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CHAPTER 2

Advanced Practice Nursing and Governance

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Learning Objectives

At the completion of this chapter, you will be able to:

1. Explain the significance of organizational structure to the role and power base of the APRN.
2. Analyze fiscal pressures placed on clinicians in relation to the concept of productivity.
3. Envision a professional practice environment in which an APRN is optimally deployed and valued as an integral and essential member of the healthcare team.
4. Explore key organizational relationships that are essential when planning significant change.
5. Examine opportunities for meaningful partnerships with chief nursing officers of healthcare organizations.

In this case, environmental and fiscal pressures converge to threaten the job security of more than 200 Advanced Practice Registered Nurses (APRNs) within a large, multispecialty

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physician group practice at a rural academic medical center. A particular group of APRNs explores new organizational relationships and resources in an attempt to respond proactively to the crisis. The APRNs must confront personal biases and deep-seated organizational culture biases to make the changes in their model of care delivery that will ensure this ongoing role in patient care. Establishing a linkage with a pivotal nursing leader proves to be the key to the group's success.

BOX 2-1: *Core Dimensions of Professional Governance Models*

Professional control over practice

Organizational influence of professionals over resources that support practice

Organizational recognition of professional control and influence

Facilitating structures for participation in decision making

Liaison between professional and administrative groups for access to information

Alignment of organizational and professional goals and negotiation of conflict

Source: Data from Hess, R. G. (1998). Measuring nursing governance. *Nursing Research, 47*(1), 35–42.

Part I: Background

Valley Medical Center (VMC) is a rural academic institution with a 500-bed inpatient hospital (full service) and a large, multispecialty physician group practice with more than 400 physicians. The nursing division of the hospital is well known for its early adoption in the late 1970s of clinical nurse specialist practice as well as its innovation with professional governance models for staff nurses.

As the role and specialty practice of the APRN began to expand in the 1990s, the number of advanced practice nurses (APNs) grew rapidly at VMC. Today there are more than 200 APNs employed by the medical group practice, including Certified

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Registered Nurse Anesthetists (CRNAs), Neonatal Nurse Practitioners (NNPs), Certified Nurse–Midwives (CNMs), clinical care APRNs, and a multitude of primary and tertiary care APRNs.

Because the APN role at VMC emerged within the physician group practice (the organization that provided the APNs with credentialing and privileging benefits and supervision), very little interface with the hospital-based division of nursing was established. A relationship with the chief nursing officer (CNO) of the medical center is lacking. (Also note that a centralized nursing organization for the multitude of practices and clinics in the medical group practice is also absent.)

For years, this separatist model of nursing practice administration operated quite well. For those rare times when a unified nursing organization across VMC was called for (such as during an accreditation visit by the Joint Commission and, later, when the organization was applying for Magnet designation by the American Nurses Credentialing Center), "box and line" organization charts were created that demonstrated "dotted line" relationships between the advanced practice nurses in the group practices and the CNO of the medical center. The arms-length relationship was effective from an operating standpoint and so was expanded, codified, and enculturated for years.

DISCUSSION QUESTIONS

1. Using a box and line chart, diagram the reporting relationships for the APRNs in your operating unit.
2. Where is professional practice for an advanced practice nurse in your organization discussed? How are policies for APRN practice developed and updated?
3. Does an individual with intimate knowledge of APRN practice and regulation within the state oversee the privileging of APRNs in your organization?

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Part II: Economic Realities of the 2000s Set In

As the number of APNs in the VMC organization grew, so did the diversity of roles. With the implementation of the 2002 Graduate Medical Education 80-hour work week rule for resident physicians, numerous APNs were recruited by the specialty physicians group to provide essential coverage for the inpatient services, critical care areas, and emergency department. Each specialty physician group sought to credential and privilege the APNs, known as "resident extenders," in the group's own specific specialty skills and procedures.

In the outpatient clinics, APNs further extended physician practice in specialty areas by carrying full outpatient client responsibilities. Such activities provided time and coverage for physicians to engage in research and education of medical residents. The physician service chief functioned as the leader for all physicians, residents, and APNs within a specialty area. Few, if any, relationships among APNs across the organization existed.

