How to Run Your Nurse Practitioner Business
A Guide for Success
This book is dedicated to the many nurse practitioners and nurse practitioner students with whom I have collaborated and worked over the years. I especially want to mention my colleagues, Patricia Poli, PhD, CPA, Associate Professor School of Business, Fairfield University, for her insightful comments regarding business management, Kathleen Wheeler, PhD, APRN-BC, FAAN, who initially inspired me to become a nurse practitioner and always encouraged me, along with Anne Manton, PhD, APRN-BC, FAAN, to be the best I could be. I am privileged to work with the most collegial and knowledgeable nurse practitioners (Maria Banevicius, Martha Burke O’Brien, Lynda Tagliavini, Stephanie Taylor, Kathleen Hayes, and Danielle Morgan) and staff (Jeannette Gomez and Lori Clapis) at Trinity College Health Center, where the mantra is R. E. S. P. E. C. T. for patients and each other.

I also dedicate this book to my sister, Ellen C. Bernstein, who role models the “art of possibility” to perfection and assisted in proofreading this manuscript, to my husband, Bob, for his great humor, sarcasm, and patience, and to our daughters, Lisa and Beth, who have always been motivational forces for me to follow my heart and do things right.

Sheila C. Grossman

This book is dedicated to my husband Kevin for his love and support, for his unequivocal acceptance of my style and practice of nursing, his acceptance of “I’ll be late again tonight,” his thoughtful and intelligent demeanor that challenges me to be always mindful, and his unfettered encouragement to be and become the only type of clinician and nurse I could respect being.

I also dedicate this book to my professional mentors and clinical role models with whom I have been so blessed to practice: Dr. Elaine Yordan and Dr. Sharon Herzberger. You inspired my creativity, laid the foundation for my high standards, and encouraged me always to practice for the patient.

Lastly, I dedicate this to my current clinical staff, whose members show me the essence of caring, competence, and compassion, and who demonstrate the true meaning of being an independent nurse practitioner each day we work side by side.

Martha Burke O’Brien
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Sheila Grossman, PhD, FNP-BC, APRN, is a Professor of Nursing and Coordinator of the Family Nurse Practitioner Track at Fairfield University School of Nursing. She received a BS in nursing from the University of Connecticut, her MS as a Respiratory Clinical Nurse Specialist from the University of Massachusetts/Amherst, a postmasters degree as a Family Nurse Practitioner from Fairfield University, and her PhD from the University of Connecticut. She has worked many years as a clinician on a variety of medical, surgical, and critical care units and presently practices as a Family Nurse Practitioner in a primary care clinic. She is the coauthor of The New Leadership Challenge: Creating A Preferred Future for Nursing, which is in its third edition (2009) and received an AJN book of the Year Award. She has also received an AJN Book of the Year Award for Mentoring in Nursing: A Dynamic and Collaborative Process (2007), and co-authored Gerontological Nurse Certification Review in 2008. She is the author of multiple chapters and journal articles on leadership, mentoring, gerontology, adult health, and palliative care. Her research interests focus on symptom management in palliative care, leadership, pedagogy, cultural competence, and adult patient outcome studies. She is active in Sigma Theta Tau International Honor Society, American Association of Critical Care Nurses, National Organization of Nurse Practitioner Faculty, American College of Nurse Practitioners, and is a certified End of Life Nursing Education Consortium Educator and a Commission on Collegiate Nursing Education Accreditation Site Visitor. She is the winner of the 2009 Josephine Dolan Award for Outstanding Contributions to Nursing Education sponsored by the CT Nurses Association.

Martha Burke O’Brien, MS, ANP-BC, APRN, has been the Director of the Trinity College Health Center (TCHC) in Hartford for 11 years. Early in her tenure, she received a commendation from the American College Health Association for her creative practice model of an all Advanced Practice Nurse staff, using physician collaboration in the “true” sense of collaboration. She received her BSN from Northeastern University and worked at the John Dempsey Hospital of the University of Connecticut Health Center after graduation. She received her MS from Boston College in Adult Primary Care. Before becoming the Director of the TCHC, she worked as a Primary Care Nurse Practitioner in the Adolescent Clinic at St. Francis Hospital and Medical Center for several years. She was involved in the Connecticut Nurse Practitioner Group, Inc., now known as Advanced Practice Registered Nurse Society, serving as President and Membership Chairperson for years. In addition, she has received multiple awards, including The
Nurse Practitioner of the Year Award in 2001. As a member of the American College Health Associations’ Consulting Services Program Advisory, she has also consulted with several college health clinics throughout the northeast about setting up nurse practitioner run clinics. She has done several presentations on Adolescent Health, Sexually Transmitted Diseases, and Reproductive Health, and has published in Nurse Practitioner journals.
This is a most stimulating time for the expanding number of nurse practitioners (NPs), who are seeking challenges and opportunities that will also be financially profitable. But how does the NP take advantage of these opportunities? Grossman and O’Brien have written How to Run Your Nurse Practitioner Business: A Guide for Success for the NP of the twenty-first century.

The authors have threaded their model, “Elements of the Nurse Practitioner Role,” throughout the book and given realistic examples to explain the four elements of the NP role: Clinician, Leader, Manager, and Professional. The authors have combined their collective knowledge and experience to illustrate how these four elements can prepare an NP to start a business.

Section III contains templates that the NP can individualize for his or her own practice setting. In addition, examples show how to develop many essential documents, including:

- Letter of intent for applying for a grant
- Résumé and biographical sketch
- Patient satisfaction tool
- Collaborative practice agreement

Everything needed to develop one’s own practice is generously shared, along with an explanation of the regulatory statutes for starting a business, managing a practice setting, budgeting and planning for financial stability, obtaining practice accreditation, evaluating staff, and generating high-quality patient outcomes.

In addition, the authors have woven reflective practice into their recommendations as a way for NPs to acquire further insight and skills. The book’s purpose, to generate excitement for learning a new way of thinking reflectively, of seeing things more holistically as opposed to in a detail-specific environment, and of collaborating with networks of people on a continuous basis to establish partnerships, comes through clearly and offers the reader a path to gain confidence and growth in each element of the NP role.

Resilience is one of the characteristics NPs embody, as they have the innate ability to persist and succeed in the face of adversity. In How to Run Your Nurse Practitioner Business: A Guide for Success, the authors reflect on how NPs need to practice the “art of possibility” (Zander & Zander, 2000), so that they are always prepared to answer the next question about management, address a clinical concern, or resolve a reimbursement issue with a creative plan. Grossman and O’Brien also recommend collaborative networking and partnering as opposed to the mentality that says “everyone for themselves” or “the fittest survive and the others lose.” NPs need to learn through collaboration. In this way, NPs
will ultimately improve their leadership, management, professional, and practice skills.

Many healthcare work settings are led by managers who have been educated clinically, but often lack proactive leadership skills. Grossman and O’Brien advocate for change that will result in a win-win workplace that is led by NPs who are true leaders, not simply managers. They agree with Bennis and Nannus (1985), who remind us that “managers are people who do things right and leaders are people who do the right things” (p. 21). This is not one of those “Okay, I read that new NP book” that you will put on a bookshelf, but rather a book that you will use time and again.

