Transitioning Into Hospital-Based Practice

A Guide for Nurse Practitioners and Administrators

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Transitioning Into Hospital-Based Practice
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Editors
To all of the pioneers who have gone before us and continue to inspire us...

Mona N. Bahouth

For Mary Beth Esposito-Herr
Vision where others didn’t know to look. Courage where others were afraid to try... You are missed.

Kay Blum


Shari Simone

To the nurse practitioners and physicians at the University of Maryland Medical Center who have provided guidance and support over the years and continue to inspire me, but most importantly to the dedicated, talented group of NPs who I have the pleasure of working side by side with every day in the pediatric ICU—Amy Donaldson, Jennifer Nordling, Melanie Muller, Jill Siegrist, Jessica Strohm-Farber, Megan Trahan, Jamie Tumulty, and Anne Vasiliadis—without their support and encouragement this project would not have been a reality.
## Contents

**Contributors**  ix  
**Foreword**  Loretta C. Ford  xi  
**Preface**  Mona N. Bahouth  xiii  

### Introduction: Innovation and Transition  1  
*Kay Blum*  

### Part I Embracing Transition: A Guide for Nurse Practitioners  
1. Forces Affecting Nurse Practitioners in Hospital-Based Practice  23  
   *Kay Blum and Elizabeth Fuselier Ellis*  
2. Organizational Assessment and Development of the Business Plan  49  
   *Janet Fuchs and Kay Blum*  

### Part II Framing the Innovation: Developing the NP Role in the Hospital  
3. Developing a Model for Centralized Nurse Practitioner Leadership  69  
   *Carmel A. McComiskey, Renay Tyler, and Lisa Rowen*  
4. Centralizing Leadership for Advanced Practice: A Model Program  89  
   *Michael Ackerman, Susan K. Bezek, and Anne Swantz*  
5. A Practical Approach to NP Recruiting and Onboarding  99  
   *Mona N. Bahouth*  

### Part III Implementing the Hospital-Based NP Practice: A Guide for Administrators  
   *Cheryl R. Duke, Shari Simone, and Mona N. Bahouth*  
7. Measuring the Professional Growth of the NP  141  
   *Shari Simone*  
Contents

Alice D. Ackerman

9. Building the Practice Community 181
Tim Porter-O’Grady

Part IV Reinforcing, Measuring and Sustaining Success: Integrating the Models

10. Quantifying the Value of the Hospital-Based NP: Billing for Clinical Services 205
Robert P. Blessing

11. Measurement of Success 227
Clare Thomson-Smith, April N. Kapu, and Elizabeth Zink

12. Performance Improvement: Refining the Innovation 249
Kay Blum

13. Sustaining Success 263
Jennifer L. Titzer and Maria R. Shirey

Epilogue  Ruth Kleinpell  277

Appendices

A: Part I: NP Job Description Template 281
Part II: Applying the Job Description Template to Specialty Practice 284

B: Examples of Start-up Activities Initiated Upon Acceptance of Position 289

C: Clinical Orientation Timeline Template 293

D: Peer Review Evaluation Tool and Self-Evaluation Tool 299

E: Example of Nurse Practitioner Clinical Competencies 305

Index  309
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Reflecting on 47 years of the growth of the nurse practitioner (NP) educational and practice programs and on the changes in their integration into the health care sector is a formidable task. From a public health nursing role expansion model in well child care, the model was adapted to fit the needs of many health service venues: schools, clinics, veterans and military services, and so on. Most of these were ambulatory sites; they trained their own nurses to fit their particular needs. Some were newly created while other older ones were adaptable and flexible in their organizational structures. A few neonatal nurseries began to use NPs, but for the most part, the inpatient services were wedded to the Clinical Nurse Specialist model of advanced nursing care.

However, in my combined positions as Dean of the School of Nursing and Director of Nursing at the Strong Memorial Hospital, University of Rochester Medical Center, I became convinced that the NP was the nurse for all settings, including inpatient, acute care hospital settings. From an experience with experimental cardiothoracic NPs, it was obvious that while nurse educators were quite adept at preparing NPs, the major barriers to their successful integration into the total health care sector would require institutional changes in preparation, placement, practice, and policies if the patients and their families were to receive top-quality nursing care from a fully integrated, skilled team of health professionals of which the NP was an integral player. Changing the role of one professional required alterations in many aspects of the so-called “most entrenched, change adverse industry in the US” (Christensen, Bohmer, & Kenagy, 2000).

One of the many factors that escalated the NP into inpatient services was the impending crisis of reduction of surgical resident training funds. This provided an opportunity for NPs to demonstrate their value and worth in inpatient services, not as substitutes for the missing surgical residents, but introduce a comprehensive service of management of the surgical patient, which included continuity; increased communication with the total team of caregivers; coordination of care; patient and family education; support of nursing staff; transitional and follow-up to prevent recidivism and readmission. The NP could improve the safety, quality, patient satisfaction, and education as well as prevent suffering, dissatisfaction, and costly aftercare.

Except for descriptive articles, few guides exist to cover the many facets of inauguring, implementing, and evaluating the successful integration of the NP into acute care settings. That is what makes this
publication a valuable resource for NPs and administrators as well as stu-
dents, faculty, and health service planners. This reality-oriented and experi-
entially documented guide provides a comprehensive map of the various
stages of development from the transitional period to framing the inno-
vation and the evaluative process. It surely will be a major resource of
information, referral, and research for some years to come.

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REFERENCE
Christensen, C. M., Bohmer, R., & Kenagy, J. (2000). Will disruptive innovations
Preface

The decision to write this book—to call upon the experience of nurse practitioners fresh from the hard work of creating a culture that nourishes and cultivates the best practice—evolved from the desire of the authors to contribute on a larger scale to the well-being of both nurse practitioners and the organizations to which they belong. It is grounded in the fundamental belief that both must prosper or neither will; there must be mutual advantage, mutual reward, and mutual accountability, or the energies of both will be wasted in the struggle to be heard and appreciated. This book provides critical information to the nurse practitioner and supports the successful integration of nurse practitioners into hospital-based practice.

Challenges exist in the integration of nurse practitioners into the organization whether that is a hospital, clinic, medical practice, or tertiary referral center. Societal, political, and economic forces in the environment have led to the hiring of nurse practitioners without planning or thought as to the impact this change would have. The designations of adult, pediatric, neonatal, acute care, and family nurse practitioner and the legal requirements that differ from state to state lead to confusion in the credentialing and privileging that are critical to functioning within an organization. Defining the scope of practice and even naming jobs and creating job descriptions are difficult because the patients we care for cross age and setting categories. Organizing practice, especially in large organizations, is difficult and makes a systematic approach almost an impossible task. Trial and error becomes the most common and the most expensive strategy. This tactic often leaves the participants discouraged and distrustful of the process.

The purpose of this book is to provide a critical summary of resources needed for the nurse practitioners who are entering or refining their role within the hospital setting. The book also helps to facilitate this process for organizations that wish to plan ahead for the integration of nurse practitioners into the models of care. It is also for nurse practitioners who are seeking an environment where they can grow and develop into the best possible providers and have a genuine sense of accomplishment that nourishes them and benefits the patients they care for. We have chosen to take a systematic approach to bring together theory, research, and our experience in a meaningful and pragmatic way. It has been said that there is nothing as practical as a good theory. We have taken that to heart and, just as people use a map to reach a destination they have never traveled to, we see a conceptual framework as a map to guide our
journey as advanced practitioners. Conceptual frameworks not only keep us on an efficient path to our destination; they provide a systematic way of examining phenomena that illuminate our way back when we stray, ensure that important components are not missed in our haste, and provide a means of evaluating our progress; they also help us to identify new strategies when old ones have not worked as well as we had hoped.

We have chosen two frameworks to guide the development of this book. First, for organizations, the Diffusion of Innovation Model, initially developed by Everett Rogers in 1962, provides direction for planning and evaluating the introduction of an innovation such as nurse practitioners into an established organization. It suggests strategies for decision making and planning for change (Rogers, 2003). For nurse practitioners and organizations, the Theory of Experiencing Transition suggested by Meleis, Sawyer, Im, Hilfinger Messias, and Schumaker (2000) offers a means of examining the complexity of change in transition and of utilizing supportive strategies to facilitate the transition.

It is our sincere hope that our experiences and the national expertise represented in this book can be useful to our colleagues who are in all stages of transition and who view nurse practitioners as an innovation in the way we care for patients who have sought our help. We believe that respect and collaboration are the fundamentals of practice and that practice must take place in an environment that appreciates and acknowledges the work of nurse practitioners as fully integrated professionals. We believe that successful, productive nurse practitioners see their success as the success of the organization and see the organization’s success as part of and not separate from their own success. Our vision for this book is that it will provide guidance for novice and experienced organizations and practitioners and that all can use the information here to develop a dialogue that reflects the common purpose, common language, and common good of organizations and practitioners alike.

REFERENCES


Introduction

Innovation and Transition

Kay Blum

He who loves practice without theory is like the sailor who boards a ship without a rudder and compass and never knows where he may cast.

LEONARDO DA VINCI (1452–1519)

Just as travelers would use a map to get from where they stood to a place they wanted to be, we must use a map to ensure we reach our desired destination of the successful integration of nurse practitioners (NPs) into an organization. This is true for any organization whether a large academic medical center, a community hospital, managed care organization, or private practice. Leonardo da Vinci understood this, and intuitively we all recognize the benefit of a plan or road map to achieve our goals. How then do we identify the right map and then use it to our benefit?

The purposeful introduction of NPs into an organization is innovative. Historically, changes in nursing’s scope of practice have epitomized innovation. Florence Nightingale introduced a totally new and innovative definition of nursing in Crimea. Cleanliness, fresh air, and decent food delivered by healthy, attentive, caring women reversed the diseases that killed many more soldiers than battle.

In the 1960s, nurses and cardiologists came together to develop coronary care units. There, specially trained nurses could act quickly to save the lives of myocardial infarction patients without waiting for the arrival of a physician to order them to do what they already knew how and when to do. That innovation was the beginning of today’s modern critical care units. The integration of critical care into the fabric and culture of hospitals today, to the point we cannot conceive of a modern hospital without a critical care unit, is the perfect representation of the successful organizational adoption of innovation.