As the mid-2000s arrived, significant reductions in funding for physician services began to erode the bottom line of the nation's physician organizations. Academic medical centers

BOX 2-2: *Productivity = Value / Time*

There are two ways to increase productivity:

1. Increase the value created.
2. Decrease the time required to create that value.

For a concise discussion of productivity, see Steve Pavlina's blog post at www.stevepavlina.com/blog/2005/10/what-is-productivity/.

Clinical productivity is commonly measured in the outpatient setting using relative value units (RVUs). RVUs are standardized, weighted measures that comprise estimates of clinician work (time and intensity of service), practice expense, and malpractice expense. A helpful primer on RVUs as a measure of productivity is from the National Health Policy Forum at www.nhpf.org/library/the-basics/basics_rvus_02-12-09.pdf.

Consider also: Kleinpell, R. M. (2013). *Outcomes assessment in advanced practice nursing* (3rd ed.). New York, NY: Springer.

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(AMCs), often serving as a region's healthcare safety net for the underserved and uninsured, were particularly hard hit financially.

VMC's board of trustees appropriately began to exert pressure on the management staff to enhance physician productivity in all areas of practice. Because VMC was rurally sited, essentially no new markets were waiting to be developed to provide new patients for VMC. With no new additional sources of patient revenue available to enhance productivity, a reduction in clinician staff would become inevitable.

As the physician service chiefs came to terms with the magnitude of practice change required to achieve new relative value unit (RVU) and visit volume targets, it was increasingly clear that all clinician roles would be closely examined, realigned, and, if necessary, eliminated. Many of the VMC APNs grew concerned about how they would fare in this dynamic environment; several, particularly those practicing as a solo APN in a medical specialty group, felt especially vulnerable.

DISCUSSION QUESTIONS

1. Why did the pressure to increase physician productivity cause the APNs to grow concerned?
2. Other than RVUs, what other measures might be useful to demonstrate contributions of the APN to patient care?
3. What proactive communication or meeting might the APNs have considered as the service chiefs embarked on making changes in the various areas?

Part III: A Path Forward

The Cancer Center at VMC employed one of the largest cohorts of APNs in the physician group practices. When the service chiefs began to plan meetings with their clinician groups to discuss impending changes in the work of the members, Elaine, the longest-tenured, informal leader of the APN group,

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called an after-hours meeting of the APNs. The purpose of this meeting, she said, was to share information and brainstorm potential responses to the job security threat the APNs were experiencing.

As the meeting progressed, it became clear that, even within the operating unit of the Cancer Center, wide variation existed in the roles of the APNs. Some saw patients with their physician colleagues; others had more independent practices and had individual appointments with patients. In some practices (subspecialty disease groupings such as breast cancer specialists, gastrointestinal cancer specialists, etc.), APNs billed for visits; in others, no bill was issued. Some APNs covered the inpatient services, and others were on call. Some covered telephone triage, and others, the chemotherapy infusion center. In one area, radiation oncology, the APNs' role was to intervene with patients requiring symptom management.

An interesting commonality among the APNs was their weekly "academic day" when they could develop their own scholarship or research program. This opportunity was modeled on their physician counterparts' method of career advancement, which, unlike the APNs', was linked to research productivity. On this day, the APNs participated in many non-patient-care activities that provided personal and professional satisfaction. Many were leaders in professional societies and research cooperative groups, while others regularly contributed scholarly work to specialty journals. The APNs were especially concerned about losing their "academic day" in the new environment.

Elaine, an APN in the oncology service, began to see that the group needed help thinking through options that could be presented to the service chiefs–options that could continue to meet the goals of providing high-quality cancer care while enhancing clinical productivity (revenue). She suggested reaching out to VMC's new chief nursing officer, Anne Butler. Anne, though virtually unknown to the APN group, was a strong nursing advocate and proponent of professional governance models for staff nurses. Elaine was hopeful that Anne might have some guidance for the oncology APN group.

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DISCUSSION QUESTIONS

1. Of the various practice models in which the oncology APNs were engaged, which increased their vulnerability during efforts to enhance productivity? Why?
2. How is the APNs' academic day both an opportunity and a threat in the new environment?
3. Are there models that quantify productivity in research settings? Education settings? How might the APNs characterize the value of their collective academic and professional activity outputs in a way that would be meaningful and beneficial to VMC? The Cancer Center?

