, and knowledge of a specialty would need to be left to the purview of employers, professional organizations, and individuals.

From its introduction, the ACNP program was geared toward educating the student who was interested in critical care or working with high-acuity, complex patients. Admission to ACNP programs in the past 20 years has been relatively low compared with other cohorts mostly because of the perception that family or adult programs provided more versatility in job opportunities.[13] For example, an adult NP student could choose to work in an outpatient setting, an inpatient setting, or a hybrid of the 2. The training for ACNP students was clearly based on an inpatient population, with a bias toward critical care. In fact, the majority of graduates (68%) from an ACNP program were working in critical care in 2004 and 2005.[14,15] The coursework clearly focused on complex patients and performing procedures such as lumbar punctures and inserting arterial lines, central lines, chest tubes, and so on. Students interested in working in areas of the hospital aside from critical care gravitated toward the adult or family NP programs.[16]

The Consensus document[2] made a distinction between primary care NPs and ACNPs for adult, acute, and pediatrics foci, stating that NPs should be employed in the population foci for which they were licensed and certified. One of the ramifications of this distinction was the dichotomization of NPs into