This is what NPs have been waiting for – a book that inspires them to energize their practices, provide a framework and reference to make their practices more rewarding, and to create work places where all can strive for best practice. Nurse practitioners must take the opportunities that come with these expanded practice and leadership responsibilities and be prepared to fulfill the exciting and challenging role of the twenty-first century NP.

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**References**

How to Run Your Nurse Practitioner Business: A Guide for Success was written as a reference book for nurse practitioners (NPs), masters and doctoral level students, and administrators interested in developing and managing high-quality, cost-effective, and patient-accessible healthcare in NP settings. The Doctor of Nursing Practice (DNP) Essentials are described and implications of the practice doctorate are integrated into this special and comprehensive text designed to assist the reader in learning the principles of business management, including:

- Setting up primary care and other NP specialty practices.
- Collaborating and networking with partners.
- Choosing a business structure.
- Setting up a governing board.
- Creating business plans.
- Developing budgets.
- Writing letters of intent for grants.
- Evaluating patient outcomes.
- Providing ongoing quality improvement.
- Integrating appropriate accreditation regulations.
- Managing compliance, risk, and reimbursement issues.
- Developing policies and procedures to manage a business.

The book was developed with the idea of the NP role as autonomous, but operating within the practice guide parameters determined by local and state legislation. The purpose is to identify the professional, clinical, leadership, and management qualities necessary for a successful patient-centered practice in healthcare settings employing and run by NPs.

The book is divided into three sections. Section I, Regulatory Implications for the Nurse Practitioner Practice, includes the scope and role of the NP, the changing vision of healthcare delivery and its impact on NPs, and an analysis of the impact of statutes and legislation on NP-run practices. Section II, Essentials of Developing and Managing a Nurse Practitioner Practice, offers information about patient safety, evidence-based practice, working with business consultants to develop a practice, financial management of a practice, explanations of the roles of the director/owner and other providers, and collaboration and consultation, as well as a review of entrepreneurial models of NP delivery settings. Section III, Templates, Documents, Policy, Procedures, and Plans, provides templates of policies, procedures, and documents that readers can adapt for their own settings regarding referral, release of healthcare information, on-call correspondence, chart audits, and mission statements. Information regarding all
aspects of running a clinic, such as on-call scheduling, job descriptions, staff evaluation, managing patient records, marketing services, collaborative practice agreements, business plans, sample budgets, and specimen processing are shared.

Many entrepreneurial ideas are presented, including delivering health care in creative, innovative, and effective ways in private practice, community health centers, hospital clinics, healthcare homes, homecare, occupational health, juvenile detention centers, prisons, college health, homeless centers, long-term care facilities, and specialty settings. Interviews with experienced NPs representing provider-driven practices are included, as are interviews with new practicing NPs about recommendations for preparing for an NP position.

The major points emphasized throughout this book are: (1) the necessity of knowing local and state legislation and principles of business management as a guide for setting practice parameters; (2) the importance of engaging in reflective practice to enhance creative thinking; and (3) the specific contributions NPs make to health care that result in high patient satisfaction and cost-effective outcomes in providing holistic care as a clinician, leader, manager, and professional.

Key features of the text enhance the readers understanding, including:

- Exploring potential career paths while understanding the breadth of opportunities available to NPs.
- Developing a fundamental framework for establishing an autonomous practice with business management strategies that also take into account the necessary background work needed to start a cost-effective practice.
- Analyzing statutes and legislation affecting the feasibility of developing an NP business.
- Planning for the operational success of an NP practice.
- Implementing changes after evaluation of successes and planning opportunities for continued improvement.
- Providing the business structure necessary to deliver safe and high-quality patient care in an NP clinic.
- Evaluating outcomes, such as patient and provider satisfaction, institutional perception of the healthcare delivery system, and cost effectiveness.
- Examining the structure and functioning of different settings as examples for creating NP practices.
- Integrating the knowledge required to prepare for acquiring and transitioning into the NP role.

Nurse practitioners are encouraged to follow Siegal’s (2007) framework on mindfulness to increase their ability to think and learn. Learning through instruction or experience enables NPs to acquire new knowledge and skills by reorganizing neural pathways in the brain. Reflective learning increases the brain’s neuroplastic ability, which causes new neurons to be recruited, facilitates different neuronal pathways, and changes the levels of the neurotransmitters. These mechanisms actually have the potential to change the way one thinks. Generally this will improve one’s ability to think creatively. By rewiring our brains, reflective thinking enhances our learning ability and passion for our work.

Nurse practitioners need to be aware of how the mind affects who we are, our state of mind, and what information means to us. By practicing active learn-
ing strategies, we can improve our clinical, leader, professional, and manager skills. Each chapter includes “Reflective Thinking Exercises” that will assist you in developing the professional leadership, managerial, and clinical aspects of the NP role. Power point slides are available for each chapter.

How to Run Your Nurse Practitioner Business: A Guide for Success is intended to help practicing and student NPs students realize that they must not become the “physician extender” in the physician practice medical model and thereby convert our complex teachings to a 6- to 10-minute meet, treat, and street mentality. Nurse practitioners must resist the temptation to be so cost conscious that they create a health business instead of a healthcare practice. At the same time, NPs must learn to manage a practice like a business.

Many practicing NPs ask: “Why should I go back to get a doctoral degree?” Because, as this text illustrates, the advanced practice role has evolved into one that offers so much more than just excellent care. To be effective as a provider, NPs need to develop skills in the areas of business, policy, statistics, evidence-based practice, billing/coding, and compliance. NPs require additional education in these areas, over and above their education in clinical care, to succeed and to have advanced practice nursing evolve even further.
The authors thank Allan Graubard, Senior Acquisitions Editor at Springer Publishing Company, for his creative and exciting ideas for this book, and Barbara Chernow for her editing assistance. For her business expertise, we thank Patricia Poli, PhD, CPA, Associate Professor School of Business, Fairfield University, who is a contributing author in the area of business management. We also thank Dr. Margaret Fitzgerald for her thought-provoking foreword to this book.

We extend our deepest gratitude to the nurse practitioners who expressed their personal thoughts about becoming and being an NP in the interviews cited in Chapters 1 and 8: Jen Cooper, MSN, APRN-BC, Patricia Dunn, MSN, APRN-BC, Michelle Leonard, MSN, APRN-BC, Leslie Spain, MSN, APRN-BC, Mary Tuttle, MSN, APRN-BC, Melinda Wellington, MSN, APRN-BC, Cheryl Anderson, Ed. D, APRN-BC, Christine Berte, MSN, APRN-BC, Jaclyn Conelius, MSN, APRN-BC, Vanessa Pomarico-Denino, MSN, APRN-BC, Louise Moon Rosales, MSN, APRN-BC, Tracy Shamas, MSN, APRN-BC, Corin Shenuski, MSN, APRN-BC, Jacqueline Spano, MSN, APRN-BC, and Kathleen Wheeler, PhD, APRN-BC.
Regulatory Implications for Nurse Practitioner Practice
Learning Objectives

1. Examine the evolving role of the nurse practitioner as a clinician, leader, manager, and professional.
2. Identify the many role opportunities for a nurse practitioner in primary, secondary, and tertiary care.
3. Describe the scope of practice for nurse practitioners.
4. Outline how the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education will impact the role of the nurse practitioner.
5. Emphasize the value of developing leadership skills to assist nurse practitioners in seeing things from a new perspective and making creative changes.
6. Use self-reflection techniques to create a personal vision of the role of a nurse practitioner.

Key Words: scope of practice, nurse practitioner roles, leadership, Consensus Model for APRN Regulation

This chapter describes how the role of the nurse practitioner (NP) has evolved since the 1960s and teaches advanced and novice practice NPs to create and expand their own roles through self-reflection. Existing employment opportunities are explored, as are ideas for creating new roles consistent with those of advanced nursing practice. As a result of weaknesses and inefficiencies in the delivery of primary and subspecialty health care, NPs now have many more opportunities to expand their scopes of practice by:

- Obtaining new advanced practice skills.
- Acquiring more depth and confidence in their decision making abilities.
Appreciating the resilience of people rather than focusing on the disease model.

Increasing expertise in managing individual patients and populations.

Participating in health policy development.

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (2008) standardizes the NP's preparation, licensure, and maintenance of competency. Nurse practitioners can examine their own visions and goals for developing individualized practice models. They can also mold their practice framework as an advanced practice nurse (APN), rather than as a "physician extender" or "midlevel provider."

The factors affecting the healthcare system—technology, electronic record maintenance, high costs, inefficient payment systems, lack of access to health care, and other variables affecting health maintenance, health promotion, and illness prevention—have created new and exciting opportunities for NPs. In fact, the National Salary and Workplace Survey of Nurse Practitioners, conducted by ADVANCE for Nurse Practitioners in 2007, found that 89% of practicing NPs were satisfied with their careers and more than half of these (49%) were very satisfied (http://nurse-practitioners.advanceweb.com/Editorial/Content/Editorial.aspx?CC=200814).

Still, not all NPs are content with their positions. Among the barriers to role fulfillment are issues related to the work setting, including organization, legal problems, and environmental constraints (Plager & Conger, 2007). For example, NPs working at the same location as MDs are often expected to perform RN duties for the physician’s patients, as well as for their own. These responsibilities include obtaining laboratory specimens, setting the patient up for a pelvic exam or procedure, and/or teaching a patient about the need for a Coumadin clinic bi-weekly. Legal and/or organizational problems facing NPs include policies that prevent them from administering desensitization shots without a physician present. Another occurs when the organization’s administrators insist that a physician must be the “Medical Director,” as opposed to a “Collaborating Physician,” even though the physician is not on site. The NP who actually manages the clinic on a 24/7 basis should have the title of Medical Director.

Nurse Practitioner Education

Loretta Ford, PhD, RN, and Henry Silver, MD, started the first NP program, which focused on well child care, at the University of Colorado (Ford, 1979). The four-month program of didactic classes was followed by a 21-month clinical internship, during which NP students worked with experienced NPs in a preceptor format.

As the need for NPs grew, many postbaccalaureate programs emerged, requiring varying amounts of class time and clinical hours. Some of these programs were not college based. Rather, they were continuing education courses with timeframes ranging from a few days to 24 months. In addition, some nurse educators did not want NPs to be graduates of a formal nursing education program. They felt that these nurses had left the nursing profession to become medical professionals or physician extenders.
Since the 1960s, NP programs have grown to include Nurse Practitioner tracks in Family, Adult, Pediatrics, Psychiatric, Neonatal, Geriatric, Acute Care, and Women’s Health. In addition, the role of the APN now includes some degree of autonomy, ranging from an autonomous practice with full prescriptive authority without a collaborating physician contract in some states to NPs working under the direct supervision of a physician in other states. Buppert (2008) delineates how each state defines the role in terms of an NP’s ability to manage care and prescribe medications independently. Most NPs have two or more years of postbaccalaureate education, certification by a credentialing body in their specialty, the ability to make medical diagnoses, and some degree of prescriptive authority. For further clarification of the legal implications for NPs related to scope of practice, see The American Association of Nurse Attorneys’ Web site (http://www.taana.org) (2005).

The American Nurses Association (ANA) defines an APN as a postbaccalaureate educated nurse who is engaged in practice, thereby excluding master’s-prepared nurses specializing in education, administration, or research. In 2004, the ANA published Nursing’s Social Public Policy Statement and Nursing: Scope and Standards of Practice, which standardized certification, licensure, and educational preparation for the four types of APNs. According to this document, APNs are prepared for “specialization, expansion, and advancement of practice.” The policy further describes specialization as a specific area of practice; expansion as the ability to expand one’s knowledge and skills duplicating those of the medical profession; and advancement as the integration of research-based evidence. Some functions overlap with the duties of the medical profession, including the ability to diagnose; make differential diagnoses; order and interpret diagnostic and laboratory tests; and prescribe pharmacologic treatments in the direct management of acute and chronic illness. Furthermore, the policy distinguishes APNs from other medical professionals by listing the additional duties of the NP role as comprehensive assessments, health promotion, and the prevention of disease and injury.

Multiple Role Opportunities to Practice as a Nurse Practitioner

Nurse practitioners provide patient-centered health care in acute, primary, and long-term settings. They also serve in various clinical settings as researchers, consultants, and patient advocates for families, individuals, groups, and communities. During the last fifty years, the NP’s role has become more complex and autonomous. Ford (2008) emphasizes the continuing evolution of the NP scope of practice to include all patient populations and multiple medical specialties/subspecialties. She highlights the independence that many NPs in rural areas have enjoyed when compared with NPs working in private practices, who may serve more as physician extenders than autonomous providers. The NP role is truly visible in almost every care setting, but the scope of practice differs depending on the organization’s policies and culture, the environment, and even the NP’s perception of the role. As NPs continue to expand their skill sets and launch their own practice sites, their scope of practice will further broaden. In
today’s world, NPs should take the lead in changing healthcare policy, managing care effectively, representing the profession in interdisciplinary initiatives, setting up advocacy programs for patient populations, and practicing as excellent clinicians. Figure 1.1 illustrates the multifaceted and expanding NP role, including clinician, leader, manager, and professional functions. NPs need to incorporate all four of these functions into their daily practices.

One variable that differentiates the NP from the physician is the NP’s use of a holistic approach in determining patient care management. This means that an NP who sees a patient presenting with pharyngitis would identify both the need for health advice and pharyngitis as problems, according to the International Classification of Diseases (ICD) codes. In contrast, a physician would generally identify only pharyngitis as the patient’s problem. The NP’s holistic approach includes assessing the patients’ ability to use personal characteristics—such as hardiness, courage, resilience, will to live, basic beliefs, value systems, and literacy level—to create a mutually agreeable plan of care. Primary care providers cannot focus only on the patient’s specific complaint(s), such as shortness of breath or fatigue; they must function in an all-encompassing way with each patient encounter.

Clinician

The clinician role encompasses the holistic care NPs render to patients and communities (see Table 1.1). Although the majority of NPs have provided pri-
### Levels of Care: Implications for Nurse Practitioners

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<th>Definition of Level</th>
<th>Examples of NP-Run Activities</th>
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<tr>
<td>Primary</td>
<td>Prevention of disease or injury</td>
<td>Immunizations, good hygiene, smoking cessation, fluoride supplementation, exercise classes</td>
</tr>
<tr>
<td>Secondary</td>
<td>Screening of disease or injury in order to diagnose early to decrease further problems</td>
<td>Pregnancy testing, mammography, testicular self assessment, hearing and vision screening</td>
</tr>
<tr>
<td>Tertiary</td>
<td>Prevention of complications and rehabilitation to promote health after an injury or disease</td>
<td>Lifestyle changes, diet, exercise regimen, stress management, support groups, psychotherapy</td>
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Because of the holistic nature of the NP’s practice, complementary and alternative techniques are frequently combined with integrative medicine and health teaching. NPs must think about the whole person and not just focus on the episodic nature of the patient’s visit.

### Healthy People 2010+ Topics

- Exercise and Activity
- Obesity
- Cigarette and Tobacco
- Substance Abuse
- Sexually Transmitted Disease
- Mental Health
- Violence
- Environment
- Prevention of Disease—Immunizations
- Healthcare Access

Leader

The transformational model of leadership provides direction to the NP who wants to make a change. An example is an NP who wants to make a difference for the patient and, therefore, spends extra time teaching patients how to be more responsible for their health. Patients who better understand their health and potential medical problems should see the importance of exercise, reducing caloric intake, and compliance with a health management program. They should, in brief, assume greater responsibility for themselves. Shanta and Kalanek (2008) describe strategic leadership as a way of formulating and implementing a vision. These authors offer a process by which leaders can be successful agents of change. Gardner (1989) also explains how to implement change and includes the following nine tasks in the leadership role:

- Envisioning goals—developing a goal and influencing others to work toward a common goal.
- Affirming values—encouraging people to rethink and change old visions or beliefs.
- Motivating—providing the impetus for the group to make a change and embrace a new way of thinking.
- Managing—moving the group toward the new goals and implementing the new vision.
- Achieving a workable unity—gaining the trust and loyalty of all involved in creating the new vision.
- Explaining—continuously increasing awareness about changes and new beliefs, which will grow as the new vision is achieved.
- Serving as a symbol—being the champion for the new vision and instilling hope in the group as the vision unfolds.
- Representing the group—advocating for the group and its new vision.
- Renewing—reinforcing hope and encouraging others to believe in the new beliefs and vision.

Nurse practitioners often find themselves in situations that demand new ways of thinking. As the challenges arise, a good framework, such as the Tasks of Leadership discussed above, will guide the NP in problem solving and reaching the best possible decisions. For example, a colleague tells an NP that their practice, composed of five physicians and three NPs, needs to improve patient management benchmarks. To achieve that mandate, all walk-ins will be assigned to NPs. The rationale is that the physicians will then have more time to achieve benchmarks with their regularly scheduled patients. This approach will significantly improve benchmark goals for the overall practice, as walk-ins generally present with multiple comorbidities, some degree of acuity, and no recent care. As a result, it is more difficult and time consuming to bring these patients to goal and to meet benchmarks. Instead of arguing or complaining about this change in assignment, the NPs decide to accept the challenge and demonstrate that they can succeed in achieving benchmarks even with walk-ins. Using the above framework one NP, Marion, led her group to success by:

Identifying the goal—NP patients will achieve similar, if not increased, benchmarks as compared with the physicians’ patients.
Affirming values—Marion holds a dinner meeting at her house for the other two NPs to discuss plans for scheduling/assigning the patients.

Motivating—Marion suggests that each month one of the NPs take all the walk-ins. The other two will cover their own case loads and share the load of the NP doing the walk-ins. As a result, they will have more time to set up achievable plans for the walk-ins, while giving these patients continuity with their first few visits and possibly increased motivation to comply with treatment.

Managing—Marion volunteers to take the walk-ins first and plans weekly lunch meetings to discuss how the new patient assignment is going and to evaluate the benchmarks. The group determines progress has been made and invites the physicians to a meeting to share the results.

Achieving a workable unit—Marion and the other two NPs share their findings via e-mail on a daily basis and strategize on how to best assist each other so that benchmarks can be improved. Two of the physicians volunteer to take a month of walk-ins because they see the NPs new work assignment approach is successful.

Explaining—Marion and the other NPs agree to meet with the remaining physicians to share their progress, and they find these physicians open to participating in the new approach to managing walk-ins.

Serving as a symbol—Marion sets up a schedule and works with the office staff on programming the new method of patient assignment. Lunches are scheduled for all providers to share their concerns and ideas.

Representing the group—Marion analyzes the achieved benchmark data for the patients in the practice and shares positive news with the group as well as the practice group administration.

Renewing—Group meetings reinforce this creative scheduling as a way of improving effective patient management, and increased bonuses are realized for each provider. Marion and one of the physicians present their “Collaborative Scheduling Model” at a primary care conference and receive positive feedback. The group publishes its findings in a family practice journal. Using Gardner’s leadership framework, the NP has a method by which to organize strategies to implement a change.

Wheatley (2006) explains how important it is for leaders to capture a holistic view of an organization and examine all aspects of relationships among members of the workforce. By conducting such an in-depth analysis, leaders can more effectively influence how people act and how they interact with others to develop more effective organizations. Wheatley suggests a constant state of change is a good way for organizations and individuals to grow and become more effective. So, to solve the challenges of the chaotic healthcare delivery system currently practiced in the United States, NPs need to lead in creating new methods of healthcare delivery by embracing new ideas and ways of thinking.

Manager

Nurse practitioners must be savvy managers, who are aware of the mission, goals, vision, and strategic plan of the organization with which they are affiliated, as well as those of their own clinic/unit/office. Not only are NPs responsible for managing their patient case loads, but they often also participate in the
business aspect of their delivery system. With the changing paradigm of physician-owned to NP-owned primary care practices, understanding financial management has become a necessity. As Gawande (2007) wrote in *Better: A Surgeon’s Notes on Performance*, going into a healthcare profession is all about “diagnosis, technical prowess, and some ability to empathize with people,” but soon one learns the need to “grapple with systems, resources, circumstances, people—and our own shortcomings” (p. 8). Certainly, this is true for the NP in any healthcare system, including one that is self-owned.

**Professional**

Because of the complex nature of the illness and health continuum and ever-evolving medical technology, NPs need to be lifelong learners. This involves:

- Continuously learning new information.
- Reviewing research-based studies to assess best practices.
- Being aware of new guidelines of care management.
- Gaining more knowledge regarding variables that impact health, such as the rationale for the regulation of genes so better pharmacological and nonpharmacological treatments can be given to specific patients.

And, the list continues to grow, as there is always something new to learn. For example, NPs need to know about the neuroplasticity of the brain, which allows certain neurons to regenerate and retool certain brain tissue. As a result, patients can relearn function lost because of injury. Another example is a new bio-modulator drug therapy that stops further pathology from developing in specific autoimmune diseases. Continuous learning, knowledge sharing, and networking with other healthcare professionals is crucial for NPs to provide the best care for patients and to know when to refer patients to specialists. Maintaining and gaining new information is certainly part of the professional responsibility of a NP. Such knowledge increases the NPs confidence and depth in clinical decision making.

NPs must learn to manage the care of populations—and not just of individual patients. Some examples include administering influenza vaccines each fall or screening for sexually transmitted infections at a booth at a community health fair. In the first case, the NP-owned practice should consider partnering with a pharmaceutical company so the vaccine can be offered at a reduced cost. In the latter case, an NP-owned practice and a diagnostic laboratory might collaborate to possibly reduce diagnostic testing costs and generate a higher number of participants. To successfully manage an NP-owned business, NPs must be competent and professional. Each time the NP or a designated staff member partners with another agency or company, the potential for positive networking can ultimately improve the quality and outcomes of the business.

In addition, NPs should become involved with national and local professional organizations. Often, the professional agency serves as a vehicle for participation in discussions about regulatory and health policy issues, in developing legislation regarding health care, and in obtaining access to continuing education programs. For example, the American College of Nurse Practitioners (ACNP) offers members access to current legislation on its Legislative Tracking Chart,
1. Scope and Role of the Nurse Practitioner

which is available at www.acnpweb.org. This invaluable forum enables NPs to be involved in the evolving healthcare delivery issues facing the country—who better to assist with developing health policy than NPs who are in the trenches of patient care management? Most policy change seems to focus on quality of services, costs, and access in three areas:

- Public policy—policy developed by local, state, or federal governments.
- Organizational policy—policy formulated by an institution or organization.
- Professional policy—policy set forth by professional organizations, such as the American Academy of Nurse Practitioners or American College of Nurse Practitioners.

Fawcette (2008) also explains that each policy has three components: personnel, services rendered, and costs of services. Nurse practitioners can impact any of the three types of policy depending on their networking interests and abilities.

Scope of Practice for Nurse Practitioners

The scope of practice for APNs is regulated by the State Nurse Practice Act and Board of Nursing. Each state has its own regulations that specify the limits for nursing practice and the sanctions for violation of any nursing regulations. Advanced practice nurses include nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists. Advanced practice nurses do not include nurses with an advanced education in administration, education, or research. The advanced nursing practice concept focuses on the specialty clinical practice of these APNs, although NPs are also involved with fiscal management, education, and research in daily practice.

Nurse practitioners are also responsible for knowing the state Medical Practice Act and Board of Medicine rules that give physicians the authority to delegate certain medical acts to other healthcare professionals. The NP is obliged by law to follow the state’s defined scope of practice. An NP who practices beyond the agreed-upon scope may be considered to be practicing medicine without a license. In addition, NPs must be aware of the state Pharmacy Practice Act and Pharmacy Board regulations that may impact prescriptive authority.

Depending on the state where the NP is practicing, a collaborative agreement with a physician may be necessary to comply with an NP’s scope of practice. By reviewing the Pearson Report, the Annual Legislative Update, by Linda Pearson, who writes the Annual State-by-State National Compilation of Nurse Practitioner Legislation and Healthcare Issues in the American Journal for Nurse Practitioners (2009), the reader can determine the scope of the NP’s role in every state. This report describes state-specific practice issues, barriers, and legislation affecting NPs and is available at http://www.webnp.net.

At present, the United States has 147,295 licensed NPs (Pearson, 2009), who have a greater opportunity than previously to practice autonomously. Not only do NPs work in traditional settings, such as community health centers, urgent care clinics, and private practices, but also in specialty areas, such as dermatology, infertility, long-term care, pain management, and pediatric psychiatry.
Nurse practitioners also serve as hospitalists in Emergency Departments and intensive care units in hospitals; as palliative care directors; and as owners of primary care and home care practices. They perform a variety of surgical and other invasive procedures and are directly reimbursed for their skill and expertise.

One important variable driving direct reimbursement for NPs is the legal ramifications of the expanded scope of the NP role. Regulatory bodies and insurance companies routinely dictate how health care is delivered. In additional, regulatory and institutional requirements must be met prior to practice. As such, NPs are mandated to have specific curricula, clinical hours, and time with specific patient types to develop certain expertise and certification in their specialty area before they can apply for licensure as an APN.

The Consensus Model for APRN Regulation—Licensure, Accreditation, Certification, and Education: Implications for the Role of the Nurse Practitioner

The National Council of State Boards of Nursing (NCSBN) (2009), which oversees the APN title and scope of practice, endorsed the Consensus Model for APRN Regulation in September 2008. As of 2007, the NCSBN states that “45 out of a total of 50 State Boards of Nursing use APRN certification as one of the requirements of advanced practice licensure for NPs” (Chornick, 2008, p. 90). A distinct difference exists between licensure and certification for APRNs.

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (2008) is the product of four years of meetings between members of the country’s leading national professional organizations and boards of nursing to develop APN regulation. Licensure, accreditation, certification, and education (LACE) were examined regarding the four advanced practice nurse categories (i.e., nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists), with the purpose of standardizing criteria. Under this model, NPs “will be educated in one of these four roles in addition to one of six population foci” (Stanley, 2009, p. 101):

- Individual across the lifespan/family
- Adult—gerontology
- Pediatrics
- Neonatal
- Women’s health/gender related
- Psychiatric/mental health

Nurse practitioners will only be licensed as APRN, CNP, which represents Advanced Practice Registered Nurse, Certified Nurse Practitioner. Education must include a graduate degree in one of the population-focused NP areas, and the training must include “educational preparation to assume responsibility and
accountability for health promotion, assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and non-pharmacologic interventions, and successful passing of the national certification test” (Stanley, p. 101). The Consensus Model, scheduled for implementation in 2015, allows specific grandfathering for NPs practicing in the state that granted their license.

The Consensus Model also defines standards of practice from well care to acute care. Nurse practitioners who are certified as a Family Nurse Practitioner or Pediatric Nurse Practitioner, for example, can be also certified in a specialty area, such as Palliative Care or Oncology. A copy of this Consensus Model can be accessed at http://www.aacn.nche.edu/Education/pdf/APRNReport.pdf.

**Licensure**

Once the Consensus Model is implemented, all of the standards for licensure, accreditation of educational programs, certification, and education will be universal. Thus, an NP will have less difficulty in obtaining license reciprocity to practice in other states. Until the Consensus Model is implemented, NPs must apply for new APRN licenses when moving to another state. An NP should continue to maintain their RN license as well as their APRN license.

**Accreditation**


**Certification**

Certification, under the Consensus Proposal, is earned after an individual completes a Master’s Degree NP program, submits an application to the Certification Board, and passes the specialty certification exam. Certification is necessary to apply for licensure in most states. Currently the American Nurses Credentialing Center (ANCC) is the largest certification board and certifies nurse practitioners in eight areas. Once the Consensus Model is in place, all new graduates of NP programs will take a “certification exam recognized by all state licensing bodies” (Stanley, p. 101). These certification exams will evaluate “the nationally recognized competencies of the APRN core, role, and at least one population-focus area of practice” (Stanley, p. 101).

**Education**

Education is the last component of the Consensus Model. The National Organization of Nurse Practitioner Faculties (NONPF) and the American Association
of Colleges of Nursing have worked with the American Nurses Association to further standardize master’s program guidelines and NP competencies. The American Association of Colleges of Nursing developed the Essentials of Master’s Education for Advanced Practice Nursing (1996—in revision, 2009), which specifies the core courses all NPs must take before starting their specialty track courses. These core courses include:

- Advanced Physiology and Pathophysiology
- Advanced Assessment
- Advanced Pharmacology
- Advanced Practice Role
- Epidemiology and Health Promotion
- Advanced Nursing Science and Research
- Advanced Health Care Policy

The NONPF Guidelines for Competencies in each track guide the curriculum development of the didactic specialty courses and list the number of clinical practicum hours mandated for all students.

The Doctorate of Nursing Practice (DNP), which was passed as a resolution by AACN in October 2004, is the goal for NPs graduating after 2015, and educators have worked to prepare curricula to provide the added information NPs need to succeed in the future. AACN and NONPF have standardized the criteria for curricula across programs and also for accrediting bodies, such as the CCNE, to assure all NP graduates are competent in providing safe and high-quality care. See Chapter 2 for a discussion of the DNP Essentials.

Adapting to the Nurse Practitioner Role as a New Graduate NP or NP Considering a Change of Position

In Zander and Zander’s Using the Art of Possibility: Transforming Professional and Personal Life (2002), the authors provide techniques for a new way of thinking. These techniques can help strengthen self-confidence and decrease the need for ongoing professional reassurance in daily care management. NPs need to imagine a different frame around difficult situations and identify new ways of managing problems. Most NPs know others who have triumphed despite personal difficulties in the workplace. What made those NPs stay and reframe the situation so they could succeed? The Zanders suggest that the world needs to transform itself. We need to shift our very core of “posture, perceptions, beliefs, and thought process” (p. 4), rather than engaging in yet another round of self-improvement exercises. We are all weary of hearing top administrators lament budget cuts, the lack of funding for travel to conferences, and the placing of new initiatives on “hold.” NPs must not accept the status quo but try to create new ways of working with new methods of practice. Perhaps, some activities thought to be essential for high-quality care are not necessary. In the end, NPs should work differently and conduct business so practices can remain cost effective while achieving high rates of good-patient outcomes.

These ideas came from interviews with NPs who have 1 to 3 years experience in the role. The demographic was all women, aged 29 to 50 years, and ex-
experienced as an RN from 8 to 30 years. None had been in another profession before becoming an NP, and all seemed to respond similarly regardless of age.

Questions and Answers

Question #1—Approximately how long did it take after you graduated to get a position? When did you begin looking for a position? When did you actually start to apply for a position?

Answer:
All had started e-mailing, phoning, and interviewing in their final semester of the NP program. All passed the Certification Board before beginning an NP position, except for one who said, “if I could have started after the Boards that would have been good.”

Others offered the following advice. “Don’t let prospective employers scare you into thinking you will not get the position unless you start when they say.” If you are assertive and have good rationales, the employer will demonstrate more respect. Set the right tone from the beginning of the relationship, so the employer will understand the NP will not “cave to their every request,” but rather negotiate so both will be satisfied with outcomes. Review local medical practices as any available positions are often listed on Web sites. Word of mouth from colleagues, list-serves, NP journals, newspapers, alumni, and preceptors involved with NP program are all good sources for obtaining information about available positions.

Three NPs obtained positions in practices where they had a practicum during their NP program. And all but one chose a position in a similar setting to their last practice practicum area. All of the NPs said to take a review course, study for four to six weeks while working in the RN position, and then take the certification board exam. All agreed on the importance of looking for a position during the final semester to become familiar with what is available. This early effort often results in first chance at many positions, as many NP graduates wait until they pass the certification board to begin looking. All stressed not rushing into a position; always research the practice thoroughly. All had checked out the practice site with experienced NPs and, if there had been a previous NP in the practice, they investigated why the NP was leaving. During the investigation, check if the practice site is financially solid and if there is a “window on the salary.” In other words, can your salary increase as you can gain experience at the practice site. All NPs interviewed stressed the need to have confidence in your abilities to be successful in obtaining a position and salary equal to your competencies. They advised “Never settle for a position—be sure it is what you worked so hard to obtain.” You also need to come off as a flexible team player, but not to get “real close” to the registered nurses (if registered nurses work in the setting) or the doctors. Many were the sole NP in the practice and found it best to be professional with everyone. Be careful not
to act like a doctor or let patients and staff think you are a doctor; be very clear that you are an NP and just keep sharing your role and practice scope. Unfortunately, RNs are often the most difficult to educate to the NP role. If the NP role is not clear, the RN will let the NP do the RN work for their own patients, as well as provide the NP level care. Once they had been at the site for six to nine months, the majority of the nurses became trusted allies of other staff members.

**Question #2**—If you could share anything with someone starting a first NP position or contemplating a change in NP position, what would it be? Did you have a mentor? Have you tried reflective practice and/or meeting with other NPs to share experiences? Do you have any suggestions for the new NP?

**Answer:**

Keep in touch with the other providers in your practice, as well as the staff, on a regular basis and get to know them. Be sure they are aware of your experience and, maybe, areas in which you could use more experience. When appropriate, ask them to share knowledge and experiences. Read so you are knowledgeable about the patient types most often seen at your practice site.

Get an iPhone so you can look up information immediately on PubMed or access other Internet resources. Be sure that everyone at the practice site knows the scope of practice for an NP. This is especially crucial when you are the first NP in the practice or, even more so, if you are following an NP who was not well received and left. All recommended having several mentors with whom you can dialogue, plan for the future, and share patient experiences.

All were adamant that the NP role needs to be respected by everyone in the practice. If this does not occur, the NP needs to remedy this by talking with those who do not respect the role and/or enlisting assistance from the supervisor/director.

The only thing I wish was stressed more in my NP program was how big of a change this was going to be—going from RN to APRN. I was one of the senior staff members on my floor at the hospital—most questions about procedure or patient care were directed to me. It was a very big adjustment becoming an APRN. Starting back at the bottom of the totem pole with the feeling of not knowing what you are doing was hard. I was the one asking questions about procedures and patient care again.

So the issue of role needs some attention. Remember when starting the position that most NPs had these same feelings, as most are starting in a whole new type of practice.

*I kept a notebook in my pocket in which I wrote anything that was new to me, such as Rx for hidradenitis, pharyngitis, UTI, the usual suspects, un-
til I could remember them without looking them up. I had to learn to say, “I’ll be right back with your prescriptions” if I had to look something up online or consult with someone.

I do think it helps to keep a notebook. I carry it to work every day because it gives me security and confidence. Some of the things I put on a page that I add to about once a week I label as “clinical pearls.” I then review the notebook and think about how I came up with the patient’s differential diagnosis. I also like to reflect on what if… meaning what if I had not seen this or the patient had not told me this. I learn a good amount by just reviewing my clinical days. I try to do it on my way home from work.

I save the e-mails from the medical director. Every Sunday I review a “to do” sheet for work. I created a paper that I use for monitoring lab work and Coumadin dosages. I have another sheet that I labeled biological modifiers, where I list the people for whom I need to remember to check labs because they are on Procrit, Aranesp, etc. I review these and feel more prepared. I also have computer access from home to the hospital and the lab. It is not required but I like having the access. Sometimes it is just too noisy at the facility to concentrate.

I did keep a notebook during clinical practica and continue it to this day. Anytime I learn something that is very significant to practice, I write it down. I used this book frequently when I first started, and I still find myself referring to it now. I guess it increased confidence because it helped me build my knowledge base. I have found that I am one of the youngest NPs in the group, so my experiences are a little different than some of the others. That has been one of my frustrations—not knowing any NPs my age. I have one NP with whom I keep in touch from school, but all the other NPs I know are older and at different stages of their lives. Still, it is helpful to dialogue with other NPs.

Question #3—Kramer’s classic work, Reality Shock (2004), has been used as a framework to assess new RNs and their adaptation to the role of RN. Given the following framework stages, could you share how you have transitioned through the stages as an NP?

Answer:
Sometimes, one regresses back a stage before progressing, and it is common to stay in one stage for a long time. All of the participants agreed that knowing the Kramer Framework was helpful in explaining some of the rationales for what they were and are experiencing.

Kramer’s Framework of Reality Shock (1994) includes the following stages:

- Compliance—The RN [NP] is trying to gain respect from colleagues.
- Identification—Respect is felt and the RN [NP] wants to earn recognition for being good with certain skills, diagnosing certain problem areas, and working with certain age groups, etc.
Internalization—The RN [NP] is responsible and able to manage an “average assignment” of patients independently.

Stage 1, Compliance—One NP had worked as an RN and done some practicum work at her place of employment. As a result, she felt she had already gained respect and went directly to Stage 2. Others asked a lot of questions and often confirmed the information they received on the Internet, particularly as they gained confidence in themselves and also “got a handle on their colleagues’ levels of knowledge” and did not just accept their opinions. Because most work was in a primary care setting, few emergencies were presented, so the NPs took the time to be sure patients were managed correctly. Many soon learned they knew more than they had realized and that they had excellent backgrounds from their years of experience as RNs. After a while, most started to share information with colleagues, and this assisted them in garnering respect and improving their confidence.

Many also felt it was important to treat the staff well and thank them for their work. For example, preface requests with, “I know you’re really busy, but . . .” and engage in conversations with them as well as with the providers. One NP felt it took about two weeks before she felt respected; she also believed that she was lucky because her agency had multiple NPs and was aware of the scope of NP practice. Another NP said it took about three months to earn respect. During her formal orientation time, she took her own patients, but had to present each case to a physician before letting the patient leave. (She was the only NP in the practice.) She felt this was a good time for the physicians to get to know her and learn to trust her work. Many felt it was important to teach RNs about laboratory work, how to assess patients for certain problems, such as pneumonia, more critically, and just, in general, to make them feel “valuable” too.

Stage 2, Identification—One NP said her relationship with the Medical Director has been excellent, as he always gets back to her and he is available 24/7 for questions. His motto is, “nothing is a stupid question.” After three months, this NP feels more comfortable and shares the following example of avoiding hospitalization of a patient who became acutely ill.

_“I am, as of today, feeling more comfortable managing my residents with certain problems. I had a resident today with dementia, aphasia, and diabetes, who presented with a blood sugar of 482. Her blood sugars are never that high. I noticed that she was also tachycardic at 120, tachypnic, and warm. She had congestion in her chest and was feverish. The tachycardia and tachypnea in the first month I was there would have sent her to the ER. Today I did a stat chest film, had a UA and C&S sent to the laboratory, and started the antibiotic, Avelox. I ordered O₂ and eight units of regular insulin. If she worsens they will send her to the hospital tonight but hopefully I can keep her out of the hospital.”_
I do want the physicians to know that I am doing a good job. There have been occasions where I have noticed something like a lab abnormality that one of my colleagues missed, and I do feel respected when the physician recognizes that I picked it up and followed through on it.

Another NP shared:

I have been sought after by the female patients for sexuality issues while they are undergoing cancer treatments and/or first receiving their diagnoses of cancer. I did not seek this identification, but if I can be helpful to them I am pleased. I am the only female provider. I have chosen to focus on hematological cancers and multiple myeloma, and this has assisted me in gaining some expertise, although I certainly still feel inexperienced with most oncology problems. I am also working on gaining competency with the inpatients so I round daily, cover on-call issues, and make it a point to connect with the hospital staff.

All felt it was important to focus on specific areas and learn as much as one can. Become somewhat of an “expert” in those areas, and then gradually add on more and more diagnostic areas. It is overwhelming to learn everything about everything, so try to focus initially on specific areas.

Stage 3. Internalization—The type of practice determines how one reaches this stage. Here are some of the NPs’ ideas:

At eight months into the job I started feeling pretty comfortable and felt I could carry out a day independently. However, some days I have very complicated patients, and I require a lot more collaboration. I have been told this is true with oncology practice for most providers.

It’s taken me about six months to get to a 14-day patient load that I could handle. I’ve seen as many as 25 patients some days. It takes a while to learn to sort through all the information that a patient is bombarding you with and focus on the priority issue of the visit. I was trying to do too much in a visit when I started.

Internalization happened after about three months at the practice. Once I was off orientation, I was expected to handle an average assignment on my own. However, the physicians were always willing to answer questions or consult on a patient. I was much slower in the beginning. I would run behind because they didn’t give me any extra time to see patients. In the first two weeks of the job, they scheduled my patients every 30 minutes, after that it was every 15 minutes—the normal time allotted in this office.

**Question #4**—What were your five biggest areas of need as you embarked on your NP career and how could they have been less problematic if you had had more of “something” in your program?
Mentoring is the biggest MUST HAVE when you first start out. You have got to have someone who is smart and available to teach you and answer your questions.

The need for a really good physical assessment course cannot be ignored. It’s really true when you work in a place where there are no diagnostics (chest X-ray, laboratory, MRI, etc.) available and you have to wait for all of your results. You’ve got to be really good at physical diagnosis.

My five biggest areas of need were EKG interpretation, physical assessment, billing, support during role transition, and time management. Since I never worked with telemetry patients or ICU/ER patients, I do not have that baseline knowledge or experience and am taking a continuing education course on 12-lead EKG interpretation. I find my physical exam techniques and time management improving as I gain more experience. The practice should have a staff person manage the billing and reimbursement exclusively since this area takes up too much of my time. I am lucky that I belong to an NP Group that meets monthly for dinner and class. This affords me time to network with other NPs and see if they have advice for any issues I am experiencing.

I would have liked to have had to present more patients to my peers and instructors—it seems that is a lot of what I do in an oncology practice. I am learning to be more comprehensive and succinct. I also carry my iPhone so I can be ready with answers during the case rounds. It seems imperative to have knowledge accessible, and the PDA is not as good as the iPhone with instant information access.

Question #5—List 10 words that describe how you felt during the transition from novice/advanced beginner NP to competent NP this last year?

Answer:

Benner, Tanner, and Chesla (2009) describe the process of going from advanced beginner to competent to proficient to expert stages in clinical practice for RNs. Each of the interviewees were aware of this framework, because most had used it for their clinical ladder promotion in their hospitals. They answered this question similarly. As novice NPs, they felt stupid, incompetent, scared, nervous, and unsure, but when they gained self-confidence and competency, these feelings changed to conscientious, good, caring, helpful, smart, like “advanced beginners,” and then “competent.” No one called themselves expert; they classified themselves as in between the “competent” and “proficient” stages.

Brykczynski (1989) and Brown and Olshansky (1998) studied specifically the transition role of nurse practitioners and developed the following framework of four stages:
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- Stage 1—Laying the Foundation—This occurs just after graduation, when the new NP is looking for a position, studying for the certification board exam, and working in an RN position.
- Stage 2—Launching—Approximately the first 3 months of the first position.
- Stage 3—Meeting the Challenge—As one starts feeling more comfortable, the new NP gains competence and believes that he or she is not going to harm or kill a patient.
- Stage 4—Broadening the Perspective—When the new NP holds his or her own, feels confident, and does not have to ask as many questions or get approval from another provider as frequently. The individual realizes he or she is a safe and competent provider, but one who could always learn more.

**Question #6**—How did you see yourself going through each phase and what feelings are you presently experiencing? If you had had this kind of information about how other new NPs have felt, would it have helped before beginning your position?

**Answer:**

*Stage 1—Laying the Foundation*—Most had secured their positions during the final semester of school, but they had anxiety about taking the certification board. They all took a Board Preparation Course that helped them focus on their weak areas and took the exam 4 to 8 weeks after the Board Review. (They were also working full time in their RN positions). Three took the Board Preparation Course in the beginning of their final semester and thought it helped them feel more confident at graduation. Each NP found it crucial to set aside a certain number of hours to study for the certification board and be serious about completing the hours.

*Stage 2—Launching*—Here are some ideas the NPs shared about this stage:

> The first few weeks, you’d never have known I had been an ER nurse for 25 years. It’s like the blackboard in my head had been erased. I didn’t know anything. My confidence had totally vanished.

> This stage was very difficult. I was very stressed at my new position. I felt like an idiot—like I had learned nothing in school. The “real world” was so different than being in school. Even different than clinical rotations—because I was on my own and nobody was watching my every move. Applying the text book knowledge to real life situations wasn’t always easy. The patients didn’t fit the text book description. It was also stressful to lose my support system of nurses at the hospital that I had in my RN position. I was out of my comfort zone and thought for a long time that I had made a mistake in changing to an NP career.
I felt like I knew nothing and was afraid to make a decision at first. However I was also excited to build “my practice” and often “took” patients from the physicians. I know I am very fortunate to work with MDs who are very collaborative focused.

Stage 3 Meeting the Challenge—Most shared similar findings to the following narratives.

I’ve learned that fortunately, people are resilient. I still have daily anxiety, but more about maiming than killing at this point.

This is a cool feeling. I am feeling a little overprotective of some of my residents at times. You realize, hey I recognize these symptoms, this is what I did the last time. Let’s try it again.

I never thought it would happen but I did reach a point when I felt more comfortable at my NP job. I really do think it took about a year to start feeling more confident. There were moments of confidence before a year—but they came more frequently after the one-year mark. I have to say that almost two years into this I still have days where I worry that I might kill someone! I have a feeling that takes a long time to go away. And maybe it never goes away completely. It is a huge responsibility.

It was around eight months that I felt conscious of the fact that I probably would not kill someone. I am now [about 1.5 years] much more comfortable and enjoy my position for the most part.

Stage 4—Broadening the Perspective

This took about ten months. I’ve gone from 20 questions a day to one or two and sometimes none. I have worn out the Primary Care Book though. I always know that I’ll never know enough. But I do feel I know something.

I think I am somewhere between these last two stages. I am now more regularly utilizing certain people with important roles. For example, I am not an expert on wound care. I have a wound care certified RN with whom I collaborate with regularly. Last week I had a resident diagnosed with three fractures of the right transverse processes of L2, 3, and 4. My orthopedic background told me not to worry about the spine but why did this 72-year-old man have fractures with no trauma? So I called one of the collaborating MDs but I also spoke with the head of our physical therapy department and worked it out similar to what the physician had thought. This was a good growth for me and instilled confidence.
Conclusions

The background of the registered nurse, along with additional NP education, helps produce an NP who cares holistically for patients, families, and communities. Nurse practitioners are not miniphysicians or extenders of medical care for patients unwanted by physicians. Nurse practitioners evolve from exposure to an integrative approach to medicine that is taught and practiced in nursing undergraduate programs. They need to be successful clinicians, managers, professionals, and leaders at an advanced level. In addition, physical assessment, diagnostic reasoning, and prescriptive authority, as well as other advanced competencies NPs acquire from their education, prepare them to become board certified. The Consensus Model for APRN Regulation is a landmark document describing the titles, defining the specialties, and identifying the new roles and population foci for the NP and three other APN categories in the United States. This regulatory model will direct NPs in forming practice strategies for improved healthcare delivery, role expansion, and standardization of licensure, accreditation, certification, and education.

Reflective Thinking Exercises

1. The American College of Nurse Practitioners (ACNP) has a Legislative Tracking Chart available that lists current legislation affecting NPs. Members can access this invaluable resource at www.acnpweb.org.
3. Develop an advertisement to market your skills as an NP for a professional nurse practitioner journal. Review your state’s Nurse Practice Act regarding the role and scope of practice for an APN.
4. Nurse Practitioners have a Medicare Learning Network Web site that can be accessed at http://www.cms.hhs.gov/MLNProducts/70_APNPA.asp. If an NP provides care to Medicare beneficiaries, this Web site will be an invaluable resource for answering questions regarding policy. It also provides operational updates specific to Medicare Fee-for-Service reimbursement issues. Review the Frequently Asked Questions Section and list the five most frequently asked questions that NPs have regarding Medicare and how it impacts their scope of practice.
5. Review the NP interviews with special attention to the role and feelings of recently graduated NPs. Develop goals and a timeline for seeking NP employment. The Web site from Advance Nurse Practitioners may also be helpful (http://nurse-practitioners.advanceweb.com/Editorial/Content/Editorial.aspx?CC=200814).
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