Part IV: Linking with the Nursing Division: One Step Forward, Two Steps Back?

The day following the APN meeting, as Elaine was packing up after a long day in the lung cancer clinic, three of her APN colleagues appeared in her doorway and asked to talk more about Elaine's plan to contact the CNO for help with their situation.

"Do you really think it's a good idea to try and get support from the nursing division?" asked one of the APNs. A second said, "We've worked so hard to become meaningful participants in the physician group practice that to go back and align with nursing seems like a step backward." The third indicated, "I doubt the CNO knows anything about advanced practice nursing!"

The first speaker went on, "Don't you think it might make more sense to try and establish our own APN model within the physician practice and have a leader who has the same status as the service chiefs with a seat at their decision-making table? We just aren't nurses like those in the nursing division anymore. We're different."

Elaine understood the sentiments her colleagues expressed. But she also was very concerned about the level of tension and pressure in the physician group at the moment. Even though the physicians were their close, working colleagues, she knew that many physician-only meetings were occurring and no one seemed to be appreciating the APNs as co-equal peers in these

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meetings. In fact, the APNs were not even invited to contribute ideas about the productivity goals and how to restructure the practices to achieve them.

Elaine said to her peers, "I understand your points, but honestly, this train has left the station and we aren't on it. I'm banking on the fact that not only will Anne be an advocate for us but that she'll also have some ideas for us. I'll arrange a time to go and talk with her, and then maybe have her come to a meeting with all of us. Give me few days and then we can talk again."

DISCUSSION QUESTIONS

1. What possible issues underlie the APNs' concerns about alignment with the nursing division?
2. What could have motivated the APN's comment that to align with the nursing division is a "step backward"?
3. As Elaine makes preparations to meet with Anne, what might be the speaking points she can plan to cover? Questions she might ask?
4. What was your reaction to the comment, "We just aren't like the nurses in the nursing division anymore"? How would you respond to the comment if someone said this to you?

Part V: Anne Butler, Chief Nursing Officer

Anne, chief nursing officer, had arrived at VMC 10 months ago. Previously a successful CNO at a large metropolitan teaching hospital for 15 years, she made the move in hopes of improving her lifestyle. The chance to work in an academic medical center in a rural setting fit the bill perfectly.

Since her arrival at VMC, Anne worked closely with the nurses in the hospital nursing division to establish a professional governance model. The model included quality and safety improvement programs, a clinical and administrative policy committee, as well as clinical excellence recognition and career advancement programs. The satisfaction measures for the nurses in the division were at an all-time high, and there was planning under way

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to apply for Magnet recognition. The physician group practice leaders were both enthusiastic and supportive of Anne's goals for nursing because they could easily perceive the benefits to the entire organization of a high-performing nursing division.

Anne was intrigued by Elaine's request for a meeting. Early on, Anne had tried to establish some kind of relationship with the APNs in the group practice but had found it difficult to know where to connect, given the vast decentralization of the APNs within the group. It seemed that as she learned about one APN's roles, they were nothing like the next APN's.

Anne experienced a bit of low-level anxiety about the vast APN cohort in the group practice because, at least on the paper organizational chart, she had a "dotted line" relationship for the purpose of overall nursing practice supervision. She knew the former CNO had no relationship with the APNs. In fact, when Anne started at VMC, she had been told that she "didn't have to worry about the APNs in the group practice because they were well supervised by the service chiefs."

At any rate, Anne was pleased by Elaine's overture and looked forward to their scheduled meeting. Although she had no illusions that Elaine represented all of the APNs in the group practice, she knew that the oncology APNs were among the largest clusters of APNs at VMC. If she could make some inroads with the oncology group, it could be a great place to begin to exert some influence and lead the rest of the APNs.

DISCUSSION QUESTIONS

1. What are common elements of professional governance models in nursing? Might a professional governance model for the APNs be a potential avenue to address the present challenges? What would be the pros and cons of developing such a model? Where might one begin?
2. Could the APNs explore other potential forms of collective action? What are the strengths and weaknesses of such models?
3. What useful data should Anne gather to inform her meeting with Elaine?

