Practice Collaboration Perspectives among Ambulatory Care Nurse Practitioners in Virginia

Kimberly S. Bednar, MSN, FNP-C

Charlottesville, Virginia

Bachelor of Science in Nursing, University of Virginia 2000

Master of Science in Nursing, University of Virginia 2006

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Kenneth White, PhD, APRN-BC, FACHE, FAAN, Chair *Signature of Chair*

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Camille Burnett, PhD, MPA, APHN-BC, RN, BScN, DSW, *Signature of Member*

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Rebekah Compton, DNP, RN, FNP-C *Signature of Member*

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Abstract

Introduction: Advanced Practice Registered Nurses (APRNs) have assumed more clinical practice responsibilities and are serving as population health leaders. In addition to clinical practice, the APRN's leadership involvement with their physician and administrator colleagues at the decision-making table is necessary for inter-professional collaboration and organizational alignment. Bridging the gap between administration and practice is complicated by historical antecedents, professional boundaries, and organizational cultures. Provider-specific leadership that supports scope of practice and defines institutional regulations may guide the APRN's path to the administrative table. This study examined how one group of APRNs, nurse practitioners (NPs), perceive leadership opportunities, define collaborative partnerships, and describe involvement in the non-clinical aspects of the practice organization.

Purpose: The constructs of partnerships, practice equity, accountability, ownership, and power as defined by the shared nursing governance model and Kanter's theory of structural empowerment were used to develop a questionnaire that examined leadership characteristics and concepts utilized in NP ambulatory practice settings in Virginia.

Method: A twenty-five mixed method questionnaire was emailed to NP members of the Virginia Council of Nurse Practitioners.

Discussion: Data from 108 questionnaires were analyzed. Seventy percent of respondents do not have a shared governance model associated with their practice setting. The information from this research provides a platform for NP groups to open dialog with health care institution executives about accountability limitations within organizations as well as advocate for advanced practice provider-specific leadership.

Keywords: advanced practice registered nurses, shared governance, role development, theory of structural empowerment.

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Practice Collaboration Perspectives Among

Ambulatory Care Nurse Practitioners in Virginia

Introduction

In the latter part of the 20th century, great strides were made in developing the professional model of nursing practice (Cleland, 1978). Professional nursing practice is viewed as a collaborative approach with nurses making decisions about the various aspects of their practice, such as quality improvement, safety, professional development, clinical research, and communication with strategic partners. In the early 21st century, the numbers of advanced practice registered nurses (APRNs) began to grow in numbers and they were characterized as "physician extenders" for selected patient care needs. In response to emerging confusion regarding APRN nomenclature and to clarify educational and certification requirements, the APRN consensus model was developed to delineate advanced practice roles in association to health care needs (NCSBN, 2008). As APRNs grew in number and became more visible in health care, various reports were issued to support APRNs providing patient care to the fullest extent of their educational preparation and statutory scope of practice (NCSBN, 2008; NONPF, 2013). These national nursing recommendations were further supported by the Institute of Medicine report entitled *The Future of Nursing: Leading Change, Advancing Health* (2013) and The Patient Protection and Affordable Care Act of 2010 [hereinafter referred to as the ACA] legislation which called for APRNs to practice at the top of their license and to assume a greater clinical and leadership role in primary care and population health, especially in underserved areas. What is not well-defined is how specific APRN specialty groups such as nurse practitioners (NPs) enact effective clinical and leadership roles with other NPs and physician colleagues to make clinical and non-clinical decisions related to their collaborative practice.

Shared Governance in Nursing

Shared governance was first described by Virginia Cleland (1978) as a governing model that addressed professional nursing employee and management relations in institutions where collective bargaining existed. Cleland (1978) noted components of shared governance that allowed the professional nurse to develop their full potential as a health care provider whereby they were able to develop structures that unified nursing control over practice. Since, the inception of shared governance, application of professional nurse-structured leadership has been limited to bedside nursing staff. In ideal structured nursing leadership environments, committees within a shared governance model include shared power, control and decision-making with the professional nurse (Anthony, 2004). The structure enables the professional nurse to be accountable for their own practice, include pathways for legislative authority to develop practice policies, and allows the professional nurse to be responsible for devising and implementing practice quality and standards (Cleland, 1978). The professional nurse is then responsible for, has authority for and is accountable for their practice. Active participation in the process allows the nurse to have a sense of practice ownership, and have power and control in the delivery of patient care (Porter-O'Grady, 2004).

Effective shared governance models foster professional responsibility, interdisciplinary partnerships, and commitment to the organization by expanding authority and accountability for practice (Porter-O'Grady, 1991). The process decentralizes management and creates an empowered work environment through principles of partnership, equity, accountability, and ownership (Scott & Caress, 2005; Swihart, 2011). The work environment, within a shared governance structure promotes autonomy, provides authority for decision-making, and defines accountability for outcomes (Porter-O'Grady, 1991).

The principles of shared governance in nursing may also be applied to the advanced practice registered nurses (APRN). APRNs are nurses that have completed graduate level education and have met clinical practice requirements to provide patient-focused health care services and to improve patient outcomes within a clinical specialty (Hamric, Hanson, Tracy, & O'Grady, 2014). For purposes of this paper, the discussion of APRN practice will be limited to nurse practitioners (NPs) who practice in ambulatory settings. The shared governance principles of practice autonomy, independence, and empowerment are particularly germane to nurse practitioners. Application of these principles include the ability to fully participate in shared decision-making processes that impacts patient care delivery; supports practice partnerships with other NPs, administrators and physician colleagues; and, provides a format for greater practice accountability and guidance as may be seen in Figure 1 (Swihart, 2011; Anthony, 2004).

Shared governance provides structure and resources that address challenges that NPs face in providing a longitudinal source of health care, increasing access to care and removing barriers to needed health care services (Healthy People 2020, 2014). Shared governance is a practice-empowerment process that fosters and builds sustainable support for the NP in the clinical setting (Porter-O'Grady, 2001). The ability to improve access to care and to be instrumental in institutional and practice policy changes relies heavily on knowledge and mastery of health-related leadership skills. Adoption of shared governance allows the NP to possess control over practice and improve quality of care provided through concepts of partnership, equity, accountability, and ownership (Swihart, 2011).

A specific goal of shared governance applicable to NP practice is to ensure a collegial practice with colleagues that foster a work environment that enables the team to work closely with patients in order to develop a patient-centered shared health care decision-making process.

Shared governance strengthens professional development so that the APRN is able to practice at the highest level of preparation and expand evidence based practice through interdisciplinary team work and improve quality of care (Scott & Caress, 2005).

Relevant Environmental Pressures

The passage of the ACA ensured that millions of Americans would have increased access to care (HHS, 2010). Increased patient care needs have provided opportunities for expanded utilization of APRNs as front line health care providers. The American Association of Nurse Practitioners (AANP) (2014) reports more than 200,000 nurse practitioners (NPs) are employed in the United States of which more that 87 percent provide primary care. Nurse practitioners represent the largest proportion of APRNs who are being utilized as a health care provider source in ambulatory patient care settings. The inclusion of NPs as ambulatory health care providers has expanded their visibility which, in turn, has created a flurry of legislative discussion and practice regulation changes in many states (AANP, 2015).

The Institute of Medicine (IOM) (2011) and the Federal Trade Commission (FTC) (2014) have proposed removing practice restrictions for NPs in order to increased access to care and meet the demand for primary care providers. State practice restrictions and barriers limit the NP's ability to perform at their highest level of preparation, prevent the NP from inclusion at the executive table, and prevent the NP from being actively engaged as an equal partner in health care practice decisions. Further, administrative policy within health care institutions and individual practice sites may also limit the NP from being actively engaged in role expansion and development that includes shared leadership or practice governance.

Promoting the expansion of NP practice and appropriate utilization has been recommended as an effective solution to increased health care access demands (AANP, 2015).

Expansion of practice would include accepting NPs as clinical and population health care leaders thus changing the dynamics of the NP professional relationships with physician and administrator colleagues. Strains in professional relationships can develop when NPs are not included in shared leadership and practice governance due to an unclear understanding of scope of practice and institutional regulations.

Each state board of nursing has the capacity to define NP licensure. However in some states, the board of medicine is joined with the board of nursing to provide NP licensure and scope of practice regulations. Scope of practice laws can include the need for collaborative agreements, physician oversight, patient care responsibilities, and prescriptive authority. The health care institution is then charged with the responsibility of regulating credentialing oversight and establishing practice privileges.

Variability in NP practice becomes increasingly problematic when attempting to match health care access demands to available providers within a convoluted and confused understanding of state licensure laws and institution regulations. Appropriate provider resource utilization has been considered an administrative clinical problem in that employers often rely on the physician as the primary focus of the ambulatory clinical setting and the NP as an adjunct to the physician (Cronenwett & Dzau, 2010). Opposed to employing NPs as a bridge, optimizing NP function in the ambulatory setting makes more sense in addressing patient care access. Building an environment that ensures NPs are practicing at the fullest extent of their preparation requires a clear understanding of the NP's capabilities, scope of practice and subsequent restrictions. Furthermore, the administrative environment that encourages full participation from the NP through processes of shared governance encourages the NP to have authority for and ownership of their practice. Nurse practitioners are then able to have a voice in their practice

development which improves job satisfaction and empower the NPs to perform at their highest level of preparation within their full scope of practice.

Nurse Practitioners in Virginia

In the Commonwealth of Virginia, NPs are required to have a practice agreement with a collaborating physician and are considered members of a care team (Virginia Board of Nursing [BON], 2016). By implementing effective components of shared governance, valuable information can be gleaned that ensures the NP is able to function at their fullest extent of preparation, reduce practice barriers, improve access to health care, and build a stronger care team. Clinical and credentialing standards can be established, NP specific practice policies can be implemented, and leveled leadership can be shared through collegial NP lead committees which are cornerstones of a shared governance process. Shared governance allows NPs to be full and equal partners with physician and administrative leadership in health care practice policy development and improvement. Defining specific roles within shared governance of authority, scope of responsibility, administrative structure, and gaps in NP practice, the NP workforce would be suited to lead health care change.

Purpose of Capstone

The question that requires clarification is whether ambulatory care NPs are engaged in a shared governance process that empowers the NP to be active participants with other NPs, physicians, and administrator colleagues in clinical and non-clinical decision-making pertaining to their practice setting. The purpose of this capstone project was twofold. First, it was important to identify whether shared governance process structures and policies have been successfully implemented in NP ambulatory NP practice settings. Second, it was important to determine if there is a difference between NPs who have access and opportunities to be engaged

in processes that reflect aspects of shared governance and those that do not. The NP's perception of shared governance concepts of inclusion and active involvement in administrative policy development will therefore describe differences in practice settings.

Literature Review

A systematic literature review was performed to identify and evaluate shared governance and leadership practices and the implications for nurse practitioner practice. The search included the electronic databases CINAHL, MEDLINE, PschyInfo, PubMed, and Google Scholar from January 2003 to October 2014. Due to the paucity of research on shared governance and NP practice, the time period for the search was extended to an eleven year period in order to expand the numbers of available publications. Studies included for review were those written in English that addressed APRNs' leadership perceptions and included nursing administrative leadership. Studies performed outside the United States that focused on APRN leadership were also included for review. Key words of "clinical governance," "shared governance," "ambulatory care," "advanced nursing practice," "advanced practice nurse," "leadership," and "work environment" were used in various combinations when searching databases.

Centralized Leadership

A centralized leadership model has been shown to promote professional leadership opportunities and development. Key components of a centralized leadership model ensure that NPs are able to be effective health care providers and leaders by practicing to the fullest extent of their licensure and educational training.

Ackerman, Mick, & Witzel (2010) in an article describing "The Margaret D. Sovie Center for Advanced Practice" stated that establishing centralized coordination centers within healthcare organizations provide a well-managed resource for core advanced practice functions,

definitions, and role descriptions. The authors (Ackerman, Mick, Witzel, 2010) describe an advanced practice provider-specific leadership model that focuses on continuing education, professional development, practice innovation, and regulatory oversight which provide positive support for the advanced practice provider and bridge the gaps between the physician provider model and the nursing model. These researchers concluded that centralized formal leadership development and support provides core resources for advanced practice providers within healthcare institutions.

Bahouth and researchers (2013) performed a qualitative study that focused on six large academic medical centers, in order to identify common experiences with developing centralized leadership structures that support and provide oversight for nurse practitioners in large hospital settings. The results indicated that centralized nurse practitioner leadership provides resources that empower NPs to function at their highest level of preparation. The authors comment that centralized leadership can increase NP visibility through demonstration of contributions to the health care delivery system, and gives credence to the importance of organizational empowerment as it relates to professional practice development (Bahouth et al, 2013). Additionally, clarifying NP roles and developing standardized professional practice models supports expert NP practice and improves delivery of comprehensive health care. Bahouth and researchers (2013) also identified leadership characteristics that contributed positively to NP governance. These included being a champion of practice, knowledgeable of institutional systems and policies, being politically astute regarding philosophical issues, and becoming known for quality leadership within the health care organization.

Oliver (2006), in a professional issues article describing leadership in health care, expressed the opinion that individual leadership styles and skills fosters role development

including empowering the practitioner to implement change, be expert clinical decision-makers, work independently, and be effective collaborators. The author noted leadership skill development improves delivery of patient care and increases the practitioner's visibility as a valued member at the administrative table.

Work Environment

Lankshear, Kerr, Laschinger, and Wong (2013), in a study of positive work environments, concluded that professional practice leadership (PPL) improved the professional environment by clarifying role perceptions and functions. These researchers (2013) described organizational support as the implementation of leadership tactics such as professional practice functions of role assignments and accountability. The researchers state the power of an organization with a positive work environment relates directly to the PPL role and accountability (Lankshear et al., 2013).

Role Development

Poghosyan et al. (2013) performed a qualitative study examining nurse practitioners' perceptions of barriers and facilitators of scope of practice as primary care providers. The researchers concluded that work environments that include restrictive regulatory practices and government regulations, unclear administrative views of practice, and variations between organizations interfere with the NP's ability to improve or ensure quality of care provided (Poghosyan et al., 2013). The researchers noted poor infrastructure and relationships with administrators limit perceived NP role development and support (Poghosyan et al., 2013). Poghosyan et al. (2013) noted that NP role expansion and development is further restricted by non-involvement in administrative decision-making, lack of in-place organizational structures that support scope of practice, and absence of executive level inclusion.

Following a qualitative meta-summary that examined characteristics of advanced practice nursing, Hutchinson et al. (2014) concluded that advanced practice characteristics extended autonomous advanced nursing clinical practice, encouraged collaborative practice relationships with other health care professionals, and included opportunity for leadership external to the organization. The authors concluded that developing practice improves overall care delivery and promotes collaboration (Hutchinson et al, 2014).

Summary and Conclusion

Findings of this literature review supports the positive influence of centralized NP-specific shared governance on advanced practice development. Establishing a centralized NP leadership structure with clear and concise pathways enables the NP to address clinical concerns and perform quality improvement projects that reduce barriers to access to care (Bahouth et al., 2013). Effective centralized leadership programs such as shared governance based on authentic leadership techniques (Lankshear et al., 2013) provides a positive work environment, improves NP organizational commitment, and improves NP visibility. Leadership structures that support autonomous practice, encourage collaboration, and encourage professional development promote advanced nursing practice (Hutchinson et al, 2014). Unfortunately, organizations that have poor leadership infrastructures that perpetuate unclear understanding of the NP role limit the NP's perceived opportunities for role development and support (Poghosyan et al., 2013).

Limitations of this literature review included a small descriptive report (Bahouth et al., 20130, a self-reported nursing survey which is subject to participant bias (Lankshear et al., 2013), and administrative articles (Ackerman, Mick, Witzel, 2010; Oliver, 2006).

The lack of literature specifically addressing shared governance and leadership involvement of NPs supports the research question of this capstone. Namely, there is a need to

explore ways that NPs participate in shared governance and leadership with other NPs, physicians and administrator colleagues.

Theoretical Framework

Theory of Structural Empowerment

Kanter's theory of structural empowerment was used to describe how shared governance provides structures that include opportunity and access to formal and informal power, which is shown in Figure 2 (Kanter, 1977). The correlation between Kanter's theory and shared governance is apparent when considering the relationships between level of perceived formal and informal power as it relates to autonomy, credibility, and leadership-building capacity and being capable of use resources effectively (Kanter, 1977). Employees, who have power within the organization and are provided professional growth opportunities, tend to be engaged in their role, are able to make decisions and are empowered to use resources effectively and efficiently to accomplish clinical and non-clinical professional goals.

Theory of structural empowerment focuses on empowering structures within organizations and not individual qualities (Laschinger, 1996). Kanter's theory describes behaviors and attitudes as they relate to power, opportunity and access to resources. Components of Kanter's theory of structural empowerment that are reflected in shared governance structure include access to information; support, resource availability, and formal and informal power (Sabiston & Laschinger, 1995). Formal and informal power can increase NP visibility, sense of accountability, and collaborative team building (Nedd, 2006). Formal power, as it applies to the NP role, promotes the ability to be independent decision-makers and enables the NP to have practice ownership (Nedd, 2006). Informal power, within the NP role, describes relationships within an organization such as those associated with collaborative or interdisciplinary teams

(Nedd, 2006).

Methods

Introduction

The purpose of this study was to examine the impact of shared leadership concepts of partnership, equity, accountability and ownership as defined in the shared governance model on nurse practitioners in ambulatory care settings. The questions under examination are: Are NPs who provide patient care in ambulatory settings engaged, empowered, and involved in clinical and non-clinical decision-making with their NP, physician, and administrator colleagues? And if so, what are the characteristics that describe these shared leadership models?

Study Design

This study employed a mixed methods approach designed to describe shared leadership or governance processes within nurse practitioner ambulatory practice settings. The shared governance constructs of partnerships, equity, accountability, and ownership were assessed though dichotomous, multiple choice and open-ended questions. Questions addressed collaborative partnerships with physician and administrator colleagues, perceived barriers and perceived supports for NP practice, access to accountability measures through productivity reports and outcome measures, and involvement in practice progression and role development.

Survey Instrument

The questionnaire contained twenty-five dichotomous, multiple choice and open-ended questions that were crafted from the literature and adapted from nursing governance tools developed and validated by leaders in the field (see Appendices A). Kanter's theory of structural empowerment guided questions pertaining to perceived level of power regarding executive level decision-making and perceived practice barriers and supports. Permission to use questions from

professional nursing governance tools developed by Hess (1998) was obtained (see Figure 3). The questionnaire was validated through the Public Health Sciences resource available through the University of Virginia Health Sciences Library.

The electronic questionnaire was crafted using the University of Virginia, School of Nursing secure survey tool through SelectSurvey.Net.

Demographic information included gender, age, licensure, highest level of education in nursing, and years of experience.

Participants were asked if there are shared governance structures in place within their organization or practice site. Participants were also asked if they are involved in administrative processes that address their role as a care provider and if they are included on administrative executive boards. Administrative processes included structured and non-structured meetings addressing practice partnerships, involvement in practice committees that address patient care access needs at practice sites. Scope of practice was evaluated by inquiring about billing practices, access to productivity and outcomes data, and patient care visit specifics. Billing practice questions inquired how the NP submits patient encounter bills: under their National Provider Identifier (NPI) number, through "incident to" billing, or shared billing. Accountability was examined by addressing access to productivity and outcomes reports and how that information was used to influence practice. Practice ownership was evaluated by inquiring about patient care visit specifics such as how patient visit are typically conducted: independent, tangential, or parallel.

Definition of Terms

The following definitions describe the meaning of terms used when developing open-ended questions included in the survey.

Shared governance is an administrative process that shares power, control and decision-making with professional nurses (Anthony, 2004). The process includes principles of partnership, equity, accountability, and ownership (Swihart, 2011). Shared governance is designed so that the practitioner has practice autonomy, independence and is empowered to fully participate in shared decision-making processes that impact aspects of patient care (Swihart, 2011; Anthony, 2004).

Ambulatory care is defined as health care services including primary and specialty care that is provided outside of the in-patient hospital setting. Nurse practitioners are generally the largest group of APRNs in the ambulatory care setting.

NP scope of practice is governed by the Virginia state Boards of Nursing and Medicine. Scopes of practice are laws, rules and regulations that define what the NP can and cannot do under their professional license. Scope of practice regulation does vary from state to state. Concepts under scope of practice include providing nursing and medical services to individuals through autonomous practice authority, independent prescribing privilege for non-pharmaceutical and pharmaceutical agents and therapies, promoting quality health care, and leading and participating in professional health care forums (Board of Nursing, 2016).

Highest scope of practice refers to the NPs ability to function at the highest level of preparation is promoted through state regulations regarding scope of practice and the combination of roles as provider and administrator (AANP, 2013).

Leadership is defined as active membership in any interdisciplinary leadership counsel or committee which includes structured and non-structured routine meetings addressing patient care needs, expansion of role, and practice development. Interdisciplinary team refers to a collaborative practice in which professionals of different disciplines work jointly together,

pooling skills and expertise for broader purposes such as addressing patient care needs, improving care delivery, and addressing health care access (McCallin, 2001).

Partnerships are essential professional relationships between other health care providers and patients. The relationship is collaborative and involves stakeholder interests. Members of the partnership have roles and responsibility to the organization's mission and purpose (Swihart, 2011).

Performance improvements are measures the NP takes to improve care delivery. For the purpose of this survey, participants will be asked how productivity reports are used to improve practice. Productivity reports are further described under accountability measures.

Accountability measures include productivity and outcome reports. Productivity reports represent billing details, patient visit descriptions such as visit level and procedure performed. Billing details may include monthly relative value units (RVUs), patient acuity level, and measures that compare the percentage of new patient and established visits.

Outcome reports are used to assess therapeutic treatment as compared to evidence based practice treatment guidelines. Outcome reports are viewed for specific patient populations with specific illnesses and measure illness management over time.

Reimbursement refers to NP billing practices and how patient encounter bills are submitted for reimbursement. For the purpose of this project, billing practices are used as a surrogate for accountability and indices for extent of scope of practice privileges.

Practice progression is the process the NP takes to advance their professional role. These steps can include clinical quality improvement (QI) projects; future professional planning such as NP-led clinics or NP patient population management, integration of evidence into

practice through presentations and lectures, and active involvement in continuing education such as enrolling in DNP or PhD programs (Elliott, Begley, Kleinpell & Higgins, 2013).

Role development includes steps the NP takes to advance their professional status within their practice setting. Activities include NP involvement in administrative processes such as organization's governance committees or counsels; activities that promote NP visibility within the organization, and active involvement in clinical care policy and program development (Poghosyan et at., 2013).

Study Setting and Sample

There are over 8,000 APRNs in the Commonwealth of Virginia (VNA, 2014). Virginia APRN titling groups include licensed nurse anesthetists, licensed nurse midwives and licensed nurse practitioners. NPs represent the large proportion of the APRNs and account for more than six thousand licensed advanced practice nurses in Virginia (VNA, 2014). In order to gain insight into ambulatory patient practice, participant recruitment was limited to nurse practitioners.

The participants in this study were drawn from a convenience sample of NPs who are members of a state wide association, the Virginia Council of Nurse Practitioners (VCNP). There are over 1,700 licensed, retired, and student nurse practitioner members affiliated with the VCNP (VCNP, 2015).

The specific inclusion criteria for this study are: licensed nurse practitioners who are employed in ambulatory care setting.

The exclusion criteria are: nurse practitioner student status, retired status, NPs who provide more than fifty percent in patient care services, and nurses who are not licensed as nurse practitioners.

Protection of Human Rights

The proposal was approved on June 22, 2015, by the University of Virginia Health Sciences Institutional Review Board (IRB) (see Appendix C). Data was stored in the University of Virginia School of Nursing survey tool and on a personal computer with password protection. Information will be destroyed after completion of the capstone project and the publication of results. There was no compensation provided for participation in this study.

There were no direct risks or benefits associated with study participation. However, study participants may have indirectly realized strengths and weaknesses within their current practice setting.

Procedures

After Institutional Review Board approval and designation as an exempt study in the University of Virginia, the state president of the VCNP and administrative assistant were contacted in person and via email to inquire about permission to distribute the questionnaire to active members. The VCNP did not require a fee for the two separate email distributions.

The survey was distributed to 1,716 NP email addresses maintained by the VCNP. There were three new email addresses added following the initial distribution list. Group email allowed distribution of the questionnaire to NP members throughout the state simultaneously. The questionnaire was accessible to VCNP nurse practitioner members for a thirty-day survey access time period. For reminders and follow up, there was one membership group email sent fourteen days after the initial email distribution.

Active VCNP members were sent the initial survey email on July 2, 2015. The follow-up reminder email was sent on July 16, 2015. Eight hundred active VCNP members opened the initial email following the July 2nd distribution. There were fourteen "bounce-back" emails at that time. Six hundred and forty-two active VCNP members opened the reminder email

following the July 16th distribution. There were twelve "bounce-back" responses following the reminder survey email.

Informed consent was attached to the questionnaire (see Appendix C). Participants were asked to acknowledge consent prior to proceeding to questionnaire. In order to limit participation to NPs who primarily practice in ambulatory care, an initial question inquiring ambulatory or in-patient care provider status was asked. NPs with more than 50% of their patient care time allocated towards in-patient care services were asked not to complete the survey.

Data Analysis

One hundred seventy-four responses were returned following the distribution of the survey to 1,716 NP email addresses. This is a 10% return rate which was within the expected return rate of 5 to 20% (Fan & Zheng, 2010). One hundred and eight completed questionnaires were considered for final analysis. Thirty-seven questionnaires were excluded from final analysis due to participants providing "no" to informed consent but submitted a completed questionnaire. An additional twenty-four returned questionnaires were excluded as participants answered "yes" to clinical responsibilities include more than 50% inpatient care. Five more completed questionnaires were excluded as participants did not provide an answer regarding inpatient care responsibilities. One hundred and eight questionnaires were reviewed for completeness. An additional twenty-five questionnaires were excluded as participants failed to complete the survey beyond answering demographic information. A total of 83 questionnaires were used for the final analysis. Figure 4 illustrates questionnaire inclusion decision-making.

Statistical analysis was performed using IBM SPSS Statistics for Windows, Version 22.0. Descriptive statistics was performed to describe total sample using percentages of gender, age,

years' experience as a NP, highest level of nursing education, and licensure. Chi – squared analysis was performed on categorical variables to determine if there were statistical differences between NPs who have shared governance structure in place and NPs who do not. Qualitative responses were analyzed by the author and capstone committee chair. Common themes were summarized in a narrative description (Sandelowski, 2000). Cronbach's alpha was performed on qualitative questions to determine internal reliability between questions. The Cronbach's alpha for questions addressing practice partnerships, involvement in partnerships, interactions with professional colleagues, and opportunity to discuss role development was 0.855. The Cronbach's alpha was 0.779 for questions addressing contributions to decision-making at the executive table, perceived practice barriers and perceived practice supports. A Cronbach's alpha suggests inter-relatedness between question items with results of 0.75 – 0.95 as acceptable values (Tavakol & Dennick, 2011)

Findings

Demographic Characteristics

Demographic information (see Table 1) included age as recorded in year of birth, gender, NP credentials, highest level of education, years of experience and VCNP regional affiliation.

There were eighty-one (81) female participants and one (1) male participant. Ten-year age groups up to age sixty-nine were determined from reported year of birth. Ages greater calculated to be greater than seventy were grouped together as seventy plus (+) age group. The majority of participants (32%, n= 26) were fifty to fifty-nine years old. Seventy-five percent (n = 75) of the participants stated they are licensed primary care nurse practitioners. Additionally, 77 % (n = 64) of participants state their highest level of education is a master's degree. Years'

experience was calculated in ten-year intervals. The majority of participants have either zero – ten (34 %, n = 24) or ten – twenty (37 %, n =31) years' experience.

Council Affiliation

There are twelve regions affiliated with the VCNP within the Commonwealth of Virginia into twelve regions (see Figure 5). The VCNP members in Northern Virginia and Richmond regions provided the majority of completed responses accounting for 21.7 % (n = 18) and 18.1 % (n = 15) respectfully (see Figure 8).

Practice Site Demographics

Practice site questions included identifying number of NPs at practice site, whether or not the practice site is part of a larger system and the estimated number of NPs in the larger health system (see Table 2). Forty-eight percent (n = 40) of respondents stated they were the sole NP at the practice site. An additional 42.2 % (n = 35) of the respondents stated there were two to five NPs the at practice site. Sixty-six percent (n = 55) of the respondents' practice site is part of a larger health system with 31.3 % (n = 26) having more than 50 NPs included in the larger health system.

Presence of shared governance or leadership model

In response to whether there is a NP specific leadership or shared governance model present in the practice site, 58 respondents (69.9 %) indicated no and 25 respondents (30.1 %) answered there is a shared leadership model in place (see Table 3).

Compensation

Participants were asked to select a response that best defined how they are compensated: salary, base salary plus incentive, base salary plus incentive for volume, base salary plus incentive for quality or other. Unfortunately, the questionnaire format failed to allow

participants to write in answers therefore responses marked as "other" were excluded from descriptive analysis as there is no way to define what "other" means. The majority of respondents or 61.4 % (n = 51) selected salary only. The second most prevalent answer identified base salary plus incentive for volume accounting for 15.7 % (n = 31) of responses (see Table 4 and Figure 6).

Accountability Measures

In response to access to productivity and outcome reports, 44 % (n = 37) of respondents stated they received reports on a regular basis. The participants were given the opportunity to provide a choice of several pre-specified responses to how productivity and outcome reports are used in the practice setting. The most common responses on how the information from productivity and outcome reports are used were "affects salary" and "used for practice decision-making". Over 14 % (n = 12) of respondents stated reports affect salary, 24 % (n = 18) stated reports affect billing practices, and over 9 % (n = 8) of respondents stated reports are used for practice decision-making (see Table 5).

The survey included two questions assessing how patient visits are conducted (see Table 4) and how patient visits are most likely billed (see Table 6). Ninety-five percent (n = 79) of NP respondents conduct patient visits independently or parallel to physician colleague. Whereas 5 % (n = 4) conducted shared patient visit with physician provider. Nearly, 46 % (n = 38) of respondents replied they are most likely to bill under their own national provider identifier (NPI) number. Twenty-one percent (n = 18) of participants bill as "incident to" by using the physician's NPI number.

Chi-squared Results

Chi-squared testing was performed to determine if a relationship exists between a nurse practitioner-specific collaborative leadership or shared governance model and NP credentials, education level, years' experience, VCNP regional affiliation, compensation, practice site size, access to productivity and outcome reports, billing practices, and how patient visits are conducted. A two-sided pre-set alpha of 0.05 was used.

In order to perform a two by two comparison, credentials were grouped into acute and primary care sub-groups. Acute care NPs and adult-gerontology acute care NPs were combined into the acute NP group. Adult NP, adult-gerontology primary care NP, family NP, psychiatric-mental health NP, gerontology NP and pediatric primary care NP were included in the primary care group.