It has been 45 years since Loretta Ford and Henry Silver developed the pediatric NP role at the University of Colorado (Brush & Capezuti, 1996). The issues associated with the rapid development of NP programs
in the 1960s and 1970s have continued to foster the evolution of NP specialties and scope of practice. Those issues are access to affordable health care for children and adults, increased subspecialization of physician practice, decreased numbers of physicians, and, more recently, limitations on the number of continuous hours physicians in training can work. In order to fill the needs resulting from these changes, many activities once viewed as the exclusive purview of physicians have progressively become recognized as being within the scope of professional nursing. NPs are hardly new after 45 years of practice; however, the new arenas and developments in practice, health care, and society make NPs an innovation in many acute care settings.

The successful dissemination of these innovations did not happen by chance. Thought, planning, dedication, and even passion went into the hard work of this success. The successful integration of NPs into any organization is and will always be the result of planning and persistence. The planning requires a road map. Rogers’s Diffusion of Innovation Model (Rogers, 2003) provides an excellent road map for the integration of NP practice in organizations.

The theoretical model for Diffusion of Innovation (DOI) began as a study of the adoption of hybrid corn species by farmers in Iowa in 1960 (Rogers, 1962). The concept of individual adopters relates to the characteristics of individuals who were quick to try new things (early adopters) versus those who waited longer to see what kinds of problems or successes the earlier adopters had before adopting the innovation themselves. In the 50 years since that study, thousands of studies have been completed using and refining the original model introduced by Everett Rogers (2003). The complexities of looking at individual adopters are dwarfed by the examination of the complexities of institutional or organizational adopters of innovation. Hospitals are examples of organizational adopters. Greenhalgh, Robert, Macfarlane, Bate, and Kyriakidou (2004) reviewed the science in diffusion of innovations applicable to service organizations such as hospitals. The review by Greenhalgh and colleagues and Rogers’ evolution of thought presented in the latest edition of his seminal book form the foundation for the use of DOI in the planning and adoption of NPs as an innovation in hospital practice.

The purpose of this chapter is to introduce DOI and explain its concepts as they relate to the adoption of NP practice in hospitals and other organized health care systems. The concepts introduced here will be woven into the fabric of subsequent chapters in order to thread together the practical recommendations provided by content experts who have walked the roads of integrating NPs into the hospital setting. In addition, the Theory of Experiencing Transitions (TET) will be introduced to guide understanding of the challenges and resources that emerge in both organizational and individual transitions.
INNOVATION

What then is an innovation and what is it about NP practice, which is hardly new, that makes that practice innovative? An innovation is a product, technology, procedure, or idea perceived as new. The newness of the innovation is unrelated to the length of time it has been available. All innovation is change, but not all change is innovation. The adoption of any particular innovation is uncertain at best and is not as simple as a decision to implement a new way. Not all innovations are adopted, even if they offer advantages over current practice.

There are five characteristics of innovations that influence adoption. Relative advantage is the sense that the innovation is better than what is current practice. Compatibility refers to the degree to which the innovation is similar to current practice or consistent with the goals and culture of the organization. Complexity refers to the difficulty one might have in understanding, implementing, or incorporating the innovation. Trialability refers to the ability to “try it out,” to implement the innovation in a stepwise manner, or to experiment with the use of the innovation. Observability is the ability to see the benefit or outcome of using the innovation.

DIFFUSION

Diffusion is the communication of the innovation over time throughout the social system. Some authors distinguish between the passive diffusion of the innovation and active dissemination of the innovation (Greenhalgh et al., 2004). Rogers does not make this distinction, but has acknowledged the evolution of thought about diffusion as more than the passive communication of ideas. Whether the diffusion of the innovation is active or passive, the newness of the innovation guarantees that there will be some risk or uncertainty in rejection or implementation. Rogers asserts that diffusion is social change and the result is a change in both the structure and function of the organization. The risk and uncertainty associated with the adoption of any innovation should not be taken lightly; however, respecting the lack of predictability of all aspects of the change improves the likelihood that the innovation will meet desired goals.

The bulk of the research in DOI and the majority of Rogers’s books (2003) are related to individual adopters of innovation and to the traditional model of innovation Figure I.1 diffusion reflects this research. However, some aspects of organizational innovation depart from Rogers’ original work (1962), which portrayed diffusion of innovation as a linear process.

DIFFUSION OF INNOVATION IN ORGANIZATIONS

Organizations are relatively stable systems of people who work toward common goals through a “hierarchy of ranks and a division of labor”
Prior conditions
1. Previous practice
2. Needs/problems
3. Innovativeness
4. Norms of the social system

Characteristics of decision making unit
1. Socioeconomic characteristics
2. Personality characteristics
3. Communication characteristics

Perceived characteristics of the innovation
1. Relevant advantage
2. Compatibility
3. Complexity
4. Trialability
5. Confirmation

Communication channels

FIGURE I.1 Original diffusion of innovation model.
An organization functions through rules, regulations, formal roles, and agreed-upon goals. Organizations are relatively stable, but, like living organisms, change on a continuous basis. Some of these changes are evolutionary and some are innovative. Hospitals are such organizations and, in addition to internal forces for change, there are external regulatory, financial, political, societal, and scientific forces that contribute to an internal and an external environment of change.

The innovation process for organizations is represented in Figure 1.2 (Rogers, 2003). For organizations adopting an innovation, the implementation decisions may be more prominent than the decision to adopt the innovation. Several factors have been shown to have positive and negative effects on the implementation of organizational innovations. Strong individual leader characteristics have a positive effect on implementation. Internal organizational characteristics such as complexity of the organization, interconnectedness within the organization, organizational slack (flexibility of roles and resources), and size of the organization have all been positively associated with successful implementation. Centralization of decisions and formal or rule-oriented cultures are less successful in implementing innovative solutions to problems. System openness is a positive external characteristic for innovation success.

Prior conditions associated with individual decisions as well as the perceived characteristics of the innovation itself are still relevant for organizational innovation. Most of the DOI research on individual adopters looked at technology or procedure, neither of which was expected to change significantly over the adoption period. These innovations were also assumed to be consistent across individuals and context. These assumptions cannot be safely held in relation to the NP as innovation nor can they be assumed within organizations where culture may differ from division to division.

Planning can help to mitigate undesired changes and create an atmosphere or culture that is prepared to exploit positive unintended consequences while minimizing the effects of negative consequences.

IMPLEMENTATION OF NP PRACTICE AS AN ORGANIZATIONAL INNOVATION

For any model to be useful, it must first have the concepts operationalized so that the model makes sense within the context. See Figure 1.3. There are basically three time-related concepts. These periods— Initiation, Decision, and Implementation—are presented as linear in the model and each has its tasks. In reality, they are nonlinear and different tasks may be revisited as the final stage of routinization or sustainability is reached.
Initiation

Agenda setting

Organizational problems that may create a perceived need for innovation

Matching

Associating a problem from the organizational agenda with an innovation

Decision

Redefining/restructuring

Innovation is modified and reinvented for the organization and the organization is restructured

Clarifying

Relationship between the organization and the innovation is defined more clearly

Implementation

Routinizing

The innovation becomes an ongoing element in the organization’s activities and loses its identity

FIGURE I.3 Five stages of the innovation process for nurse practitioners in organizations.  
Agenda Setting

For most organizations, the decision to integrate NPs into clinical practice has been the result of changes in medical practice. The most recent trends include fewer physicians, fewer physician specialists, and a mandated decrease in work hours for house officers. The latter relates predominantly to academic medical centers and hospitals that depend on residents and fellows for their around-the-clock care. These recent changes in work hours have created several issues as organizations strive to maintain an adequate quality and continuity of care.

Hospitals struggle with the financial bottom line, which is affected by series of complex multifactorial issues. Timely discharge of patients from the hospital is critical to the financial stability of the organization since it makes beds available to new admissions and increases the likelihood that reimbursement will cover the expense of care. Hospital readmission is often not reimbursed at all. Unnecessary testing increases the cost of care in a climate of reduced reimbursement. This testing is often the result of poor communication between provider groups or at the time providers change services in teaching hospitals. Consequently, even if staffing of physicians is not an issue, the financial bottom line may be the agenda item that leads the organization to explore innovative ways to maintain or improve quality of care at a reduced cost.

Matching

Once the agenda setting is complete and the problem is clearly defined, the decision makers embark on a search for possible solutions to the problem. It is critical that the problem be clearly defined so that reasonable and accomplishable outcomes can be identified. Without these outcomes, the search for a solution—an innovation—will be inefficient and ultimately unsuccessful.

In the case of a shortage of physicians and a desire for a team-based approach to maintaining quality patient care, the match is intuitive. As with many things, however, assuming that everyone has the same intuition about team-based care and the practice of physicians and NPs will lead to a less than satisfactory solution. A critical part of the matching is determining whether the culture of practice in the institution is one that will foster collaboration or competition. If the prevailing climate is one in which physicians may see NPs as competition, there is no match even if the innovation makes sense from a purely objective view. Realistic and frank discussions must occur at this stage in the process before any innovation is selected. The expense and investment in NP practice in an organization is not to be taken lightly, and identifying and addressing potential negative consequences up front will increase the likelihood that the integration will be successful in meeting the organizational goals.
In determining the adequacy of the match, the prior conditions as well as the perceived characteristics of the innovation that are described in Figure I.1 continue to hold true for organizational decisions about the adoption of an innovation. Prior conditions include previous practice, both the way medical practice is delivered, governed, and reimbursed, and the relationship of medical practice with any previous NP practice. An unsuccessful attempt to integrate NPs into hospital practice will make a future new decision more difficult to implement. The degree of respect and collaboration between physicians and staff nurses or NPs is a powerful influence on the success of a decision to fully implement NP practice in an organization. Organizations such as hospitals are social systems with their own social norms, and any decision to implement an innovation must consider the social order within the organization as it is and not as the decision makers wish it to be. An honest assessment of the social environment prior to the decision to implement NP practice will enable the decision makers to avoid a number of pitfalls and will improve the likelihood of success.

The personal characteristics of the decision-making body, individually and collectively, are significant factors in the success of the matching and of the ultimate success of the innovation in achieving organizational goals. Of the three characteristics listed, personality and communication characteristics have the most impact on the decision to implement NP practice in the organization as a strategy to alleviate the physician shortage and maintain quality care. The personalities of the decision makers contribute to cooperation and power sharing within the group and powerfully affect their consideration of unexpected consequences of the innovation. Communication within the decision-making group and between that group and the organization members affected by their decision to implement NP practice is critical to success. If the group or the organization has a history of control of information and a top-down, hierarchical communication style, the innovation is unlikely to be well accepted and therefore is unlikely to succeed (Rogers, 2003).

The perceived characteristics of the innovation are critical to both the decision to implement NP practice as well as the strategy for implementation. It seems intuitive that there should be a perceived relevant advantage to NP practice. The relevant advantage of NP practice must relate specifically to the goals and outcomes specified in the agenda. NPs must realistically be able to achieve the goals in a cost-effective way within the organization. Their ability to accomplish these tasks in other organizations reported in the literature is important, but the decision-making body must be convinced that those same outcomes are not just possible, but probable within their own organization as a fundamental step in the matching process.

Once the decision makers establish that the implementation of NP practice in the organization is a match for their goals they must decide whether NP practice is compatible with the culture and social environment
of the organization. This is not a simple task and should involve stakeholders and champions as well as careful planning for when and where implementation has the best chance of success within the organization. Timing is critical here as well. Compatibility decisions are often made on the basis of familiarity rather than careful analysis. Moreover, there may be a misconception that everyone defines NP practice the same way and has the same vision. Discussions at this point about definitions and expectations can preempt a number of often expensive problems down the line.

The complexity of the innovation has a direct effect on the success of its implementation (Rogers, 2003). Large, complex organizations are capable of absorbing innovation, even complex innovation. NP practice is quite complex and is regulated by the state practice act, organizational bylaws and organizational culture. Furthermore, no two NPs are alike—each comes with his or her individual clinical experience and education. The individual characteristics of the NP are not separate from the collective in terms of importance and likelihood of success. While each individual NP must demonstrate ethical, knowledgeable, professional practice, there must be a collective identity that demonstrates the same qualities. It is the development of a community of NPs that provides the mentoring, socialization, support, and encouragement that elevates the practice of all. The community is more than and different from a group of people who happen to practice in the same organization. It is the mutuality of the individual and the community or “collective” NP identity that ties the success of the individual to the community and the success of the community to each individual member. Furthermore, the success of the individual/community identity of the NPs is interdependent with the success of the organization in achieving the purpose for which it adopted the NP innovation. This mutuality compounds the complexity of the innovation. The combination of individual, collective, and organizational capacity for variability make this a very complex innovation, and utilizing the full capacity of the NP is not always an easy task. This requires knowing the scope of NP practice as well as knowing the individual hired to meet the needs of the unit/organization.

Unfortunately, in an attempt to simplify the complexity, decision makers may use analogy or establish practice based on previously known roles. For example, if they have worked with nurses or house officers—what health care professional has not?—they may translate their experiences and understanding of that relationship to the relationship with NPs. This underestimates the contribution NPs are prepared to make within their scope of practice, limits their productivity, and can lead to significant dissatisfaction with the innovation. Ultimately this may result in failure for both the institution and the NP if the situation is not remedied.

Any organizational innovation potentially involves large investments of human and financial capital. The matching stage is critical to the stewardship of that capital. When the innovation requires the addition of a whole
new category of providers, which includes recruitment, orientation, development and governance, the decision makers have a duty to engage in the difficult discussions. These difficult discussions involve clear definitions of the role and how it will be implemented in a way that both achieves organizational goals and nourishes the NP. The failure to achieve organizational goals or to provide a work environment that promotes stability and successful NP practice can usually be traced back to failure in this matching stage. The best innovation will fail if implementation and adaptation of that innovation to one’s own organization is not adequately planned. Even with excellent planning, a period of trialability will allow the organization to further redefine and restructure the innovation to best succeed in the organization.

**Redefining/Restructuring**

Rogers details the evolution of thinking about innovation from the studies of individual adopters of innovation in which the innovation does not change with its adoption, to complex, variable, adaptable innovations that are remodeled and reinvented to fit the goals of an organization. (Rogers, 2003). Organizations such as hospitals are systems of organizations within organizations, and a one-size-fits-all approach is shortsighted and suggests a misunderstanding of the complexity of organizations. Considering these complexities is important as one envisions how the organization will respond to any change, especially the addition of a new group of personnel. The honest assessment of the organizational culture and expectations that went into the matching process provides some guidance for how the innovation—NP practice—should be designed within the organization, as well as where to begin and what kind of education and preparation needs to be completed prior to the implementation if it is to be successful. A careful examination of the project management process that goes into the implementation of a new computer system for the entire organization is a good way to envision the scope of the work necessary to implement NP practice within an organization. No one would consider implementing and electronic health record throughout a hospital by just installing it and letting people figure it out by trial and error. Yet, this is often the level of planning for implementation of human innovations such as NP practice.

Planning takes advantage of another characteristic of innovation, trialability. Selecting one or more venues to “try out” the planned practice can provide valuable information about how the practice will work in the organization and can explore the cultural and social changes that occur within the organization and identify some of the unintended consequences that always attend innovation. It may also become obvious that one definition or practice guideline that works well in one area does not work at all in another. These trials clarify the advantages and challenges that can be addressed in a timely and productive way.
Clarifying
Clarifying is that stage where the innovation is fine-tuned to the organization. During and after the trial and initial implementation, responses to and consequences of the change will become obvious. It is not humanly possible or financially feasible to try to predict every consequence of an innovation decision. In the Redefining and Restructuring stage, the decision team has tried to foresee any obstacles or barriers to success and address them in the initial project plan. Contingency plans are just good business, but given the complexity of the innovation and the organization, issues will arise that were not predicted. Plans made ahead of time may not be effective in achieving the goals originally set and thus require clarifying. Clarification is the time for working out those problems before full implementation and routinization.

Routinizing
The notion of sustainability of the innovation is a concept that only recently appears in Rogers’ writings (Rogers, 2003). Routinization is the full integration of the innovation into the culture and social fabric of the organization. In some organizations this never occurs, and the innovation is eventually rejected as unworkable or it changes to something less than the original plan because there were too many barriers to successful implementation. Still others adopt the change permanently. Even after the innovation becomes part of the fabric of the organization, it must be nurtured, guided, and generally attended to in order to grow and be productive in achieving the goals of the organization. Evaluation is ongoing to be sure that innovation continues to meet the goals of the organization even if the goals have changed.

Organizations are much like living organisms in that there is little in the way of a steady state. Organizations and the individuals within the organization must respond to the constant change in the environment from trends in technology, political and economic forces, and even globalization of life. Hospitals in particular are subject to many forces outside the organization that influence the survival of the organization and the professionals and patients who make up the human side of the organization’s purpose in being. The ongoing role of decision makers in organizations such as hospitals is to keep vigilant for new problems and trends that initiate the Diffusion of Innovation cycle. The cycle begins with agenda setting. The infinite potential for complexity, organization, and change guarantees that agendas will continue to be set that require innovation in thinking and acting. It has been said “Change is the only constant;” for the living organism that is a hospital, that is very true. That change is both evolutionary and revolutionary; over time, the organization transitions to something new. Transition is more than change. It is change
that creates a profound difference, sometimes only recognized in retrospect. Transition occurs in both the organization and in the individuals who make up the organization.

**TRANSITIONS**

Transitions may be deliberate or forced upon us by forces outside our control. Transition involves a new path, a new vision, a new story. For early adopters of an innovation, transition may be more reflective of Frost’s “road less travelled” as they often must use trial and error as they find their way. As pioneers, they map the wilderness of the change so that others can follow more assuredly and safely. Just as the Diffusion of Innovation Model helps with the safe passage of decision making and Integration of NPs into the organization, a model that reflects the predictable and unpredictable aspects of personal and organizational transitions will facilitate the success of those transitions. The Theory of Experiencing Transitions (TET) is such a model (Meleis, Sawyer, Im, Hilfinger Messias, & Schumacher, 2000).

**THE THEORY OF EXPERIENCING TRANSITIONS**

**Nature of Transitions**

The TET (Figure I.4) describes types, patterns, and properties of transitions. Types of transitions include developmental, situational, health/illness, and organizational ones. Developmental transitions are those somewhat predictable transitions that occur as one grows and develops, in the case of NPs, professionally, personally, and socially as they mature as individuals. Situational transitions are those predictable and unpredictable transitions as NPs become part of the organization and as they move from being new to the organization to organizational veteran. Organizational transitions occur at the individual, group, and organizational levels. Organizational transitions involve the movement of the organization from the identification of the agenda item to the full integration of the innovation, in this case the NP. This organizational transition is a mutual, symbiotic process that involves the adaptation, success, evaluation, and growth of both the NP and the organization, and one cannot successfully transition without the success of the other.

Meleis and colleagues (2000) also describe six patterns of transition. Transitions may occur as single, multiple, sequential, simultaneous, related, and unrelated events. Both the NP and the organization will experience multiple, sequential, simultaneous, related and unrelated patterns of transition. It would be rare to have only a single transition occurring at any time.
FIGURE I.4  Reconceptualization of the theory of experiencing transitions.
The properties of transitions distinguish transitions from simple changes. First, there must be an awareness of the transition. Transition results in a change in the essence of the person or organization. Transition often begins before there is awareness, so awareness is not necessary for the transition to begin. However, for successful resolution of the transition, awareness of the process and the difference is critical. Another property that helps to distinguish transition from change is engagement. Transition is an active rather than a passive process. Change occurs without the requirement for active participation by the person affected by the change, but transition in response to the change requires the engagement of the person or organization in the transition. The fifth property of transitions is that of critical points and events. Not all transitions have clearly identifiable critical points and events; however, many times they are obvious more in retrospect than real time.

**Transition Conditions: Facilitators and Inhibitors**

A host of personal, community, and societal transition conditions contribute to the success of the transition. Personal factors such as the meaning or purpose the individual attaches to not only the transition but also the situation itself have great impact. The individual’s cultural beliefs and attitudes—those personal ones gleaned from the life experiences of that individual in addition to those of the nursing education process and matched with the culture of the organization—may determine the success of the NP and that of the organization. The individual’s socioeconomic status and the knowledge and experience that individual brings to the organization heavily influence both the person’s decision to stay or go and the success of the integration within the organization.

A community is a group of people who have common goals and similar beliefs who come together for a common purpose. Communities and the larger society that we live and work in are defined by and define the members. NPs may draw strength from their perception of membership in a community of NPs—strength in numbers—or support from more experienced NPs within the community. The same NPs may feel gratified by the opportunity to give back to that same community. With each individual transition, the essence of the community evolves and develops as well. Support or disapproval from those communities and society are strong influences on both NPs and organizations as they work toward successful transitions that mark the successful integration of NP practice into the organization.

**Patterns of Response**

The TET describes both process and outcome indicators that reflect the success of the transition. Process indicators include a sense of feeling connected. Connections develop among individuals, community, and society.
That feeling of connectedness is the foundation for interacting and a sense of being in the right place at the right time—belonging. The sense of belonging is the pattern referred to as location and being situated. A natural reflection of these patterns is the pattern developing confidence and coping.

Feeling connected, interacting, location, and being situated represent a complex destination for the transitioning NP. Perhaps this destination is best understood in contrast to that first day of work, whether the person is a new NP or a seasoned NP in a new organization. The anxiety of not knowing where things are or who to call, and not knowing organizational politics can be overwhelming. Questions of “What have I done? Can I do this job?” plague the new NP. Then one day, that NP realizes, “I do know where things are, who to call, and I know that I am exactly where I am supposed to be and doing my job well.” Over some individually determined period of time, that NP has made this transition, one of many recognized only in retrospect. Upon looking back, the pattern of events that led to this confidence in one’s abilities and in one’s colleagues is clear, as are the coping mechanisms that have developed along the way.

Outcome indicators are mastery or competence and fluid integrative identity. As the NP examines an individual transition trajectory, there are identifiable tasks and challenges that have been mastered. The TET designates fluid integrative identity as that level of mastery where competency is “second nature,” that is, so much a part of who the NP is that there is no question of one’s ability. The ultimate outcome then is seamless integration of the role, changes in the story of who the individual is, and the sense of competence that defines successful transition.

**Nursing Therapeutics**

The fundamental assumption of the TET is that interventions to enhance facilitators and minimize the barriers to successful transition are possible. The model is not explicit about what those interventions are, but the model does offer suggestions about how those strategies can be identified and implemented. Although the model is not explicit about the strategies that facilitate the successful transition of NPs in practice, the purpose and content of many of the chapters in this book are precisely that. Recruitment, orientation, mentoring, coaching, development, governing, credentialing and much more make up the interventions that determine the success or failure of transition.

**NP TRANSITIONS**

Regardless of the number of years a NP has practiced, there are still developmental changes. Arguably, the NP never stops growing and developing. Whether this development is actually part of a transition or just individual
growth is less clear. There are clear transitions, however, described in the literature. The transition from novice to expert NP and the transition from new hire to full integration within the organization are two transitions that are common to all NPs who work within organizations. From the perspective of TET, the transition from novice to expert is a developmental transition and the transition to full integration in the organization is a situational transition. Along the path of any professional transition are personal developmental, situational, health/illness, and organizational transitions. A new NP may be engaged in the novice to expert transition as a clinician while progressing through the situational transition of a new organization. The situational transition may be a new role—for instance, NP in the same organizations where the NP was a staff nurse. Even seasoned NPs may experience the organizational transition of a new role as a lead NP or administrator or educator that changes the NP’s practice significantly enough that the NP no longer views himself or herself as only a care provider.

One of the most difficult situational transitions for new NPs is the transition from expert staff nurse to novice NP. To experience the professional validation of being the person everyone looks to for the answers to their questions and help with difficult situations as staff nurse; and then to have to prove oneself all over again can be overwhelming. In many ways, this is not so much a transition as a new beginning.

It is obvious from the types of transitions described above that any one NP may be experiencing multiple sequential, simultaneous related and unrelated transitions all at the same time. Feeling overwhelmed may be the catalyst to awareness of the transitions that the NP is experiencing. Awareness can be heightened and facilitated by a mentor or other interested person whom the NP respects. Once the NP is aware of the transitions, he or she can make choices about the priority of engagement in each. The mentor can help the NP explore true transition and differentiate it from change and can help to set goals that optimize the transition time. Professional development that includes an individualized orientation and preceptorship can facilitate the developmental transition and improve the efficiency of the situational transition within the organization. Setting intermediate goals can help the NP consciously benchmark critical points and events in the transition.

Personal, community, and societal factors facilitate or inhibit the successful transition for each individual NP. The individual NP attaches meaning to everything in his or her life, including the transitions in the role, transitions in personal life, and each event that transpires over the course of the NP’s life. These meanings are the attachment of purpose to the roles and events that make up the NP’s personal and professional trajectory. The NP who sees the role as an escape from the perceived oppression and lack of autonomy of the staff nurse role will view the transition, the organization, and the role differently than the NP who sees the role
as the next step in his or her professional nursing development. The NP’s cultural influences as well as the culture of the organization influence the success of the NP within the organization. The NP who attaches an emancipatory meaning to the NP role, but chooses to work in an organization where the culture is one that marginalizes NPs to very dependent roles, will be faced with a paradox that causes tremendous dissonance. If that dissonance is not resolved positively, the NP will likely leave or become disruptive.

Dissonance can be an especially significant factor for new NPs, who may feel after graduation that they are not adequately prepared and knowledgeable enough to assume the role for which they have been hired. This “imposter syndrome” can lead to the failure of the NP to successfully transition into a seasoned, integrated member of the organization if it is not addressed early. Again, the presence of a mentor can help new NPs adjust expectations and explore the meanings that they have brought to the transition in a way that facilitates the success of the NPs. Being part of a community of NPs within the organization or within a professional organization can mitigate some of the dissonance that naturally accompanies unmet expectations. And even more important, having a forum to discuss all of the changes through the transition period with peers who are experiencing a similar phase of transition is an additional support. The larger society has a less direct impact on the successful transition of the individual NP, but it is not insignificant. Society’s expectations of NPs, nurse/physician relationships and the role of health care in people’s lives all influence the success of the NP, but it may be more obvious in relation to NPs as a group than it is for any one NP.

Process indicators of a successful transition include a feeling of being connected and interacting with other NPs as well as other care providers. The NPs’ sense of developing confidence in the role and in the organization as well as the development of strategies for dealing with new situations are important indicators of the progress of the transition process. Ultimately, a sense of being in the right place to be successful (location and being situated) develops. These are internal benchmarks for the transitioning NP. The community, the mentor, and other members of the team of providers the NP works with are important in increasing the awareness of the NP that he or she is moving along the continuum from new to seasoned, novice to expert, and new employee to fully integrated member of the organization. The sense of being a part of the organization, and of the NP community and the provider team, and a sense of mastery of the requirements of the role are key outcomes of the successful transition. A sense of mastery and belonging do not imply that learning and growing in the role are done. The transition is one of accomplishment and is the completion of a portion of a lifelong journey.
The transition of the organization is inevitable with the adoption of an innovation (Rogers, 2003). Like the transitions of individual NPs, the organization may experience multiple simultaneous and unrelated transitions while integrating the innovation of NP practice. It is critical when the decision is made to adopt the innovation that the organizational decision makers are aware that the organization will transition into something new and that they prepare for the concept of a new and improved system of care. An institution that is prepared and welcoming to the concept of change will have more chance for success. The recognition must lead to engagement in the process, both for the successful transition of the organization and for the successful transition of the NPs who will practice there. The successful transition of each is dependent on the successful transition of the other. Part of the trial that occurs in the redefining/restructuring and clarifying stages in the DOI is the development of strategies and tactics that will promote the success of the innovation and the mutual transitions of the organization and the individual NPs.

The TET can provide some guidance as the organization develops these strategies and tactics. As part of the agenda setting and matching process of the DOI, the ideal process would include a careful examination and clarification of the meanings for the organization that NPs and their practice represent. It is easy to assume that everyone in the organization has the same agenda and beliefs about NP practice, but it would be naive to make this assumption. The culture of the organization and the attitudes of the stakeholders can facilitate or sabotage the success of any innovation, and the polarization that can develop around NP practice requires careful consideration and attention in order to make the successful transition. Socioeconomic factors often drive decisions within large organizations such as hospitals, and the adoption of NP practice as an economic decision without attention to the social and cultural aspects can doom the process before it starts. Many of the advantages can be enhanced and the barriers mitigated by adequate preparation and knowledge. First, the organization must know itself. The matching process described earlier emphasizes the organizational assessment and a candid evaluation of the culture and the attitudes of stakeholders, mainly physicians, nurses, and administrators related to NP practice. If that information is ignored or dismissed, then the successful transition to NP practice will be more difficult than necessary and may not be successful at all. However, careful examination of this assessment information can be incorporated into the strategic plan, and tactics such as education, orientation, trialability, and refining of the plan can address problems before they threaten the success of the overall innovation.

It is in the organization’s best interest to promote community within the organization, planning ahead for the developmental transition needs of the NPs as a group and as individuals. For the individual NP, the
community that is formed among NPs, as well as the larger team of care providers, facilitates the transition of the NP who is new to practice or to the organization. The conscious engagement with an existing community such as an Advanced Practice Nurse (APN) network, or the development of a community as a new entity such as a peer support group, can facilitate the developmental transition through mentorship and support. For the organization, conversations and the development of a community of organizations that are integrating NP practice provide the same support. The acceptance of NP practice by the larger society as a whole is important. The acknowledgment of goals and missions of patients as well the acknowledgment of as other disciplines, medicine in particular, is extremely influential in the realization of the full scope of practice for NPs and for the mutual success of the organizations that have decided to integrate NP practice. Community is important for the organization as well. Problem solving and sharing of information about successes and failures among organizations that have adopted NP practice improves the likelihood of success for all involved. In addressing societal issues around NP practice, the organization has an obligation to the customers of the organization—patients, families, communities—to educate and inform the public about the nature and quality of NP practice. The influence of these organizations on public policy and on reimbursement can promote the success of NP practice as well.

The measurement of the success of the organization’s transition depends a great deal on the clarity and measurability of the organizational goals set out at the beginning of the process. The goals of adopting NP practice as an innovative approach to maintaining the quality of care provided by the organization are the clear, measureable outcomes that are critical to both the clarifying stage and ultimately to the routinizing or sustainability of the innovation. The ultimate goal of the DOI of a sustainable innovation is consistent with the outcome indicators of the TET. Mastery of the innovation and the fluid integration of NP practice reflect a new organizational culture that now includes NP practice, not as a trial or as a temporary solution, but a fundamental, identifiable characteristic of the organization.

Figure 1.5 summarizes the relationships between Diffusion of Innovation and the Theory of Experiencing Transitions. This discussion is meant to be a road map reflecting multiple paths to the same end, namely successful integration of NP practice in organizations such as hospitals. The remainder of the chapters in this book will elaborate on these processes and explore in more detail the challenges and rewards of the integration of NP practice. Four very important themes have come up in this discussion, and will be explored in more detail.

- The decision to implement NP practice in an organization is a huge and expensive undertaking and must be planned in detail after much candid, frank discussion.
FIGURE I.5 Combined diffusion of innovation and theory of experiencing transitions in organizations.
NP practice, like any successful innovation, must be adapted, tested, and refined to the needs, goals, culture, and resources of each organization.

Each NP progresses at an individual pace through multiple transitions and benefits from and provides benefit to a community of NPs.

The success of NP practice and the success of the organization are interdependent and mutual. One cannot succeed without the other, and the measure of that success is the sustainable integration of NP practice into the culture of the organization.

REFERENCES


Forces Affecting Nurse Practitioners in Hospital-Based Practice

Kay Blum and Elizabeth Fuselier Ellis

We live in a complex world where shifting and often conflicting forces affect our lives. These forces weave their way into the tapestry of our personal and professional lives individually, collectively, and organizationally. We may welcome them, push back against them, or react passionately or powerlessly against the effects of these forces, but we cannot ignore them.

This chapter will discuss many of the significant forces influencing the practice of nurse practitioners (NPs) in a hospital setting. Many of these issues can be generalized to other settings, but for the purpose of this chapter, will remain focused on hospital-based practice. While some attempts to explain these relationships have reduced them to simplicities that trivialize their significance, they must be understood in dynamic relationship to be fully meaningful.

Adler, Kwon, and Heckscher (2008) describe a model of three forces that affect professional work. The three forces they describe are market forces, hierarchical (regulatory) forces, and community forces. These forces are not mutually exclusive and change in relation to each other, affecting professional work over time (Figure 1.1). This chapter will use Adler’s model to describe how these forces and their contributing issues affect NPs and hospitals. The interrelationship between these forces helps explain both difficulties and successes in implementation of the role in complex organizations.

MARKET FORCES

It is easy to think of market forces such as the economic and financial forces associated with reimbursement, health care services, or cost of care. There are also political, sociological, demographic, ethical, legal, geographical, and meteorological forces that can affect health care markets. These forces may have a direct, acute effect on health care markets as happened with Hurricane Katrina, or may have a more prolonged, chronic effect, as happens with the aging of the population.
Critical Forces

Market forces are basically defined by the tension between the demand for resources and the availability of resources to meet that demand. The availability of resources is defined by both the quantity and quality of those resources. In health care, the demand for those resources may arise from not only the real need defined by health care problems but also by sociological demands, ethical demands, and cultural demands of how health is defined. The availability of health care providers in terms of the individuals who are available to provide that care and their educational preparation as well as the equipment, pharmaceuticals, and facilities, independent of the quality of those resources, determine much of the care that is provided. In the past, the quantity of resources, number of facilities, number of providers, and the availability of technology services and pharmaceuticals were based on fee-for-service calculations and were the metric of choice in determining adequacy of resources. This has resulted in huge increases health care services costs and has led to discussions about changes in how we purchases and pay for health care in the United States. Those discussions have led to changes in the way the largest purchasers of health care services in the United States, Medicare and Medicaid, will pay for those services in the future. In the past Medicare and Medicaid have led the way for third-party payers, therefore everyone is paying close attention to the results of new strategies for identifying quality and value in health care and how that is reported.

Although there are an infinite number of forces that are acting together to affect current health care market services there are a few major influences that are affecting the market long term. These forces include the aging of the population, including health care provider
shortages, changes in the way we deliver and pay for health care; the Affordable Care Act the current methods of reimbursement for physicians, NPs, and other providers of care; and the global recession. These key forces will be discussed in greater detail.

Workforce

Aging Population

Much has been written about the aging of the population in the United States. The US Department of Health and Human Services Administration on Aging projects that by 2020, 25% of the population will be 60 years of age or older; 17% of the population will be 65 or older; and approximately 3% of the population will be 85 years of age or older (Figure 1.2). The aging of the population is significant for a number of reasons. With aging of the population come a greater number of patients with chronic disease, as well as increases in other age-related acute problems such as heart disease, cancer, and stroke. These patients at advanced age use more resources, both as outpatients and inpatients; require more pharmaceuticals; require more procedures; and have more hospitalizations than younger persons.

Aging Workforce

Not only is the population in general aging, but also so are the providers of care for these persons who are aging. It is reported that the average age of the practicing nurse is 43 years old (Fleming et al., 2003). The average age of practicing physicians has not been reported. However, Young, Choudhry, Rhyne, and Dugan (2011) report statistics on currently practicing physicians and noted that one-fourth of all physicians practicing
now are 60 years old or older and half of all physicians are 50 years old or older.

**Decreasing Numbers of Providers**

Aging of the workforce is one factor that has been reported for the decreased number of providers of primary care. Aging has also been suggested as a cause of the inadequate numbers of nurses available for bedside care. In addition to aging, poor working conditions, lack of time for family and nonwork pursuits, work stress, poor sense of fulfillment, and decreasing relative earnings have all contributed to decreasing numbers of persons entering the workforce.

For NPs, the issues are likely somewhat different from those for bedside nurses. Salaries increased 5.9% from 2004 to 2009 (American Academy of Nurse Practitioners, 2011). Since nurse practitioners need at least a master’s degree, the shortage of faculty to teach at the graduate level remains a limiting factor for NPs. The shortage of faculty is the result of two major factors, inadequate numbers of NPs with doctoral degrees who are eligible for graduate faculty appointments, and faculty salaries that are significantly lower than those for practicing NPs. For both physicians and NPs, the length of time for study limits the numbers of practitioners that can be produced to address the shortages.

**Changes in Education Programs**

*Doctor of Nursing Practice.* The American Association of Colleges of Nursing (AACN; 2004) has taken the position that the entry level for NPs should be the Doctor of Nursing Practice (DNP) by 2015. This position is not without controversy (Chase & Pruitt, 2006). Statistics published by the American Association of Colleges of Nursing (2011) indicate that there are currently 153 programs that had enrolled students in their DNP program with 160 programs in the planning stages. As of 2011, 37 states and the District of Columbia have programs and eight states have more than five programs currently enrolling students. There is great controversy and concern about the requirements for the Doctor of Nursing Practice as entry level into practice for NPs by the projected date of 2015. Concerns that have been voiced including the limited number of faculty to teach in these programs; the longer period of education that is necessary to graduate with a doctorate; the concerns that there will be fewer positions willing to pay salaries for nurses with doctoral degrees, and that the graduates will be overeducated for the positions that are available. There are also territorial concerns from our medical colleagues. The major concern that has been voiced by some physicians is that role confusion on the part of patients is occurring as the patient may not understand the difference between a
nurse who calls herself doctor and a physician who is a medical doctor. There are also unfounded concerns by NPs that they will be forced to return to school for a DNP in order to continue to practice. Concerns have been voiced by a number of nurses and nursing faculty as well about diluting the educational value of the doctoral degree in nursing by yet another degree, referencing the past in nursing where there were multiple research doctorates—the DNS, the DSN, the PhD, and the DNSc—which led to confusion. Another concern is that the degree will not be rigorous enough to be a legitimate entry into the doctoral world and will detract from the gains that nurses have made in the world of academic legitimacy. The conversation is ongoing, but the American Association of Colleges of Nursing, through their regulatory arm, the Commission for Collegiate Nursing Education, the CCNE, has developed clear criteria for the accreditation of Doctor of Nursing Practice programs.

Changes in Medical Education. There are currently a number of controversies in medical education as well. In 2009, Medicare invested $9.5 billion in graduate medical education. Medicare is the largest single payer for graduate medical education for physicians. The Medicare Payment Advisory Commission (MedPAC) recently conducted a review of graduate medical education and of the graduate medical education system to evaluate how well clinicians are being trained in the use of cutting-edge technology and the provision of quality health care to severely ill or injured patients. There was some concern that current methods of education were not maximizing the provision of skills for the use of evidence-based practice and quality measurement, cost awareness, and care coordination as well as the leadership of interdisciplinary teams to ensure shared decision making (Hackbarth & Boccuti, 2011).

At the request of MedPAC, the RAND Corporation surveyed 25/381 eligible internal medicine program directors to review their curriculum and their methods of preparing internal medicine physicians (Kane, Diemer, & Feldman, 2011). The survey identified problems with three Accreditation Council for Graduate Medical Education (ACGME) core competencies.

Those three core competencies are:

- Practice-based learning and improvement, to include evidence-based medicine, quality improvement methods, and using clinical decision aids.
- Systems-based practice, specifically across provider handoffs in the hospital and other settings, and communicating and coordinating discharge.
- Interpersonal and communication skills—communicating with other providers and communicating with patients; communicating with special populations; and communicating about End-of-Life issues.
Although these are not all of the issues that were raised in the RAND report, these are the specific issues that are of interest for hospital-based NPs. Methods used to teach nurses and physicians for centuries, primarily Socratic and didactic methods and apprenticeship methods that have served well when the amount of information that needed to be distributed was limited, are no longer the most advantageous in today’s explosion of information that needs to be disseminated, integrated, and used on a daily basis. This approach is no longer ideal when attempting to educate clinicians about the highly technical modalities of our current health care environment.

For nurses, physicians, and all other members of this team, poor interdisciplinary communication, poor communication between inpatient and outpatient providers, poor communication during handoff between providers at different times within the same institution, poor communication with patients and their caregivers decrease quality and safety for patients and even for providers. The safety and quality concerns decrease the value of the health care that is provided and increase the cost not only to patients, to insurers, and to other payers, but to each of us as taxpayers through government-sponsored programs such as Medicare and Medicaid. Consequently, there is a close relationship between regulators, the regulations and laws that they pass to try to control costs, safety, and workforce issues that have just been discussed.

The Global Economy

The private National Bureau of Economic Research announced that the United States, economic recession began in December 2008 and ended in June of 2009. It ended, not with a return to economic health, but with an end to the economic slide (New York Times, 2010). In examining the recovery from that low point in June of 2009, the Federal Reserve Bank in St. Louis (2011) published graphs of four leading economic indicators: industrial production, retail sales, employment, and real income.

Over 30 months following the reported end of the recession in June of 2009, there were gradual increases in both industrial production and retail sales. In spite of this improvement in sales and production, real income stayed completely flat for 10 months longer. It was 21 months before any improvement in employment began to emerge.

The recession, the subsequent unemployment, and lack of real income growth affected the health care market in a number of ways. Of real significance is the fact that much of private health insurance is offered through employers. When people are unemployed, their ability to afford health care is very limited and they often put off treatment for real and acute health care problems and certainly for preventive care. This leads to more expensive care for problems that have become more difficult and more expensive to treat, which could have been treated earlier for less
cost, or prevented altogether. It also means that more expensive emergency room care must be provided when less-expensive primary care may have been provided if the person had insurance or had the money to pay for the care then. It may also mean that people are unable to afford medications to treat chronic problems that now have become poorly controlled because medications were unavailable to maintain a steady state.

Increased unemployment, increases in poverty, and decreases in real income lead to poor nutrition and poor sanitation, resulting in decreased resistance to disease and a greater burden on the health care system. Unemployment and the inability to care for one’s family and provide for one’s children may also be associated with higher incidence of depression, alcoholism, drug abuse, trauma, domestic violence, and suicide. All are factors that increase the cost of care for everyone.

**Health Care Costs**

The Centers for Medicare and Medicaid Services (CMS) projected that 2009 National Health Expenditures (NHE) would grow by 5.7%, reaching $2.5 trillion even though the economy was still in recession (2012a). Martin Lassman, Washington, and Catlin (2012) report that U.S. health care spending did, in fact, reach $2.5 trillion in 2009, and $2.6 trillion or $8,402 per person in 2010. While this is still a mind-numbing figure, rates grew more slowly in these 2 years than in any other of the 51 for which records have been kept. Private health insurance spending for in-hospital care declined while Medicare and Medicaid spending on inpatient care increased 28% and 19%, respectively (Martin et al., 2012).

Private insurance pays for 46% of provider and clinical services with Medicare accounting for 22%. Out-of-pocket expenses increased about 10% in 2010. Last-minute action by a divided Congress prevented a 27% decrease in Medicare payment rates for physicians and therefore for NPs due to the Sustainable Growth Rate (SGR) provisions (Centers for Medicare and Medicaid Services, 2009). The SGR is designed to control health care costs, but it cuts indiscriminately, satisfying no one, provider or legislator. Attempts to change the law have been unsuccessful and legislative “Band-Aids” have been used to mitigate its effects.

**The Patient Protection and Affordable Care Act**

Throughout history and in all cultures, there have been segments of society that have been less able to care for themselves because of illness, disability, poverty, social status, or perhaps just bad luck. Those societies, through philanthropy or legislation, cared for this segment of the population through almshouses, debtors’ prisons, veterans’ benefits, or old age pensions. Many modern societies, most notably Canada and Europe, provide
a nationalized, one-payer health insurance for their citizens, guaranteeing a minimum level of care for all citizens.

Even in colonial times, the ruggedly individual American colonists provided for those less fortunate (Social Security Administration, 2011). This assistance often came at a price for the recipients in the form of wearing a letter “P,” much like the adulterer’s scarlet letter. The shameful-ness of poverty persists into the 20th and 21st centuries, with stories of “welfare queens” and “class wars.” The debate rages between conservative calls for the poor to “pull themselves up by their bootstraps” and liberals, cry of “we must protect the weakest of us all,” and the truth, as it often does, lying somewhere in between.

Social Security was approved by Congress in response to the worst depression in U.S. history (Social Security Administration, 2011). Reading the history of this act is enlightening, particularly in relation to the current discussion of health reform. Although Social Security made a significant difference in the lives of older Americans, it was not until 1965 and passage of legislation creating Medicare that real improvement in health care for older Americans became a reality (Centers for Medicare and Medicaid Services, 2005). Most people have likely forgotten the huge opposition by physician groups and insurers to the passage of Medicare at the time.

Over time, Medicare has expanded to include those with disabilities, and programs have been developed for those in poverty (Medicaid administered through states) and for children (Child Health Insurance Program, CHIP, also administered through state grants). Other major government-managed health care programs include the military health system for active-duty military, the Veterans Health Care System, and Tricare, for military families and retired military. After consideration of all these government-managed health care systems and private insurance, there remain a large number of citizens without any health insurance. They often work for wages that are inadequate to afford individual policies, which tend to be very expensive, and work for employers that do not provide health insurance. They may have preexisting conditions that are excluded or prevent them from finding insurance. Hospitals and taxpayers bear the burden of their health care.

The last of the modern industrialized societies to address universal health care for all of its citizens, the United States passed the Patient Protection and Affordable Care Act and President Obama signed it into law on March 23, 2010. The key provision that all citizens have health insurance was immediately protested and has been before the Supreme Court. The Supreme Court ruled that the individual mandate is constitutional and therefore can be enforced. The Court’s decision raised other questions, however, by suggesting that states were not required to expand Medicaid to cover larger numbers of low income individuals and families, even though the federal government would be covering the increased cost.
fully for three years and at 90% after that. As a result of this ruling, a number of state governors have announced that they will not be participating, leaving many of their citizens and the health care systems in those states without access to many of the provisions of the ACA.

Many of the provisions will not be law until 2014, but some key provisions allow children to continue on their parents insurance until age 26 and place increasing emphasis on value-based purchasing of services for Medicare and Medicaid (Kaiser Family Foundation, 2011). In spite of the results of the Supreme Court decision, the remainder of the Affordable Care Act will be implemented in 2019, adding millions to the health care system (Kaiser Family Foundation, 2011).

For hospital-based NPs, several key components of the Affordable Care Act offer opportunities for expansion of practice. The emphasis on value-based purchasing, team-based care, and preventive care offer fertile areas for NPs to bring together their nursing background and their medical acumen and critical thinking to the patient-centered care for which they are best prepared.

**Value-Based Purchasing**

The original rules under which Medicare pays for hospital care were derived from the traditional means of billing for care that were in place when it was approved in 1965. Under that program hospitals billed Medicare for whatever they would ordinarily charge and Medicare paid for a percentage of that charge. As those charges increased over time, the fees and the cost of Medicare increased phenomenally and Medicare changed to the current prospective payment system in 1983 based on diagnosis-related groups or DRG. Under this system, a hospital was paid a fixed amount, based on the diagnosis group that was submitted for payment.

This system was problematic in that hospitals that routinely treated the sickest of the sick received the same payment as a hospital that routinely treated only the easiest cases and transferred the sicker patients to tertiary referral hospitals. In response, Medicare developed a new DRG system that accounted for the sicker patients. However, when patients acquired hospital-related or iatrogenic complications, the DRG was enhanced and payment for the hospital-related or iatrogenic complications increased the cost of Medicare for poor quality care. In response to this problem of paying for poor quality care, Medicare rules have again begun to change, based on three principles.

The reforms suggest that:

- Medicare should pay for care that is reasonably more expensive because of complications to the patient.
- Medicare should pay more for care that is evidence based.
Medicare should pay less for care that is of low quality. This is the beginning of what has now become law and is labeled *pay for performance*. (Box 1.1, page 32, lists conditions Medicare associates with low quality, which it will no longer pay for when not present on admission.)

Furthermore, patients readmitted within 30 days of discharge have been targeted as an area for improvement in terms of quality for Medicare patients. The Affordable Care Act provided for $500 million for community-based transition programs (CCTP) to reduce 30-day readmissions for patients with chronic diseases—in particular, heart failure, acute myocardial infarction, and pneumonia. The community-based transition programs are administered out of the Center for Innovation at CMS and are awarded to collaborative centers who are able to take proven programs such as Naylor’s Transitional Care Model (Naylor et al., 2004) and apply them specifically to their own populations. The desired outcome of each of these programs is to reduce 30-day readmissions and therefore reduce costs for Medicare. These goals are consistent with the goals of other programs, to improve communication between providers both within the hospital and between providers within the hospital and within the community. It also increases the transparency of care, which is consistent with the Affordable Care Act’s goals. The goals of all of these programs come together synergistically for patient-centered care. The focus on patient-centered care models seeks to focus care away from providers and settings and onto whatever is necessary to meet the needs of patients and caregivers. Figure 1.3 contrasts traditional care, delivered in settings that operate independently of each other with limited communication, with the patient-centered approach. NPs are seen as agents of greater communication and continuity, both within the inpatient units and between hospital settings, leading to better patient outcomes and fewer complications. NPs bring not only their advanced education and practice skills, but their practice wisdom and experience as RNs at the bedside which, although it is a different experience, informs and enriches the NP practice.

**BOX 1.1 Eight Conditions Medicare Will Not Pay for if Not Present on Admission**

1. Object left in patient during surgery;
2. Air embolism;
3. Blood incompatibility;
4. Catheter-associated urinary tract infection;
5. Pressure ulcer;
6. Vascular catheter-associated infection;
7. Mediastinitis after coronary artery bypass grafting;
8. Fall from the bed.
A nurse or physician transported from 1980 to 2012 would be unable to function in today’s technological and informational environment. Most of the medications and therapeutic and diagnostic procedures are more
scientically and technologically advanced, and yet our care delivery models remain essentially the same as they were in the 1960s and 1970s. The exceptions are additional care providers such as respiratory therapists, NPs, and physician assistants, rather than new models of care. There are a few other exceptions.

Hospitalists and Intensivists

Prior to the mid-1990s the same physician delivered inpatient and outpatient medical care to patients known to that physician, unless the hospitalization was the first contact with the health care system. The emergence of physicians whose sole practice was acute inpatient medicine and, in the case of intensivists was critical care medicine, met several needs. Hospitalists were often the agents of managed care plans in decreasing length of stay and minimizing cost of care, which also benefitted hospitals by increasing patient flow and improving bed availability (Schneller & Epstein, 2006). Many were not only agents of managed care companies, but also were their employees. Hospitalists benefited patients by being more readily available, usually onsite 24/7, and were more versed in evidence-based therapies, more current on clinical literature, and more experienced and practiced in procedures and emergency response, compared to generalists.

Acute care nurse practitioners (ACNP) have been certified by the American Nurses Credentialing Center (ANCC) since 1995 (Rosenthal & Guerrasio, 2009). ACNP competencies were written by the National Panel for Acute Care Nurse Practitioner Competencies in 2004 and the American Association of Critical-Care Nurses in 2006 to specifically address the scope of practice for NPs caring for adults with acute and complex chronic illness (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). There is an effective and safe collaboration between NPs and physicians working as hospitalists and intensivists in patient-centered care (Cowan et al., 2006) even when the contributions of the NP are limited by design (Ettner et al., 2006).

Transitional Care

Transitional care is a loose, umbrella term that has evolved out of a very specific model called the Transitional Care Model (Naylor et al., 2004), developed and tested to facilitate the discharge of patients with heart failure from the hospital to home and to reduce readmission to the hospital. This model uses a combination of patient education, discharge planning, home visits, and follow-up employing NPs to engage patients and their caregivers in self-care and self-management of their heart failure. Transitional care has emerged in response to the realization that in-hospital care can no longer be delivered without reference to the care that came before and that which comes after. There must be continuity among providers and the continuation of a plan of care between settings for any lasting benefit; this is particularly true for chronic diseases characterized by cycles
of compensation and decompensation. Transitional care, and the philosophy of collaboration, communication, and patient centeredness that forms its core, is on the crest of a wave of new initiatives that bring together the CMS Center for Innovation; the Institute for Healthcare Improvement; the Agency for Healthcare Research and Quality (AHRQ); as well as the RAND report on internal medicine education; the Institute of Medicine Report on the Future of Nursing; and the (Advanced Practice Registered Nurse) APRN Consensus Model.

Chronic Disease Care

Recent studies have challenged whether hospital nurses know what to teach heart failure patients (Albert et al., 2002; Dickson & Riegel, 2009) and whether teaching patients about their care without teaching them how to self-manage has any effect on outcomes (Lee, Moser, Lennie, & Riegel, 2009). These studies in transitional care and in heart failure self-care management reflect two critical trends that have significant importance for hospital-based NPs and for the health care marketplace in which they work, far beyond what they report about heart failure:

- The escalating prevalence of all chronic disease
- The increasing expectation that there are informal caregivers available to provide care in the home for the person with one or more chronic diseases.

The prevalence of chronic disease increases dramatically with increasing age. The elderly are also more likely to have multiple chronic co-morbidities, and chronic disease disproportionately affects the poor and disadvantaged (Bodenheimer, Chen, & Bennett, 2009; Boult, Green, Bult, Pacala, Snyderm, & Leff, 2009). Even the lay literature and newspapers are replete with stories of the epidemics of obesity and diabetes, in addition to increasing numbers of persons with heart failure, Alzheimer’s disease, and chronic mental illness. Often forgotten in the discussion are children living with congenital and genetic disabilities and acquired problems of asthma and diabetes. Many congenital abnormalities that formerly led to early demise in infancy or childhood today are treated with sufficient success for those same persons to see adulthood, requiring close follow-up and specialized health care. Rarely spoken of are the new veterans of the wars in Iraq and Afghanistan with the physical and mental wounds of amputation, traumatic brain injury, and chronic posttraumatic stress disorder. The definition of chronic health problems for these veterans must be expanded to include homelessness, depression, suicidal ideation, domestic violence, and chronic mental illness. Because of their youth, and because the complexity and impact of their injuries is still not completely understood, the contribution of their injuries will continue to be a significant factor in the burden of chronic disease.
Caregiver Burden

The truth of chronic disease is that it cannot be cured and must be managed. The fact that symptoms and limitations of chronic disease can be managed is the upside. The potential downside is that the individual with the chronic disease can seldom manage alone, especially as the disease progresses. Throughout time, extended families have taken on the responsibilities of family members who, through age or disability, required help or supervision to guarantee their safety or well-being. Today, the extended family is rare and the nuclear family, often a blended or single-parent family, is more common. When elders are a part of a family, the caregiver is often a woman, daughter, and daughter-in-law, who has children of her own, sandwiched between generations, who may also have a job outside her home and is stretched to meet more responsibilities than she has hours in a day (Blum & Sherman, 2010).

The greater burden that is placed on patients and their informal caregivers to manage symptoms and manage their disease process outside the hospital has also increased the burden on providers, especially NPs, to partner with patients. Hospital performance measures publicly reported by CMS in Hospital Compare (www.hospitalcompare.hhs.gov/), the Joint Commission Core Measures, and the Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS) survey of patient experiences are all impacted directly or indirectly by how well patients and their caregivers are prepared to manage their care at home post-discharge, and how well they understand their instructions and responsibilities, and make arrangements for follow-up. Meeting these requirements, is impossible without clear communication provided at a literacy level understood by the patient and caregiver; the hospital-based caregiver’s responsibility for continuity does not end at the hospital door. The promotion of Accountable Care Organizations (ACOs) and medical homes in the Patient Protection and Affordable Care Act, and funding for the CCTP and the Primary Care at Home program at CMS, are examples of the government’s commitment to funding new care-delivery models that recognize the changes in the marketplace for health care. Patient-centeredness, continuity, comprehensiveness, value, and prevention are the watchwords of the marketplace going forward.

**HIERARCHICAL (REGULATORY) FORCES**

There are a number of hierarchical or regulatory forces that affect individual and collective NP practice. The most direct are regulation of licensure, certification, and privileges controlled by Boards of Nursing, accrediting organizations, and the hospitals that hire NPs. The details of acquiring licensure, certification, and prescriptive privileges are described in other
chapters, but the issues underlying the significance of these important procedures will be discussed here. In addition to the regulation of NPs, there are specific regulations of, most notably, the physicians-in-training that have had a profound influence on the practice of NPs in hospitals.

Licensure, Accreditation, Certification, and Education

The first NPs who completed certificate programs in the mid-1960s were not regulated or licensed outside of their RN license. As they became more prominent and became recognized as an answer to the shortage of primary care physicians, especially in rural and underserved areas in the 1980s, state Boards of Nursing began to have serious discussions about regulation of advanced practice nurses within their mission of protecting the safety of the public. Professional organizations, certifying bodies, and practicing NPs who found it difficult to move from state to state shared many of the same concerns, if not for the same reasons, as the state Boards of Nursing about the inconsistencies in education, scope of practice, and licensure for advanced practices, nurses (Ballard, 2006; Hartigan, 2011; Kleinpell, Hudspeth, Scardo, & Magdic, 2012; McCabe & Burman, 2006; Philips, 2012; Stanley, Werner, & Apple, 2009).

From the fall of 2004 through July of 2008 the APRN Consensus Work Group labored to produce the consensus document for licensure, accreditation, certification, and education, or LACE for short. This APRN regulatory model standardizes scope of practice, educational requirements, certification examinations, and licensure, based on APRN roles and populations. It localizes the expertise of the NP in the needs of the patient, not in the location of the patient. Figure 1.4 is the Consensus APRN Regulatory Model. McCabe and Burman (2006) movingly describe their dilemma when patients in their clinic have a problem outside the usual description of their practice such as depression in primary care, or hypertension in a community psychiatric practice that begs for treatment but is outside the strict purview of the NP seeing that patient. The Consensus Model rejects arbitrary designations for practice based on location or subspecialty. The Consensus Regulatory Model attempts to meet the National Council of State Boards of Nursing’s duty to protect the public and to protect the nursing profession’s need to organize care delivery in a way that is patient centered and rejects arbitrary divisions and classifications that interfere with access to care rather than facilitating it.

There is evidence that restrictive prescribing practices and requirements for physician supervision of practice or proscriptive protocols limit not only the numbers of practicing NPs in a state (and therefore access to needed health care), but also restrict enrollment in educational programs that graduate NPs (Kalist & Spurr, 2004). Extremes of difference exist in scope of practice from state to state, making mobility difficult. Advanced practice nurses that practice near the border of two or more state and see
patients from multiple states may need to have licenses in each state. Each of those licenses may have different scopes of practice, licensing requirements, and collaboration/supervision requirements, with physicians.

**Scope of Practice**

In 2010, the Robert Wood Johnson Foundation in conjunction with the Institute of Medicine released their report on the future of nursing (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2010) recommending that nurses, and—of significance for this discussion—NPs be allowed to practice at the full extent of their education and training. The full extent of their education and training is defined by law in each state as scope of practice. The scope of practice defines who can be seen by the NP, in what setting and under what circumstances as well as what guidance and/or supervision must be in place and by whom. Scope of practice also determines the limits and privileges of licensure, the ability to bill for services, and the limits of liability. The limits of liability determine the need for and the required limits of malpractice insurance. Currently, scope of practice for NPs, unlike physicians, is different from state to state (Klein, 2005). Furthermore, scope of practice for hospital-based NPs has some special requirements (Kleinpell et al., 2012).

**Credentialing and Privileging**

When a hospital hires an NP, there is an obligation—a duty—to perform due diligence in relation to the veracity of the NP’s credentials and
competency. The staff bylaws will describe a procedure for this process and it is reviewable by the Joint Commission. NPs usually are subject to the same process as physicians unless there are sufficient numbers or there is an organization of NPs with its own process and bylaws that are subject to the same rigor and review as Joint Commission standards. The hospital process may be more rigorous than the individual state’s Scope of Practice requirements, but may not be less so (Kleinpell et al., 2012). If the NP is to perform procedures, there must be a process in place to document competence, with reviewable records. This process may or may not be reviewable by the Board of Nursing, depending on the state requirements.

ACGME Hour Limitations for Residents

The first restrictions of medical resident work hours in 2003 and the revision with updated restrictions in 2010 were clearly a catalyst for the increased utilization of NPs in hospital-based practice (Pastores et al., 2011). This rapid introduction of NPs was often accomplished with little planning or thought as to how their practice would be integrated into the units or how they would be evaluated and by whom. Because they were nurses, they were often included with staff RNs reporting to nurse managers who did not understand the NP role. The NPs often worked in settings where their education and abilities were not appreciated and, since they were replacing interns and residents, they were seen as such and were given low-level responsibilities and seen as peers of student physicians rather than as licensed, autonomous practitioners with experience and critical thinking skills. These two factors have contributed to job dissatisfaction and high turnover in some settings. In other settings, NPs had already made an inroad in hospital practice and there was experience with their abilities and scope of practice that could guide the expansion of the numbers that grew in response to the ACGME requirements.

HANDOFF AND INTERPROFESSIONAL COMMUNICATION

One very clear and significant issue persists however, independent of the amount of planning that went into the integration of NPs into hospital-based practice. That issue is handoff from one provider to another. When residents were in the unit for 36 to 40 hours at a time, there was rarely a need to hand off the care of their patients to someone else. Their responsibility to know everything about that patient was clear and there was little uncertainty about what was expected of people. Now, hour restrictions, limited involvement in planning discussions, the need to trust others to provide care for their patients, and the uncertainty of increased
frequency of handoffs can lead to frustration and even hostility if steps are not taken to reduce the uncertainty. The uncertainty can be reduced by being clear about responsibilities and expectations; having a clear, standardized, systematic handoff routine; and providing regular opportunities to evaluate issues with communication.

COMMUNITY FORCES

The NP in hospital-based practice holds membership in multiple communities, some more loosely organized than others. Hospitals and other large organizations are communities of communities. Communities are more than groups and are organized around common goals, passions, and purposes. In nursing academia, there has been acknowledgment of communities of scholars who have come together to advance research and theoretical knowledge. Parse and Rogerian scholars have forged recognizable community identities that foster knowledge development and mentor new scholars into their society. These are the goals and purposes of communities.

Communities of practice (Adler et al., 2008; Li et al., 2009; Kislov, Harvey, & Walshe, 2011) have been described in business organizations and management research for over 30 years as a way of studying and describing the communication of knowledge. More recently, communities of practice (CoP) have been proposed as a way of examining the dissemination of information (Li, Grimshaw, Nielson, Judd, Coyte, & Graham 2009) and collaboration (Adler et al., 2008; Kislov et al., 2011) in health care.

Communities of practice may arise spontaneously and informally and communicate the culture and social norms of the organization to new members and novice NPs. This informal information transfer and socialization has the potential for good or bad outcomes depending on the culture of the organization.

The good news is that communities of practice do not have to be left to chance. They are effective and useful management tools. Citing Saint-Onge and Wallace, Li and colleagues (2009) note three major components of a community of practice. Those components are people (the members), practice (what they do), and capabilities (their shared advantages). Furthermore, they describe three different levels of CoP. There are informal groups, which develop somewhat spontaneously around shared interests and self-identified learning; supported groups, which have formal acknowledgment and support from management to build learning; and structured groups, which are developed and managed by the organization and aim to advance the organization’s business. This last CoP best is exemplified by administrative councils of directors and lead NPs, described in other chapters of this book, which provide self-governance structure for NPs within the organization.
Dissemination of Knowledge

Health care is a knowledge industry. It is more than and different from the sum of all that knowledge. It is the infinite combination of multidisciplinary knowledge and practice wisdom of countless years of provider experiences, passed down from provider to provider in formal and informal teaching sessions. Health care knowledge is as significant for what we do not know as for what we do know. In a world of clinical practice where disciplines—medicine, nursing, respiratory therapy, nutrition—worked in independent silos with only physician orders to communicate between them, knowledge acquisition, dissemination, and utilization was discipline specific and limited to the silo. Even in multidisciplinary teams, much of the silo mentality is maintained. However, in a true interdisciplinary philosophy of teamwork, those silos are broken down and knowledge acquisition, dissemination, and utilization is shared by all members of the team without regard to discipline. There is mutual respect and acknowledgment of each team member’s contribution to the work of the team because the patient is the focus, not the rank of the team member.

Professional Socialization

It is in this way that new professionals are socialized. The communities in which they seek and gain membership professionally, whether they are professional associations aligned with the clinical specialization they have chosen for their work or general professional associations chosen for advocacy for professional issues, socialize the new professional by disseminating social norms. These social norms include the issues that the community prioritizes, the behaviors it values, and the people whom it esteems from the membership. Whether or not NPs participate in professional organizations, or even belong to them; participate in or originate research; write for publication; precept or mentor new NPs; or participate in advocacy efforts for the profession is determined by the professional socialization they receive by the community to which they belong. Their professional behavior is most influenced by the first community to which they belong.

The same is true within the hospital organization. When a new NP joins the group, the social norms of the NP group are communicated to the new NP in much the same way. Because the group is much smaller than a professional organization, the new NP’s decision to conform or not to the professional social norms of the group will be obvious quickly and will often determine the new NP’s success at the hospital. A healthy organization will promote healthy social norms and will provide multiple opportunities for professional socialization for new NPs, whether they are new graduates who not only need socialization to the organization’s social order, but to the role or are seasoned NPs who are well socialized to the
role, but not to the organization. The introduction to research groups, writing groups, and education or advocacy groups within the organization can foster successful behaviors in the new member and lead to a professional life that is varied and engaged.

If you are the first NP in an organization, or one of the first, you have the opportunity to determine how this professional socialization process will occur. If you are creating a formal NP organization within your hospital, there are a number of specific things you can do with orientation and mentoring to facilitate this process. These strategies are discussed in detail in other chapters.

**Cultural Norms**

Cultural norms are related to professional socialization, but are often more insidious. A culture within an organization is more like the personality of the organization, and it can be characterized as a macro-culture made up of many micro-cultures. Organizational cultures range on a continuum from open to closed. Open cultures are welcoming and receptive to new people and ideas. Closed cultures cling to old ways and change very slowly or imperceptibly. In reality, these extremes rarely exist, and true cultures fall along the continuum between the extremes.

Cultures that exist on the more closed end of the continuum tend to make it very difficult for new people to establish their worthiness to belong. When the culture of an organization fosters or permits relational aggression, bullying, or discounting (Dellasega, 2011; Duffy, 2009; Martin & Hutchinson, 1999), the outcome of the socialization is marginalization of new NPs, whether novice NPs or experienced NPs new to the organization. The result is expensive turnover for the organization and compromised access to care for patients. Even worse is the shattered trust of the NPs who are emotionally and professionally battered by the experience. When the undermining or bullying behavior comes from a manager or supervisor, it can be even more emotionally destructive, and even economically devastating (Resvani, 2012).

On the other hand, a culture that is open and welcoming offers a safe haven for new graduates and seasoned NPs alike to grow and develop. A healthy environment for providers contributes to better care for patients by allowing the full attention of the provider to be on the patient and not on the NP’s own survival and safety. Furthermore, that safe and nurturing environment promotes creativity and innovation, which benefits the organization as well.

**Clinical Knowledge**

Clearly, no one comes out of an educational program knowing all he needs to know to be an expert practitioner in any area of practice. Learning is a
lifelong endeavor. Clinical knowledge and the evidence-base for practice are growing exponentially. Without question, the pooled knowledge of a team of providers is more powerful and helpful in the care of patients than the knowledge of a single provider or discipline alone.

**Interdisciplinary Collaborative Communities of Practice**

It is important from a legal standpoint for NPs to establish that they are licensed independent practitioners who function autonomously to provide care for patients. This legal designation is critical for so many reasons, but specific to this discussion, it buys a seat at the table where decisions are made about the provision of health care. In the delivery of that health care, that independent practitioner designation allows NPs peer status for collaboration. Providers at any level can cooperate to provide care for patients and certainly, cooperation is a necessary though not sufficient condition for collaboration. For true collaboration, there must be a level of mutual respect and acknowledgment of the fundamental value of the contribution of each of the individuals involved in the collaboration. There can be no hierarchy of value, no sliding scale of merit to the contributions of the collaborators. Interdisciplinary collaboration is discussed fully in another chapter.

**Social Media as Community**

For professionals, there are opportunities to connect and stay connected with Facebook and LinkedIn as well as with many professional organizations that have developed communities within that organization’s website for special interests. These specialized connections promote closer ties and unite people with common interests and goals who, in the past, would have had difficulty finding each other. These opportunities will only expand as technology and demand increase. These sites are so ubiquitous that even the Centers for Medicare and Medicaid Services (CMS) and the AHRQ, as well as many other agencies important to health care, have links to them.

For anyone searching for employment today and even more so in the future, a strategically placed resume or curriculum vitae on LinkedIn will bring you to the attention of potential recruiters and employers. Social media can be a double-edged sword, however, if youthful indiscretions or careless postings have left pictures or comments that are uncomplimentary to your character for potential employers to find. These are forces that newer NPs may face, which more seasoned NPs never had to be concerned with.

The opportunities to use these sites as well as Twitter to form virtual support groups, coaching opportunities, patient education delivery models, gaming for patient education, and endless other applications are unlimited.
Many organizations committed to patient and community education and outreach already have a presence on these sites and are taking advantage of the market penetration.

**Developing Technology to Expand our Definition of Community**

One of the biggest threats to patient safety and preventable readmissions is poor patient adherence to medication regimens. Patients rarely set out to miss medications, however, they often just forget. Almost everyone these days has a mobile phone. Apps are available to help patients remember to take their medications, and to know what their medicines are and what they look like. They can get reminders about diet, exercise, and symptom management. We have only just begun to tap into the use of mobile phones, interactive television, and telemedicine to increase the opportunities to benefit patients and their caregivers. Consider the future in which some ambulatory patient appointments or post-discharge follow-ups might be completed using Skype.

![Critical Forces Diagram](image_url)

**FIGURE 1.5** Dynamic model of market, hierarchical, and community forces on NPs, with major influences.
SUMMARY
This chapter has introduced a few of the forces that are in dynamic interaction and that affect the practice of NPs. Market, hierarchical, and community forces are not mutually exclusive, as we have seen, and in particular, market and hierarchical forces related to licensure and workforce are closely bound to each other. Other chapters will develop these ideas more completely so that there are specific strategies for making NPs’ practice and the organizations in which they practice mutually successful. Figure 1.5 brings together all these forces within Adler’s model to form the context for later discussions.

REFERENCES