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Part VI: Meeting with Anne

Elaine related to her oncology APN colleagues that the meeting with Anne went exceptionally well. Anne understood the challenges (financial, operational, and professional) that the physician group was experiencing and knew, specifically, about the nitty-gritty details of the oncology practices. Anne agreed that the job security concerns the oncology APN group perceived were real and that a bold plan to address both the organization's and the APNs' needs was in order.

Anne soon met with the entire oncology APN group and began to help them develop a professional practice model. Anne worked with the physician director of the Cancer Center to pave the way for the work. She assured the director that any model developed would positively address the productivity concerns. The director then communicated Anne's plans to the various service chiefs, who, if truth be told, were relieved that their APN colleagues were receiving help and support because, other than eliminating positions, they were not sure what else to do.

In the first meeting with the oncology APN group, Anne made a very strategic move by acknowledging potential concerns about linking with the nursing division. She acknowledged that the APN role was different from the roles in the nursing division. However, she stressed that the advanced practice nursing role was, after all, still a nursing role. Further, she talked about sources of power in organizations and suggested that expecting the physician group to advocate equally for APNs in the current climate was unlikely—not because the APNs were not individually valued as colleagues, but because the physician group practice would first ensure the viability of the physician positions in the group before concerning itself with the "midlevel provider" staff.

Anne knowledgeably discussed the contributions APNs could make in the oncology practice. She also highlighted areas of unmet patient need that could represent as yet untapped sources of volume (revenue) that the APNs were uniquely qualified to manage (symptom management, emergent care or triage, ongoing assessments for patients receiving chemotherapy or radiation

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treatments, palliative care, pain management, advance directive counseling, support groups, inpatient consultation, etc.).

In subsequent meetings, Anne helped the group conceive of a group practice model that was linked not only to their services but also to the nursing division at large. As the APNs developed their model, a more consistent role and set of expectations for the APNs emerged that resulted in very high levels of performance and satisfaction.

Anne continued to keep the Cancer Center director abreast of the work and relied on the Cancer Center director to help with removing obstacles to the changes the APNs were making. Within 6 months, the oncology APNs made a presentation to the Cancer Center physician staff to announce this new practice model as well as the expected "contribution to financial margin" the model implementation would realize. No reductions in APN staff were recommended. The work of the Cancer Center APNs was cited by the leaders of the physician group practice as proactive, innovative, and responsive to the challenges VMC faced. The leaders encouraged other specialty sections in the practices to disseminate the model more widely in the organization.

Part VII: Epilogue

Anne worked tirelessly over the next several years to encourage and invite APN participation in the professional governance nursing division of VMC. As the APNs began to actively and broadly participate in practice and administrative work, the collective quality and reputation of nursing at VMC grew by leaps and bounds. Magnet status was awarded to VMC 3 years after Anne's tenure began. Five years later, Anne, who until that time was the only voting nurse member of the VMC internal governing body, was thrilled to learn that staff nurse and advanced practice nursing chairs of the nursing division's Professional Governance Model would be invited to join her as additional voting members.

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BOX 2-3: *Contributions APNs Can Make in Magnet-Designated Nursing Organizations*

Developer of clinical expertise in nursing staff

Contributor to knowledge development and leader in clinical and system improvement processes

Role model for

- Teaching excellence
- Competence in interprofessional collaboration and teamwork
- Professional autonomy in practice

Evaluator of care quality using data and analytic techniques

Employer of timely consultation and judicious utilization of resources

Interpreter of available evidence for use in nursing practice

Mentor, coach, and collegial supporter for all nursing staff

DISCUSSION QUESTIONS

1. What strategies did Anne employ early in her relationship with the oncology APNs?
2. Why was Anne's relationship with the director of the Cancer Center so crucial in the process?
3. How would Anne's approach need to have changed when she worked with specialty sections that had only one APN?
4. What skills and knowledge did the APN group likely need during the time that they developed their professional practice model? What resources may have been beneficial in the process, and where might they be located?
5. How would one evaluate the success of the new APN practice model? What measures would be crucial in an evaluation?

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Additional Resources

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