Highest level of education was combined into two groups with master's degree representing one group and doctor of nursing practice (DNP) and doctor of philosophy (PhD) degrees were combined to represent the second group.

Due to the multiple answers provided regarding how patient visits are conducted, the responses were combined into two responses. The final two comparison groups were identified as those that conducted shared visits with the physician provider or those visits conducted independently.

In order to evaluate billing practices, responses were combined into two groups. The groups used for Chi-squared analysis were those that billed under their own NPI numbers and all other responses.

Chi-squared test results indicate there was no statistically significant difference between NPs who have a shared leadership structure in place and NPs who do not. Furthermore, there was no relationship found when comparing NP demographics that included credentials, level of

education, years' experience and VCNP regional affiliation. Chi-squared tests failed to demonstrate a relationship between shared governance and practice site as part of a larger institution. There were no Chi-squared statistically significant differences in patient visit specifics of how visits are conducted and billing practice. Results are seen in Table 7.

Qualitative Results

Seven open-ended questions were included in the questionnaire. Participants were asked to describe their involvement in practice partnerships, their involvement in practice committees, their relationship with their collaborative physician and administrator colleagues, their opportunities for role development, their contributions to decision-making at the executive level, their perceived barriers that limit ability to function at highest level of preparation, and perceived supports that enables them to function at their highest level of preparation. Common themes were identified for each question.

Involvement in practice partnerships. There were four common themes identified from self-reported responses to the question "Practice partnership includes involvement with physician colleagues and executive administrators to address patient care needs…….describe your involvement in practice partner activities." The themes identified were no involvement, limited involvement, collaborative and independent to practice (see Table 8). Twenty-eight respondents stated there is no involvement due to part-time employment status, lack of formal practice partnership within organization, practice site is a "corporate setting", or the participant has decided not to participate. Nine participants stated there is limited involvement due to "limited administration over rules decisions despite great MD NP collaboration" and "we have very little input into the decisions that have been made about the direction the group has taken over the years." Thirty-four respondents stated there are collaborative partnerships which

include weekly, bi-weekly and monthly team meetings that address concerns the NPs have, patient care coordination needs, and program development. One participant states "Actively involved in any policy changes, pilot studies, or administrative changes that deal with my job on the unit" and "equal involvement with MD and BOD for all practice concerns." Two participants identified themselves as functioning independently or in a solo setting. These participants noted "I practice fairly independently in a very small practice run by NPs" and "physician consultation occurs infrequently."

Practice committee involvement. Participants were asked to describe their involvement in practice committees. The two themes identified in the comments made by participants were no/none and yes (see Table 9). Forty-seven participants stated there no practice committees within the organization or they do not attend meetings. One participant noted "physician practice committee but no interaction nor do they have any role in what I do on a daily basis." Twenty-one participants noted some level of involvement in practice committees that were described by participants as quality improvement, interdisciplinary teams, patient access, continued medical education, and clinical leadership. One participant stated they are involved in "ACO, PCMH committee, NP workforce group," and multidisciplinary quality improvement committee" at their practice site.

Practice partnerships descriptions. Three themes were identified when reviewing participant's descriptions of practice partnerships with collaborating physician and administrator colleagues. Description themes are rare interactions, close collaborative and supportive interactions, and formal agreement. Eighteen participants noted there are rare or very infrequent interactions (see Table 10). One participant stated "none. I rarely talk to either of them. I see them at monthly staff meetings where they talk at us." Another participant stated "I rarely see

my collaborating physician. I ask questions about 4 times a year." Twenty-seven respondents state they have close, collaborative and supportive practice partnerships with their collaborating physician and administrator colleagues. The participants who noted collaborative and supportive practice partnership expressed positive collegial relationships. One participant stated "excellent rapport and complete trust in my abilities/skill set." Another stated "I have a close relationship with my collaborating physician and with the Vice President of the two sites where I work. The CEO of the organization and I frequently use email to communicate and have quarterly meetings." Four participants stated they have formal agreements. The participants who stated they have formal agreements also stated they function independently or had an autonomous role. One participant stated "I see patients independently." Another participant answered "I have an independent practice partnership. I see my own patients and utilize my collaborative physician on an as needed basis."

Role development. Participants were asked to describe practice site opportunities to discuss role development. The four common responses identified were: 1. Yes, there are opportunities; 2. practices are autonomous settings and participants were unable to identify opportunities; 3. there are no opportunities; and 4. there are limited opportunities (see Table 11). Forty-five participants responded yes and noted opportunities to expand leadership roles, where encouraged to obtain new skills to improve patient care, and had many opportunities to expand clinical services. One respondent answered "yes, we are now implementing a strategy so that I can obtain new skills to serve the patient population better." Another stated "yes, all providers in my practice have the opportunity to expand clinical skills which helps further autonomy." Three participants responded they practice in an autonomous setting. These participants were unable to identify opportunities to be more independent. One participant stated "I am already in a very

autonomous role – I am not sure that I could be more independent." Twenty participants provided a simple no or N/A response. However, one participant explained "they generally are not open to the NP expanding their skill set." Another responded "no, I do everything that the other physicians in the group do in the office setting without exception." Seven participants noted there are limited opportunities to discuss role development. One participant in this group stated "the focus is on keeping up with the patient load and EMR" and "expectation is that NPs function autonomously and see more and more patients." Another NP stated "I feel like I am too burdened with day to day tasks to pursue any additionally responsibilities."

Decision-making at the executive level. Nurse practitioner participants were asked if they contribute to decision-making at the executive level. Responses were categorized into no, yes, and minimal involvement (see Table 12). Forty-three respondents answered no. Rationale for no responses included lack of need; decisions are made by owners or directors, and size of institution as prohibiting factors. One participant wrote, "no b/c [sic] the institution is so big and decision-making so cumbersome. I have no interest in this." Another participant responded "No. This is a very disjointed institution, with lots of NPs/PAs (physician assistants) practicing in a variety of roles." Finally, a participant responded "no… We have an APP Director, but she usually makes the decisions in our name. We feel it is not by our proxy….." Twenty-eight participants provided direct yes responses. Several responded yes with no further descriptive information. However, a participant answered yes and noted "I have direct communication with administrators," and "very open communication can express opinion if needed." There were five participants who responded minimal involvement. Responses from this small group included "I feel I could if there was something that needed to be changed," and "if asked for my input or if I feel that my input would be useful."

Perceived practice barriers. Participants were asked to describe practice barriers. Forty-two participants described barriers and twenty-seven respondents answered there are no barriers (see Table 13). Barriers described by participants included lack of role clarity, Medicare regulations, state scope of practice restrictions, organizational restrictions, lack of structured leadership at practice or within organization, and lack of insurance credentialing. Lack of role clarity included "lack of understanding/knowledge about DNP", "there is not much experience with NPs working with general surgeons in ambulatory setting……The surgeons don't seem to have a good idea of how I can function independently", and "at our institution PAs and NPs are treated in exactly the same manner and have very little, if any, leadership roles."

One participant noted "Medicare rules and lack of insurance credentialing require patient encounters to be billed under the physician, NPs as a whole are not being credentialed by certain insurance companies, which necessitate billing those patients under my MD's NPI…" and "….Medicare rules that say a physician must sign home health face to face reports."

Organizational restrictions included productivity demands with a focus on volume alone, restrictive guidelines that hinder the NPs ability to practice at full capacity, and practice restrictions that are opposed to state practice laws. One participants stated "demand for increased productivity and maintaining EMR, office manager is not supportive of NPs and MDs defer to her," and "financial pressure…..This means there is a pressure to see more patients constantly". Other organizational barriers included inability to advance to "assistant professor position" and "lack of support for DNP."

State scope of practice restrictions requiring physician collaboration as required by Virginia state law were noted by several participants. One participant stated "I feel I am able to practice at the highest level my education allows. State laws are somewhat restrictive."

The 27 respondents who denied barriers or restriction for their practices described themselves as functioning independently. One participant stated "I work at a level where I am very comfortable."

Perceived practice supports. Participants were asked to list supports that enabled their ability to function at their highest level of educational preparation or promoted their desired professional role development. Supports were defined but were not limited to structured leadership, structured committees or councils, and educational opportunities (see Table 14). Fifty-four participants provided descriptions of practice supports. Supports listed by these participants included educational opportunities, continued medical education, reimbursement, organizational wide supports, structured leadership, professional membership, and peer interactions. Other common themes identified were organizational and collaborative support; continuing education opportunities; and peer interaction within organization and professional organization membership.

One participant answered "I believe that the medical director that I work with supports me and allows me to function at the highest level of my education." Another wrote "I am allowed to function independently with support of practice manager and supervising MD."

Continue education opportunity support included annual funding or allowance for continuing medical and nursing (CME/CNEs) educational opportunities which included tuition reimbursement and financial support, paid time off to attend professional conferences and licensure and credentialing fees.

Several participants noted membership to VCNP and AANP provide professional support. One participant wrote "AANP guidelines and networking at meetings are helpful in areas I'm not clear about." Another participant wrote "active role in local VCNP, communicate

regularly with physicians and PAs, feel I have the support of my medical director…,participate in monthly committee meetings to discuss and improve patient care."

Result Summary

The majority of respondents were Master's-prepared female nurse practitioners ranging in age from twenty to fifty with fewer than five years' experience participated in this survey. The majority of these NPs provide ambulatory care in settings that are part of a larger health system. Unfortunately, 70 % of the participants do not have or are unaware of a shared leadership model within the institutions in which they are employed. Interestingly, there was no statistical difference in NP practice between those that have a shared governance model in place and the NPs that do not.

Findings from the open-ended questions suggest most of the participants practice in a close collaborative setting that supports continued professional growth. Unfortunately, institutional and state practice regulations limit the NP's ability to practice at their perceived highest level of preparation within their scope of practice.

Discussion

Nurse practitioners are being utilized in health care systems to provide primary ambulatory patient care. This has prompted federal practice recommendations and has encouraged practice change legislation within many states. As autonomous NP practice evolves, organizations that employ NPs would do well to establish an effective shared leadership model that considers varying NP roles, incorporates patient care responsibilities, and acknowledges professional alliances. This model would serve to bridge the leadership gap between nursing and medical administration and to be a collaborative platform for NPs and their physician colleagues (Ackerman, Mick, Witzel, 2010). The goal of shared leadership is not to

isolate NPs in a sole NP leadership model but to empower the NPs to maximize their role and function in health care through strategic leadership processes.

The literature suggests that centralized shared leadership empowers NPs to be health care leaders who are able to practice at the full extent of their education and preparation. Furthermore, shared leadership promotes positive work environments that foster maximum professional function and accountability. Infrastructures within institutions can extend autonomous practice that encourages collaborative partnerships.

This study indicates that the majority of participants do not have or are unaware of an advanced practice provider-specific shared governance leadership model within the institutions in which they are employed. However, the majority of the participants noted they see patients independently of their collaborating physician partners and believe they provide patient care autonomously. These findings suggest the presence of shared leadership models may not impact how the NP practices as much as how it empowers them to control their practice or possess power within the organization. This is exemplified in participants' comments regarding their collaborative interactions and opportunities for decision-making. Although participants stated they have a supportive collaborative relationship with their physician colleagues and other health professionals, over half of the responses indicated there was no opportunity to be engaged in the decision-making process. It is unclear if the NPs who participated in this study have tried to be engaged in the decision-making process and met resistance or if they do not assert the importance of NP presence in the process.

The questionnaire included opportunities for the NP participants to describe practice supports and barriers. However, specific questions inquiring about perceived hierarchical relationships and professional socialization were not included. More research is needed to

investigate how power is distributed between nurse practitioners and their physician colleagues and how that impacts the NP's sense of professional empowerment. As described by Kanter (1977), the distribution of perceived formal and informal power is vital to promoting empowerment and fostering leadership skill development, promoting the sense of accountability, and encouraging professional engagement in others.

Lack of empowerment affects the NP's independent function by limiting their ability to engage in non-clinical aspects of their role−especially when they do not have access to accountability measures, such as billing practices, and are not included in administrative decision-making. These finding point to an inconsistent connection between accountability and engagement in NP practice. For example, the respondents clearly communicated they were accountable to their clinical and patient-related responsibilities. However, they were less engaged with the strategic and business aspects of their practice. These findings suggest there is a lack of structural support through decreased access to resources and information that provide a heightened sense of practice autonomy (Orgambidez-Ramos & Borrego-Ales, 2014). This is further supported by Kanter's (1977) theory as she describes people with low structural support with decreased opportunities as those who tend to be less task oriented and do not actively seek out more responsibility or participation.

Lack of power and opportunity (Kanter, 1977) is exemplified when respondents stated they were treating patients independently but without using their own NPI number for billing purposes. It is unclear if billing practices reflect personal choice or institutional policies. The institution may require the NP to forward patient encounter bills to their collaborating physician to be co-signed. Billing under the NP's NPI number would mean less reimbursement for the institution but would increase engagement as a collaborative partner in the practice. Billing

practices do not allow the NP to bill under their own NPI number may cause a sense of powerlessness and may devalue the NP role. This process is counter-productive in promoting accountability through access to information as further described by Kanter (1977). It is important to note that participants were not asked to describe specific types of institutional or administrative policies or how those policies restrict or affect their practice.

This study provided some insight into how NPs perceives their practice, leadership functions and their professional relationships. Again, it is unclear whether or not the NP possesses power within these relationships or chooses not to be involved. The concepts of formal and informal power as it affects the NP's ability to produce an outcome within the confines of available resources may explain perceived barriers and supports (Kanter, 1977). NP respondents in this study who perceived organizational wide support reported being more engaged in their role and saw themselves as valued team members. Positive support may also contribute to a sense of increased professional opportunity and role commitment (Kanter, 1977). Conversely, NPs who identified barriers of institutional regulations, state scope of practice requirements and insurance credentialing issues may perceive limited formal and informal power which can negatively impact their commitment to their professional role. The inability to exert power limits practice equity and ownership which prohibits the NP to function at the highest level of their preparation.

Variability between institutions and clinical sites may reflect individual differences in perceived access to accountability, practice equity, and involvement in leadership opportunities. Participants that work in solo practices or are employed in a corporate setting, such as retail clinics, may not have the ability to be involved in leadership opportunities. In practice settings where there is a solo NP there may be limited opportunity to build a NP-involved leadership

structure that fosters practice ownership, accountability, collaborative partnerships, and equity. Furthermore, NPs who are employed in a corporate setting may see themselves as paid employees that function within preset administrative guidelines, without an option for involvement in higher level strategic non-clinical decisions.

Findings of this study suggest there is a lack of NP engagement which may negatively impact the likelihood of individual NPs who actively pursue a seat at the administrative table. This may suggest how the NP is acculturated to practice within the institution and by colleagues. Lack of engagement may reflect the NP's perception of exclusion from or lack of knowledge about the business aspects of health care. Formal educational curricula and continuing education courses focusing on the business aspects of health care may need to be included during entry into the profession and throughout practice in order to expand knowledge of and reinforce the importance of the business and leadership aspects of advanced practice.

Shared leadership and governance may be a new concept for many nurse practitioners in the advanced practice role. Although NPs may have been exposed to the shared governance model as staff nurses, they likely have not extended its usefulness and applicability to the advanced practice role and how it can promote NP practice. A limitation of the survey instrument is that it did not investigate which practice model, nursing or medicine, the NP felt aligned most with their clinical practice. Allegiance to one administration over the other may impact responses regarding leadership involvement, institutional supports and barriers, and professional partnerships. Shared governance is one way to enhance the ambulatory NP role and may be part of the solution addressing full collaborative practice. Forming leadership structures that supports collaboration that extends from the clinical setting to the board room can ensure the NP voice is present at the strategic and operational decision-making table.

Overall, this study raises more questions than provides answers. The lack of shared governance and leadership detracts from the ability for partnerships, equity, accountability, and ownership in NP practice in ambulatory settings from the respondents of this survey. Surprisingly, patient care dynamics such as how patient visits and billing practices are organized and conducted do not seem to be affected by the absence of NP shared governance or other collaborative leadership models. More research is needed to define and describe best practices of shared leadership within the setting of NP practice and the benefits of a NP-guided governance model.

Strengths

The findings of this study demonstrated that there are no statistically significant relationships between NPs who have a shared leadership structure in place and how the NP practices. This study also provided insight into views regarding NP practice supports and barriers in the Commonwealth of Virginia. The results showed peer interactions and organizational support were positive practice supports and practice barriers included lack of role clarity, scope of practice restrictions, and credentialing limitations.

Limitations

Limiting the sample to ambulatory care NPs underrepresents APRN specialty roles and limits generalizability. A convenience sample limited the ability to compare APRN specialty groups with practice settings and role descriptors. Self-reporting of information may have contributed to participant bias and over- or under-reporting.

The author did not inquire if NP participants in this study were familiar with shared governance or how that process would potentially apply to NP practice. Therefore, prior knowledge of concepts may have contributed to participant bias in thinking about shared

leadership and subsequent responses. Furthermore, NP participants in this study may have access to a provider-specific leadership model that is inconsistent with concepts of shared governance.

Asking individuals whether shared governance promotes the NP role and practice development is subjective in that self-reported evidence by NPs may not be the best method in determining whether NPs are practicing at the highest level of their preparation or are involved in administrative decision-making. Furthermore, evaluating health care systems that have shared governance policies in place does not guarantee NP practice optimization.

Nursing Practice Implications

Information from this Capstone may be used to develop further research examining shared leadership roles and functions. Schools of nursing may use this information to examine advanced practice program curricula to include more content in the business aspects of APRN practice and the importance of being advocates for their voices being represented at the practice-setting table. Institutions and researchers may want to investigate the level of NP engagement in their practice and the reasons for what may hinder the NP's sense of professional engagement. Administrators and NPs can use this information to model work environment change, become involved in interdisciplinary leadership counsels, advocate for inclusion at the executive table, and be empowered to direct role expansion.

Professional organizations can use this information to argue for practice authority change, influence insurance companies to expand credentialing for NPs so that health care services provided are perceived as equivalent to their physician counterparts. The information from this research can provide platforms for nurse practitioner groups to open dialog with health care

institution executives about accountability limitations within organizations as well as advocate for advanced practice provider-specific leadership.

Institutions interested in addressing advanced practice provider-specific shared governance may want to learn from best practices, such as the Margaret D. Sovie Center for Advanced Practice at the University of Rochester to learn more about exemplar organizational support processes and structures. Using established models may assist in standardizing NP practice within organizations and clinics and can provide benchmark data on established accountability and outcomes reporting.

Nurse practitioners can use this data to inform institution administrators about the contributions NPs make in directly influencing health care access demands. The individual NP can use this information to bolster the argument for inclusion as a partner in practice and policy decision-making. Nurse practitioners who serve as student mentors can use these findings to educate NP students about the professionalism and the importance of being involved as a partner in the business of providing health care.

Products of the Capstone

Findings from this capstone will be used to generate a capstone project report. A manuscript will be submitted for publication (see Appendix D). A poster presentation was submitted to the VCNP annual professional conference in 2016.

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satisfaction: the mediating role of empowerment. *Journal of Advanced Nursing, 69*(4). 947-959. Retrieved from www.wileyonlinelibrary.com

Table 1
Demographic Information

Gender (n = 82)		
	Frequency	Percent
Female	81	97.6
Male	1	1.2
Calculated Participant Age (n = 81)		
	Frequency	Percent
20 – 29	2	2
30 – 39	14	17
40 – 49	18	22
50 – 59	26	32
60 – 69	18	22
70 +	3	4
Credentials (n = 83)		
	Frequency	Percent
No response provided	2	2.4
Acute Care NP	3	3.6
Primary Care	75	90.3
Psychiatric	3	3.6
Highest Level of Education (n = 83)		
	Frequency	Percent
Master's	64	77.1
DNP	13	15.7
PhD	6	7.2
Years' Experience (n = 83)		
	Frequency	Percent
Missing	1	1.2
0 – 10	34	40.9
10 – 20	31	37.4
20 +	17	20.5

Note. NP = nurse practitioner, DNP = Doctor of Nursing Practice, PhD = Doctor of Philosophy. Age was calculated from reported year of birth and categorized into decade intervals. Acute care category includes acute care nurse practitioners and adult gerontology acute care nurse practitioners. Psychiatric nurse practitioner category includes adult, family and psychiatric nurse practitioners. Primary care nurse practitioner category includes adult gerontology, adult, family, and pediatric nurse practitioners. Reported years' experience was combined into ten year intervals. Missing responses were not included in data analysis.

Table 2
Nurse Practitioner Site Census

NPs at Practice Site (n = 83)		
	Frequency	Percent
1	40	48.2
2 – 5	35	42.2
6 – 9	3	3.6
>10	5	6.0
Practice Site Part of Larger System (n = 83)		
	Frequency	Percent
No	28	33.7
Yes	55	66.3
Number of NPs in Larger Health System (n = 83)		
	Frequency	Percent
0 – 10	32	38,6
10 – 20	17	20.5
20 – 50	8	9.6
>50	26	31.3

Note. NP = nurse practitioner. Respondents who noted they were part of a larger health system where asked to identify total number of NPs employed within the system.

Table 3
Shared Governance

Response	Total Number (n = 83)	Percentage
Yes	25	30.1
No / I don't know	58	69.9

Note. Don't = do not. No and I don't know responses were combined into a single category.

Table 4
Nurse Practitioner Accountability Measures

Access to Productivity and Outcome Reports (n = 83)		
	Frequency	Percent
No response	1	1.2
Not at all	26	31.3
No, not on a regular basis	11	13.3
Yes, but not on a regular basis	8	9.6
Yes, on a regular basis	37	44.6
Type of Patient Visit (n = 83)		
	Frequency	Percent
Independent or Parallel Visits	79	95.2
Shared Visits	4	4.8
Type of Compensation (n = 83)		
	Frequency	Percent

No response	1	1.2
Salary	51	61.4
Salary plus incentive	31	37.3

Note. Compensation responses were categorized into two groups of salary and all other responses. Types of visits were combined into two groups. Responses that noted independent or parallel visits separate to physician visits were combined. Patient visits where NP and physician both see the patient were combined into the second group. Participants were allowed to provide multiple responses.

Table 5
How Productivity and Outcome Reports Affect NP Practice

How information is used	Frequency (n = 83)	Percent
No Response	18	21.7
Other	21	25.3
Affects Salary	12	14.4
Changes Daily Schedule	6	7.2
Affects Billing Practice	18	24
Affects Decision-making	8	9.6

Note. Results that included more than one response were combined to reflect first choice made by the participant.

Table 6
Billing Practices of NP in Ambulatory Care

Bill Type	Frequency (n = 83)	Percent
Other	18	21.7
Under my NPI	38	45.8
Incident to	18	21.7
Shared Billing with MD	9	10.8

Note. NPI = National Provider Number. Responses that included multiple responses were combined into shared billing category. Other responses did not include explanation for billing practice.

Table 7
Chi-squared Results

Question	Degrees of Freedom	Number	Value	X^2
Shared Leadership in Place	3	82	0.24	0.24
Credentials	12	83	2.05	0.36
Highest Level of Education	1	83	1.68	0.20
Years' Experience	12	83	6.84	0.87
Regional Affiliation	11	83	7.34	0.77

Compensation	3	82	0.24	0.97
Part of Larger Institution	1	83	0.08	0.77
How Patient Visit is conducted	6	83	0.42	1.00
Bill Under Own NPI Number	1	65	0.11	0.75

Note. Chi-square was used to compare practice characteristics between NPs who have a shared governance or leadership structure in place and those that do not.

Table 8
Involvement in Practice Partnerships

Themes	Number of Participants (n = 78)	Exemplars
No involvement	28	No formal practice partnership due to employment status (part-time employment), no formal practice partnership within organization, or the participant has decided not to participate
Limited involvement	9	"Limited administration over rules decisions despite great MD-NP collaboration" and "we have very little input into the decisions that have been made about the direction the group has taken over the years"
Collaborative	34	Weekly, bi-weekly and monthly team meetings that address concerns the NPs have, patient care coordination needs, and program development
Independent or solo	2	Function independently or in a solo setting and physician consultation occurs infrequently

Note. Themes were compiled from seventy-three written responses. Direct quotes were used when no other explanation was available.

Table 9
Practice Committee Involvement

Themes	Number of Participants (n = 78)	Exemplars
No or none	47	No practice committees within the organization or study participant is not

		involved
Yes	25	Committees included quality improvement, interdisciplinary teams, patient access, continued medical education, and clinical leadership

Note. Themes were compiled from seventy-two written responses.

Table 10
Practice Partnership Descriptions

Themes	Number of Participant Responses (n = 75)	Exemplars
Rarely	18	Rare or very infrequent interactions
Closely, collaborative and supportive	26	Positive collegial relationship
Formal agreement	4	Participants that noted a formal agreement where more likely to function independently or had an autonomous role

Note. Themes were compiled from forty-eight written responses. Participants provided single word responses.

Table 11
Role Development

Themes	Number of Participant Responses (n = 78)	Themes
Opportunities	45	Participants that noted opportunities to expand leadership roles, where encouraged to obtain new skills to improve patient care, and had many opportunities to expand clinical services.
Autonomous	3	Participants that noted having autonomous practice did not identify opportunities to be more independent
No or not applicable	20	Participants provided a simple no or N/A response
Limited	7	Several participants noted limited opportunities to discuss role development

		explaining that the main focus is on keeping up with the patient load and EMR. Expectation is that NPs function autonomously and see more and more patients."

Note. Themes were compiled from seventy-five written responses. Participants that answered "autonomous," "no or not applicable," or "limited" did not provide further explanations.

Table 12
Decision-making at the Executive Level

Themes	Number of Participant Responses (n = 76)	Exemplars
No	43	Rationale for no responses included lack of need, decisions are made by owners or directors, and size of institution as prohibiting factors.
Yes	28	Several participants provided direct yes answers with no further descriptive information. Responses included direct communication with administrators, open communication, and can express opinion
Minimal	5	Participants felt they could voice opinion if needed or asked

Note. Themes were compiled from seventy-six written responses. Participants answered "no," "yes," or "minimal" without further explanation.

Table 13
Perceived Practice Barriers

Themes	Number of Participant Responses (n = 71)	Exemplars
No Barriers	27	No barriers or restriction for their practices. Several participants noted that they function independently.
Barriers	42	Lack of role clarity, Medicare rules, state scope of practice

		restrictions (MD supervision is required), organizational restrictions, lack of structured leadership at practice or within organization, and lack of insurance credentialing.

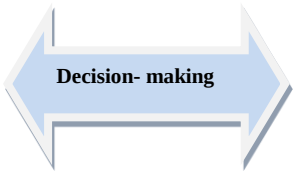
Note. Themes were compiled from sixty-nine written responses.

Table 14
Perceived Practice Supports

Themes	Number of Participant Responses (n = 64)	Exemplars
Organizational and Collaborative Support	16	Organizational and collaborative support.
CME/CEU Allowance and Reimbursement	8	Participants have a specific amount of annual funding for CME/CEUs which includes tuition reimbursement, financial support, paid time off and licensure and credentialing fees.
Continuing Education	15	Continuing education, attending professional conferences, technological support and on line tools such as "Up To Date".
Peer Interactions within Organization and Professional Organization Membership	4	VCNP and AANP provide support; "state laws and AANP guidelines"; networking at meetings are helpful in areas I'm not clear about."

Note. Themes were compiled from forty-three written responses.

Figure 1
Self-governance vs. Shared Governance



Centralized Interactions (Self-Governance)	**Decentralized Interactions (Shared Governance)**
Position-based	Knowledge-based
Distant from point of care/service	Occurs at point of care/service
Hierarchical communication	Direct communication
Limited staff input	High staff input
Separates responsibility/managers are accountable	Integrates equity, accountability, and authority for staff and managers
We/they work environment	Synergistic work environment
Divided goals/purpose	Cohesive goals/purpose, ownership
Independent activities/tasks	Collegiality, collaboration, partnership

Note. Illustration of basic differences between self and shared governance behavior and traits. Adapted from Shared Governance: A Practical Approach to Transform Professional by D. Swihart, 2011, p. 8. Copyright 2011 by HCPro, Inc. Retrieved from *http://www.hcmarketplace.com/prod-9581/Shared-Governance.html.*

Figure 2
From Hierarchy to Relational Partnership

From HIERARCHY	to	RELATIONAL PARTNERSHIP
Independence		Interdependence
Hierarchical relationship		Collegial relationship
Parallel functioning		Team functioning
Medical plan		Patient's plan
Resisting change		Leading change
Competing		Partnering
Indirect communication		Direct communication

Note. Professional Partnership Relationship Structure within Shared Governance. Model describes professional relationship change between healthcare providers, team members and patients. Adapted from Shared Governance: A Practical Approach to Transform Professional by D. Swihart, 2011, p. 11. Copyright 2011 by HCPro, Inc. Retrieved from *http://www.hcmarketplace.com/prod-9581/Shared-Governance.html*

Figure 3
Permission to use Questionnaire Tool

March 19, 2015

Kim Bednar
PO Box 96
Scottsville, Va. 24590

Dear Kim:

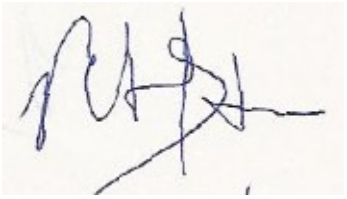
You have permission to use my instruments, the Index of Professional Nursing Governance (IPNG) and the Index of Professional Governance (IPG), for your DNP Capstone work at the University of Virginia. In return, I require that you:

- Report summary findings to me from the use of the IPNG/IPG, including reliability analysis, for tracking use and evaluating and establishing the validity and reliability of the IPG, and for possible research publication without identification of the institutions.
- Credit the use and my authorship of the IPNG/IPG in any publication of the research involving the IPNG.

A pdf of the IPNG/IPG can be downloaded for the Forum for Shared Governance's website at www.sharedgovernance.org. I will email the factor analysis-derived subscales, which are different than the subscales apparent in the instrument itself, along with text that can be used to construct the six governance subscales and the overall governance score in SPSS. I can forward the SPSS codebook for data entry. You might want to revise the demographic section to reflect the organization and/or units you're surveying, which I can have done for you.

Please don't hesitate to call upon me to discuss your process or if you need help managing the data. If you need me to perform data entry and analysis and to generate a formal report with benchmarking, there is a consultant fee. I am also available for onsite speaking or consultation. Thanks for thinking of the IPG and the Forum for Shared Governance. Good luck with your survey. I have attached an invoice.

Sincerely,

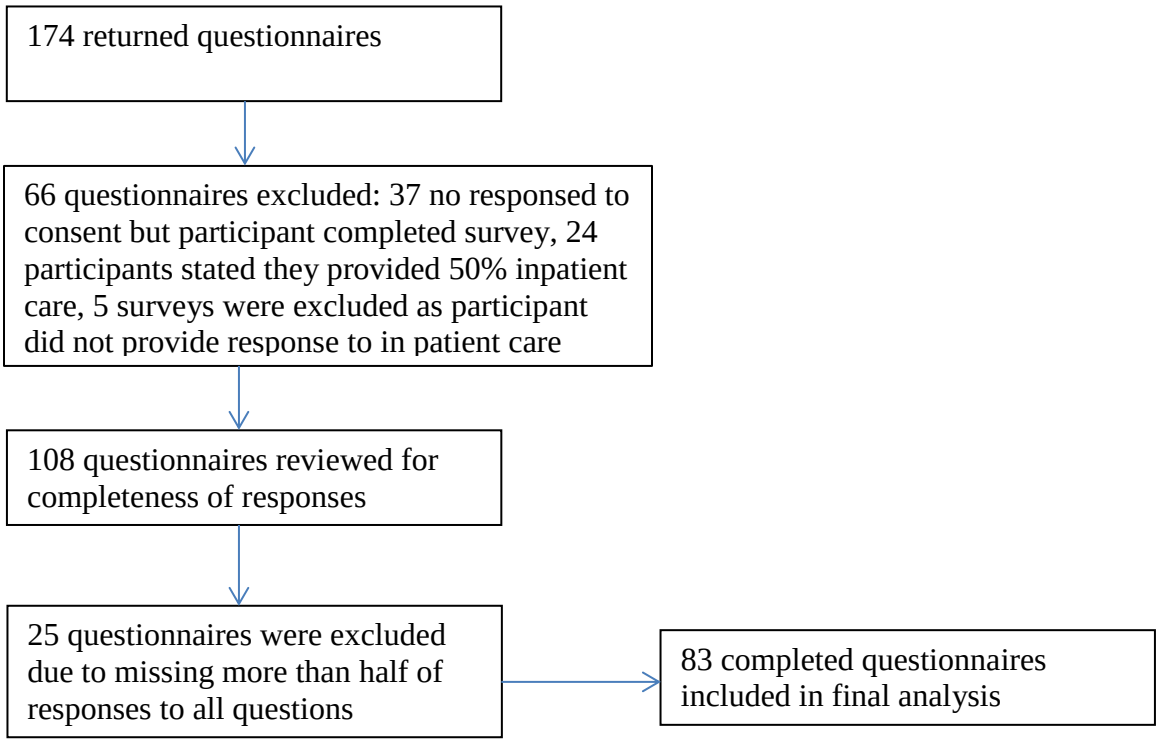


Robert Hess, PhD, RN, FAAN

Founder, Forum for Shared Governance

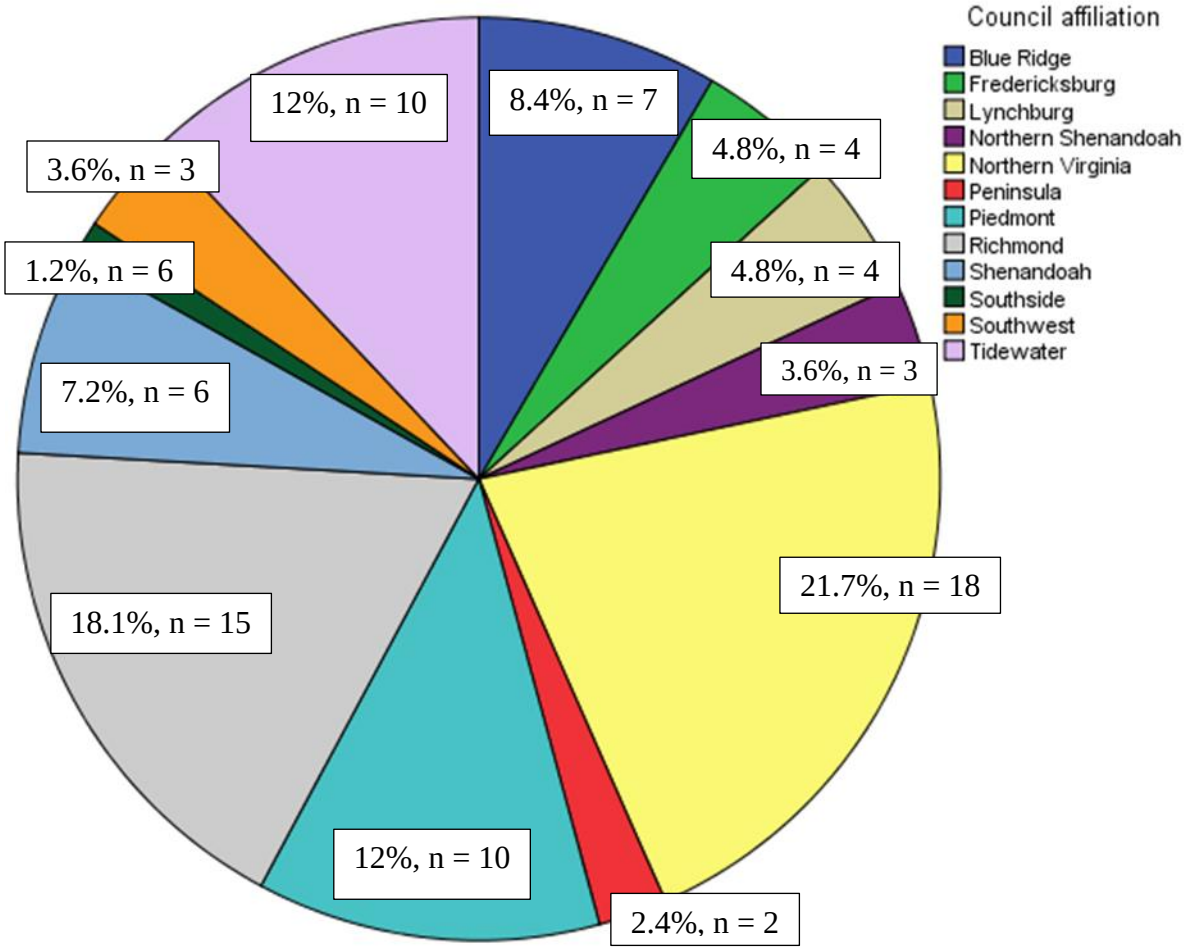
Note: Letter acknowledging permission to use components of shared governance questionnaire developed by Robert Hess, Phd, RN, FAAN. R. Hess (personal communication, March 19, 2015)

Figure 4
Questionnaire Inclusion and Exclusion Decision Diagram



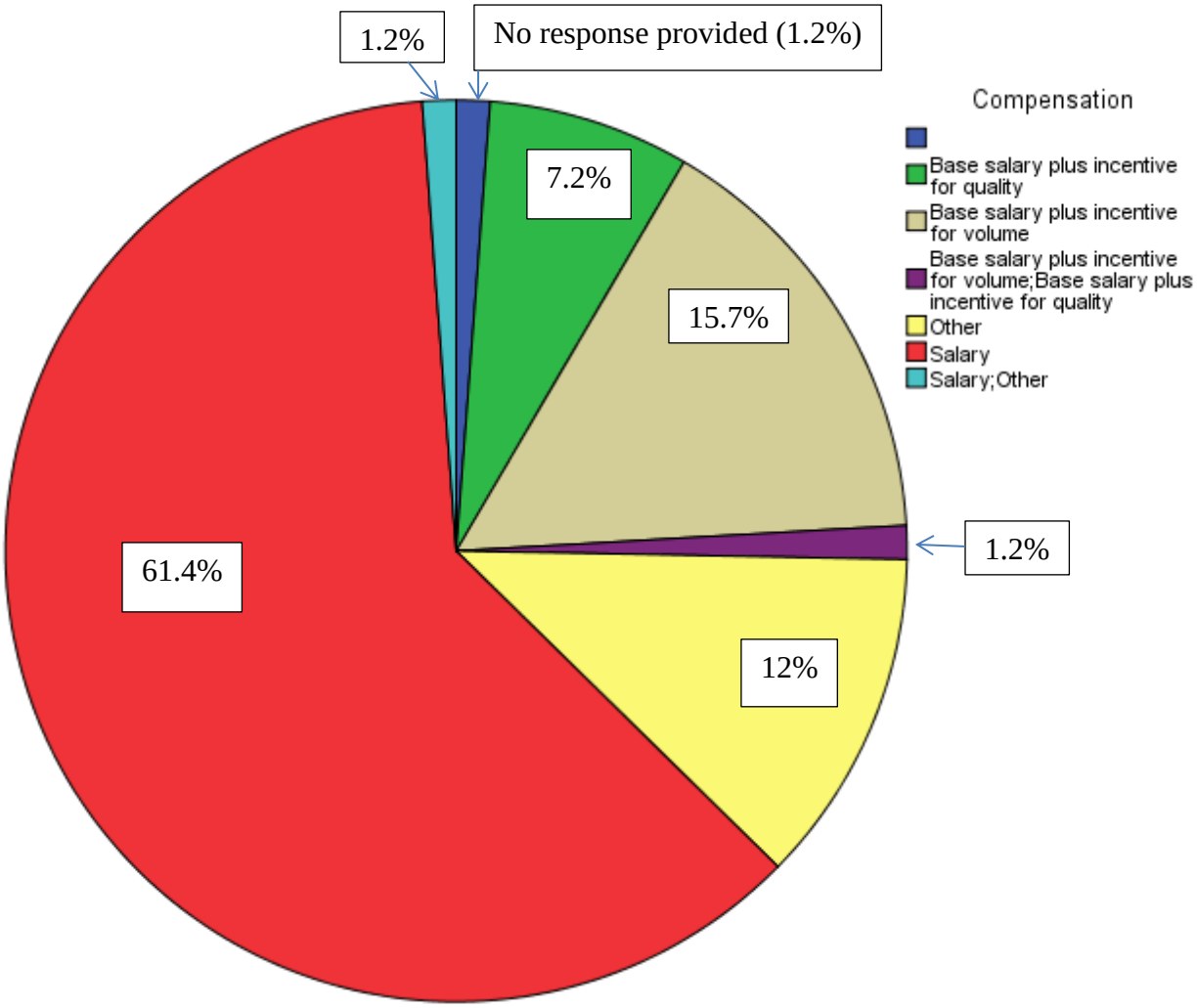
Note. Decision diagram explaining inclusion and exclusion of submitted questionnaires.

Figure 5
Participant Council Affiliation



Note. Pie chart diagram illustrates percentage and number of participants' VCNP regional affiliation.

Figure 6
Compensation Prevalence



Note. Compensation pie diagram illustrates percent of participants that responded to salary question.

Appendix A

Shared Governance Survey Questionnaire

APRN shared collaborative leadership supports APRN role maximization through well-defined institutional policies and procedures that are APRN driven, provide professional guidance, and enable APRN role development. APRN role maximization includes measures for accountability, supports professional partnerships with collaborating physician and executive administrators, and encourages practice equity through shared decision-making, and role ownership by inclusion of the APRN in practice policy and procedure development and adoption.

This questionnaire is aimed at answering whether or not APRNs are involved in collaborative practice model leadership?

1. Year of birth:

2. Gender:
   - ☐ Male
   - ☐ Female

3. What is your Nurse Practitioner Credential?
   - ☐ ACNP (Acute Care NP)
   - ☐ ANP (Adult NP)
   - ☐ AGACNP (Adult-Geriatric Acute Care NP)
   - ☐ AGPCNP (Adult-Gerontology Primary Care NP)
   - ☐ FNP (Family NP)
   - ☐ PMHNP - Psychiatric- (Mental Health NP)
   - ☐ GNP - (Gerontological NP)
   - ☐ PNP - (Pediatric Primary Care NP)

4. What is your highest level of education?
   - ☐ Master's Degree
   - ☐ DNP
   - ☐ PhD

5. Years of experience as nurse practitioner?
   - ☐ 0 – 5
   - ☐ 5 – 10
   - ☐ 10 – 15
   - ☐ 15 – 20

□ 20+

6. In your practice setting is there a dedicated APRN centralized collaborative leadership or shared governance?
   □ Yes
   □ No

7. How would you define your compensation policy?
   □ Salary
   □ Base salary plus incentive for volume
   □ Base salary plus incentive for quality

8. Which best describes the number of NPs in your practice?
   □ 1 - 5
   □ 6 – 9
   □ Greater than 10

9. Is your practice site part of a larger system?
   □ Yes
   □ No

   If yes, how many NPs are in your institution?
   □ 10 – 20
   □ 20 – 50
   □ More than 50

10. Practice partnership includes involvement with physician colleagues to address patient care needs such as access to care and provider availability. Practice committees can include wide organizational efforts (i.e. NP focus practice group) or site specific interdisciplinary groups (i.e. QI committee). Describe your involvement in practice committees:

11. Describe your professional partnership with your collaborating physician and administrative colleagues (i.e. chief executive officers)?

12. Are there opportunities to discuss role development (i.e. expanding clinic skills, leadership opportunities, or furthering autonomy)?

13. Do you receive productivity and outcome reports on a regular basis (monthly, quarterly)?
   □ Yes
   □ No

14. How is the information from the productivity or outcome report used? Check all that apply.
    - ☐ Determine billing practices,
    - ☐ Change daily schedule,
    - ☐ Effect salary,
    - ☐ Used for practice decision-making
    - ☐ other:_____

15. How are you most likely to submit you patient encounter bills?
    - ☐ Under my NPI number,
    - ☐ Incident to under the MD's NPI number,
    - ☐ Shared billing process
    - ☐ Other:_____

16. How do you conduct your patient visits?
    - ☐ Independent, without close or direct MD supervision
    - ☐ Parallel to MD provider (in office with collaborating MD but have separate patient visits)
    - ☐ Tangent to MD provider (shared patient visits)

17. Do you make decisions at the executive level that effect NP practice within your institution or practice setting?
    - ☐ No
    - ☐ Yes: Please describe with title and function:

18. Practice barriers can include but are not limited to organizational restrictions, lack of administrative support, lack of role clarity, and lack of structured leadership.

    Please list any barriers that prevent your ability to function at the highest level of your preparation or limit your desired professional role:

19. Practice supports can include but are not limited to structured leadership, structured committees or counsels, and educational opportunities.

    Please list supports that enable your ability to function at the highest level of your preparation or promote your desired professional role development:

Appendix B

Informed Consent Agreement

Please read this consent agreement carefully before you decide to participate in the study.
Purpose of the research study: The purpose of the study is to investigate how shared government impacts Advanced Practice Registered Nurse (APRN) ambulatory practice in regards to APRN role expansion, clinical practice work environment, and APRN inclusion in leadership role development.

What you will do in the study: Data will be collected from licensed Nurse Practitioners who are members of the Virginia Counsel of Nurse Practitioners (VCNP) in the Commonwealth of Virginia. A fifteen question survey will be sent to VCNP members.

Time required: The study will require about 30 minutes of your time.

Risks: There will not be direct benefits to you as a participant in this study. However, indirectly you may realize strengths and weaknesses in your current practice setting.

Benefits: There are no direct benefits to you for participating in this research study. The study may help us understand APRN shared governance programs within health care organizations. APRNs can use this information to model work environment change, become involved in interdisciplinary leadership counsels, push for inclusion at the executive table, and be empowered to direct role expansion.

Confidentiality:

The information that you give in the study will be handled confidentially. Your data will be anonymous which means that your name will not be collected or linked to the data. Because of the nature of the data, it may be possible to deduce your identity; however, there will be no attempt to do so and your data will be reported in a way that will not identify you.

Voluntary participation: Your participation in the study is completely voluntary.

Right to withdraw from the study: You have the right to withdraw from the study at any time without penalty.

How to withdraw from the study: Please contact Kimberly Bednar at kls6r@virginia.edu to withdraw your survey answers. You will be asked questions regarding your responses to open ended questions in order to identify your specific questionnaire. All attempts will be made to identify your responses and remove your questionnaire.

If you have questions about the study, contact:
Kimberly S. Bednar, FNP
Family Medicine
Lake Monticello Primary Care
112 Crofton Place
Palmyra, Va. 22963
Telephone: (434) 589-9030
kls6r@virginia.edu

Faculty Advisor:
Kenneth White, PhD
Associate Dean for Strategic Partnerships & Innovation at the School of Nursing
University of Virginia, School of Nursing
University of Virginia, Charlottesville, VA 22903.
Telephone: (434) 924-0091
krw6cc@virginia.edu

If you have questions about your rights in the study, contact:
Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences
One Morton Dr Suite 500
University of Virginia, P.O. Box 800392
Charlottesville, VA 22908-0392
Telephone: (434) 924-5999
Email: irbsbshelp@virginia.edu
Website: www.virginia.edu/vpr/irb/sbs
Agreement:

I agree to participate in the research study described above.

Checking the box agreeing to participate in the study will take place of your signature.

Signature: _____ Date: _____

Appendix C

In reply, please refer to: Project # 2015-0246-00

June 22, 2015

Kimberly Bednar and Kenneth White
Academic Divisions
PO Box 96
Scottsville, VA 24590

Dear Kimberly Bednar and Kenneth White:

Thank you for submitting your project entitled: "Leadership and Collaboration among Ambulatory Care Nurse Practitioners in Virginia" for review by the Institutional Review Board for the Social & Behavioral Sciences. The Board reviewed your Protocol on June 22, 2015.

The first action that the Board takes with a new project is to decide whether the project is exempt from a more detailed review by the Board because the project may fall into one of the categories of research described as "exempt" in the Code of Federal Regulations. Since the Board, and not individual researchers, is authorized to classify a project as exempt, we requested that you submit the materials describing your project so that we could make this initial decision.

As a result of this request, we have reviewed your project and classified it as exempt from further review by the Board for a period of four years. This means that you may conduct the study as planned and you are not required to submit requests for continuation until the end of the fourth year.

This project # 2015-0246-00 has been exempted for the period June 22, 2015 to June 21, 2019. If the study continues beyond the approval period, you will need to submit a continuation request to the Board. If you make changes in the study, you will need to notify the Board of the changes.

Sincerely,

Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences

Appendix D

INSTRUCTIONS FOR AUTHORS

Nursing Administration Quarterly (NAQ) is a peer-reviewed publication. Authors are encouraged to submit articles to NAQ that provide nursing administrators with practical, up-to-date information on the effective management of nursing services for modern health care systems. NAQ focuses on presenting timely research, issues and debate geared toward enhancing administrators' conceptual understanding of the administrative process and administrators' knowledge base and skills. Acceptance or rejection of an article is based on the judgment of peer reviewers. Since NAQ is topically focused, authors are advised to review current issues and **www.naqjournal.com** for future topics and deadlines for submission.

MANUSCRIPT SUBMISSION

Online manuscript submission: All manuscripts must be submitted online through the new web site at **http://www.editorialmanager.com/naq/. First-time users:** Please click the Register button from the menu above and enter the requested information. On successful registration, you will be sent an e-mail indicating your user name and password. *Note:* If you have received an e-mail from us with an assigned user ID and password, or if you are a repeat user, do not register again. Just log in. Once you have an assigned ID and password, you do not have to re-register, even if your status changes (that is, author, reviewer, or editor). **Authors:** Please click the log-in button from the menu at the top of the page and log in to the system as an Author. Submit your manuscript according to the author instructions. You will be able to track the progress of your manuscript through the system. All co-authors that are identified as contributing authors on a submission are required to be registered on the site and verify that they are a contributor on the submission. The Journal requires that every author has an account. If you experience any problems, please contact Linda Pickett at lindapickett@catholichealth.net, phone: 303-383-2706, fax 303-383-2699.

LWW AUTHOR'S MANUSCRIPT CHECKLIST FOR JOURNALS

Authors should pay particular attention to the items below before submitting their manuscripts.

Manuscript Preparation

- Manuscripts should be created on IBM-compatible (PC) equipment using Windows 95 or higher operating system. Our preferred software is Microsoft Word.
- Artwork submitted should be saved as TIFF or EPS files. See Figure guidelines.
- Manuscripts should be double spaced (including quotations, lists, and references, footnotes, figure captions, and all parts of tables).
- Manuscripts should be ordered as follows: title page, abstracts, text, references, appendixes, tables, and any illustrations.
- It is suggested to keep your manuscript between 12 to 15 pages and limit number of references to those which are essential. Page count includes abstract, references, tables, and diagrams.

Manuscript Contents Each manuscript **must** include the following:

- Separate Title page including (1) title of the article, (2) author names (with highest academic degrees) and affiliations (including titles, departments, and name and location of institutions of primary employment), (3) corresponding author's name and complete address including email, and (4) any acknowledgments, credits, or disclaimers. The title page must also include disclosure of funding received for this work from any of the following organizations: National Institutes of Health (NIH); Wellcome Trust; