Evolution of a Conceptual Model: Ambulatory Care Nursing

EXECUTIVE SUMMARY

- The growth of ambulatory care nursing as a profession and how it is delivered has evolved over time.
- The specialty’s theoretical professional growth began in 1998 with the development of the first conceptual model.
- Conceptualizing professional ambulatory care nursing has been an exciting challenge for the past 2 decades.
- The journey participants included multiple registered nurses from numerous settings whose intellectual efforts and contributions advanced professional ambulatory care practice to this present state of conceptual understanding.
- Future leaders will continue the journey to keep this specialty practice clearly delineated conceptually, building on the work already accomplished.

MODERN PROFESSIONAL ambulatory care nursing is a complex, multifaceted specialty that encompasses both independent and collaborative practice in multiple types of outpatient settings. The comprehensive practice of ambulatory care nursing is built on a broad knowledge base of nursing and health sciences, applying professional expertise through the nursing process during health care and interprofessional encounters (American Academy of Ambulatory Care Nursing [AAACN], 2017). Nursing encounters occur with professional colleagues, patients, families, groups, communities, and populations in face-to-face settings or virtually using a variety of telehealth technologies.

The growth of ambulatory care nursing as a profession and how it is delivered has evolved over time. Over the past 20 years, ambulatory care nursing has seen progressive and significant professional expansion. The specialty’s theoretical professional growth began in 1998 with development of the first conceptual model.

First Step in Model Development

In 1998, the Board of Directors and leading members of AAACN realized that guiding the education and orientation of ambulatory care registered nurses (RNs) and demonstrating expertise in this specialty required a simple, concise blueprint of its nursing practice (conceptual framework). Conceptual frameworks identify the major concepts and their relationships in an area of practice. A model would assist ambulatory care nursing as a profession to:

- Design ambulatory care delivery models.
- Develop educational materials for ambulatory care nursing practice.
- Design testing materials for certification.
- Develop orientation programs to the professional area of practice.
- Develop performance appraisal systems for nurses practicing in ambulatory care settings (Haas, 2001).
- Serve as a model in ambulatory care research studies (Mastal, 2013).

Development of the First Conceptual Model

To achieve the goal of initial model development, AAACN established an expert member think tank. Using a nominal group approach, the expert members delineated major areas of ambulatory care nursing practice, knowledge, and skills. The group identified 61 core areas of nursing knowledge and skills and specified how these areas were related to each other and the ambulatory care nurse role (Haas, 2001).

The 61 areas were then categorized under three types of roles:

1. Clinical nursing role. Provide nursing care in their clinical specialty setting.
2. Organizational/systems role. Manage and coordinate resources and workflow in their healthcare settings.
3. Professional role. Practice according to standards, evaluate practice and patient outcomes, and pursue education.

The emphasis of the first framework was largely on nursing, especially in terms of the nursing role and specific nursing activities (Haas, 2001).

The concept, patient, was not specifically defined. Rather the concept was addressed in terms of the nurse’s focus on the individual person. Patient populations were defined in several ways. They could be identified in terms of patients’ health states...
(well, acutely ill, chronically ill, or terminally ill), age, types of reimbursement (e.g., capitation or fee-for-service) or source of reimbursement (e.g., Medicare, Medicaid, private insurance, etc.). Populations were also discussed as patients and their families, caregivers, and significant others (Haas, 2001).

The group then developed a diagram depicting the essence of the concepts and the relationship between them. See Figure 1 for the first diagram of the initial conceptual model of ambulatory care nursing.

Second Version of the Conceptual Model

In 2009, AAACN revisited the original conceptual model and determined that an examination and potential revision was desirable and relevant. AAACN convened a taskforce of nursing leaders who, over a period of months, developed a revised draft. This second version retained the work of the original concept of nurse, expanded the concept of patient, and proposed that a third concept — environment — should be defined and added to the conceptual model. Further, the relationship among the three concepts needed to be refined as it was different with the addition of the third concept.

The draft model was posted on the membership website for a month for members to review and make comments, suggestions, and revisions (Mastal, 2010). Over 85% of the membership responding stated that “environment” was an essential concept to include as it impacted their practice. They also submitted multiple invaluable suggestions and comments that were incorporated into the final framework statement (Mastal, 2010).

**Concept of patient.** In the second version, the concept of patient was defined more explicitly. It emphasized that each person is a unique individual; functions holistically as a biological, psychosocial, and spiritual being; and is the center of the nurse-patient encounter. However, the term *patients* in ambulatory care settings was expanded to include groups of individuals, families, caregiver/support systems, groups, and populations that approach the health system in a variety of health states.

Health states were categorized as wellness or health, acute illness, chronic disease and/or disabled,
and end of life (Mastal, 2013). It was usually the individual patient who approached the ambulatory care system, either by telephone encounter or during a clinic visit.

**Concept of environment.** The concept of environment was added as the nurses perceived it set ambulatory care nursing apart from other nursing specialties. Environment was perceived as having two elements: internal and external. Although defined separately, the relationship between them was interactive.

The internal environment was defined as the system in which the nurse-patient encounter occurred. Encounters were identified as occurring in individual and group physician office practices, freestanding or hospital-based clinics, infusion centers, nursing clinics, ambulatory care medical or surgical procedure centers, telehealth centers, case/disease management and care coordination organizations, health maintenance organizations, military systems, or comprehensive, integrated health care systems (Mastal, 2010).

The external environment included two elements. The first is both the geographic locale of a specific organization and contextual factors that directly influence a healthcare facility’s mission, patient population, and practices. For example, rural and urban health centers serve patients with slightly different needs and resources.

The second element of the external healthcare environment encompassed multiple factors that affected the entire industry. These factors include health policy, federal/state/local regulations governing practice, accrediting agency standards, healthcare financing systems, advances in science and technology, and information systems that documented care and served as sources of quality monitoring and reporting.

**Concept of nursing.** The practice scope of ambulatory care nursing remained dynamic. It has evolved continually in response to changed societal and organizational needs, directions, preferences, and the growth of the knowledge base of ambulatory care nursing theoretical and scientific domains. The nursing process remained central to professional clinical practice (Mastal, 2013). The second version of the conceptual model retained the three major roles described in the first model: organizational, clinical, and professional.

The organizational role addressed the activities required of RNs to manage and coordinate resources, staff, and workflow in the ambulatory care practice setting. Activities included office support, fiscal matters, interprofessional collaboration, structuring customer-focused systems, using informatics systems, ensuring compliance with workplace regulatory standards, addressing legal issues, ensuring care for caregivers, patient advocacy, and delegating and supervising (Haas, 2006).

The clinical role referred to nursing care and services provided in the unique setting, clinical or virtual. Specific role activities applied to individual, group, and population encounters. Clinical activities included using the nursing process in patient encounters, educating patients and caregivers, care coordination across the healthcare continuum, using telehealth technology, telephone triage, conducting clinical procedures, communicating and documenting care and services, and developing and using nursing protocols (Haas, 2006).

In the professional role, nurses practiced according to professional, ethical, and organizational standards. Role activities included expanding the knowledge and skills of self and staff, evaluating the processes and outcomes of care for both the patient and the organization, exercising leadership skills, participating in quality improvement studies, managing risk and safety, and applying codes of ethics (Haas, 2006).

The conceptual diagram was depicted differently than the first diagram as it contained more sub-concepts and was more explicit in how they were related (see Figure 2). It has been used to identify, describe, study, educate, interpret, and maximize ambulatory care nursing responsibilities and the many factors that influence the outcomes of nursing care (Mastal, 2013).

**Third and Current Version of the Conceptual Model**

During the revision of the Scope and Standards of Professional Telehealth Nursing (AAACN, 2018), significant environmental changes were identified that affected the practice of nursing in ambulatory care settings. These included advances in health sciences and immense growth of healthcare technologies as well as enlargement of the healthcare system continuum where the types of outpatient organizations had grown tremendously. Further, in the past decade new aspects of the patient’s environment were identified as affecting health states and health care. AAACN convened a group of organizational leaders to update the conceptual model to include the evolution of changes in each of the three concepts (see Figure 3).

**Concept of patient.** The basic conceptual tenets of patients remain constant. Each individual patient is unique, functioning holistically as a biological, psychosocial, spiritual being and is the focus of each patient-nurse interaction. However, the term patients in the ambulatory care setting refers to individuals, families, caregivers/support systems, groups, communities, and populations. Each approaches and interacts with the healthcare system in a variety of health states (AAACN, 2017).

However, changes occurred over the past 1-2 decades in how patients contacted the health system. In the early part of this century, it was usually the patient who first made contact with the system, generally by telephone or as a clinic walk-in. Today, con-
Figure 2.
Ambulatory Care Nursing Conceptual Framework Diagram

Figure 3.
Ambulatory Care Nursing Conceptual Framework Diagram


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Contact can be made either by the patient/support system, the nurse in the ambulatory care setting, or by any of the agencies on the healthcare continuum as outreach efforts to assist in managing chronic disease or conditions. Contact occurs dependent on the patient’s status, disease state, or disability. Patients are always the center of the encounter, maintaining control with the nurse in a consultative role (AAACN, 2018).

**Concept of environment.** It is in the conceptual environmental fields that the majority of changes are seen because so many external advances have occurred. One minor addition was made in the internal environment.

*Internal environment* changes have occurred in the patient-nurse interaction. The double-sided arrow, indicating the interface between patient and nurse, has been given a label – *nursing process*. That small change makes clear the professional role of the nurse with the patient/group/community/population and adds specificity to the conceptual diagram.

*External environment* is where the majority of revisions have been made as that is where most changes addressing health care have occurred. Items listed in both types of environment have a two-way interface.

In the category *advances in science and technology*, the first alteration was to separate the two terms. These terms are now separate items, emphasizing the distinct identity of each and recognizing their unique impact on ambulatory care nursing.

Second, the term *continuum of care* was inserted. This term, well known in the ambulatory care environment as the provision of multiple levels of care through the life cycle by many providers, has recently increased its impact on ambulatory care nursing. New nursing roles have emerged. For example, the nursing role of Care Coordination and Transition Management (Haas, Swan, & Haynes, 2014), ensures the patient has access to all types and levels of care. In this new role, the nurse interacts closely with different types of providers and services across the healthcare continuum (Mastal, 2018). Another new nursing role includes expanding informatics skills, such as developing metrics to measure and report outcomes and value of nursing care services (Mastal, Matlock, & Start, 2016; Start, Matlock, & Mastal, 2016).

The third change is a major one addressing aspects of the patient and health system environment that have only been specified within the last decade as affecting health (Mastal, 2018). The term *social determinants of health* refers to conditions that exist where people are born, live, learn, work, play, worship, and age and affect a wide range of health, functioning, quality-of-life outcomes, and risk. Social determinants of health include:

- Conditions of place, such as social, economic, and physical situations, in multiple types of settings (school, church, workplace, neighborhood).
- Patterns of social engagement and sense of security and well-being are also affected by conditions of place.
- Resources that affect quality of life and health outcomes include safe/affordable housing, access to education, public safety, availability of healthy foods, local health services, and environments free of life-threatening toxins (The Office of Disease Prevention and Health Promotion, 2018).
- Social determinants of health are an integral factor in shaping the goals of Healthy People 2020 (The Office of Disease Prevention and Health Promotion, 2018) and many of the goals of the World Health Organization (2018). As such, they are critical to the ambulatory care nursing external environment, reflecting elements that drive and impact nursing practice.

**Concept of nursing.** The concept of nursing in the third model emphasizes that telehealth is an integral component of ambulatory care nursing. This version of the concept has retained the essence of the first model but added new activities to the three basic roles as changes occurred.

The *clinical role* remains centered on use of the nursing process in face-to-face and virtual encounters with patients, professional staff, and agencies across the healthcare continuum. The role includes conducting nursing procedures and patient advocacy, completing documentation and appropriately communicating. In short, it is managing clinical nursing practice, patient care, and outcomes using advanced nursing knowledge and evidence-based practices (AAACN, 2017).

The *organizational role* is the administration and coordination of resources within the healthcare setting and collaborating with other agencies across the continuum. This role has multiple dimensions such as leadership, staffing, workload, competency concerns, regulatory compliance, safety and risk management, and improving quality care systems and outcomes. Further, it encompasses fiscal management, legal and regulatory issues, application of health informatics systems, conflict management, and advocating for patients within the system and across the healthcare continuum (AAACN, 2017).

The *professional role* activities focus on nursing adhering to professional, ethical, and organizational standards. It requires use of evidence-based interventions and evaluation of outcomes of nursing practice with a lifelong commitment to the expansion of ambulatory care nursing knowledge and skills. Further, the professional RN contributes to the knowledge growth of other staff and the continuous improvement of the quality of healthcare outcomes in both the clinical and community settings (AAACN, 2017).

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While some of the role responsibilities may be a part of every ambulatory care nurse’s practice, emphasis may focus on a single role dependent on the specific functional position of the nurse in the organization. For example, when conducting direct care interventions, the nurse will most likely focus on clinical requirements of the job descriptions. However, elements of organizational and/or professional activities may be expected as well depending on the unique situation or other requirements.

In summary, the journey of conceptualizing professional ambulatory care nursing has been an exciting challenge for the past 2 decades. The journey participants included multiple RNs from numerous settings whose intellectual efforts and contributions advanced professional ambulatory care practice to this present state of conceptual understanding. Future leaders will continue the journey to keep this specialty practice clearly delineated conceptually, building on the work already accomplished.

REFERENCES

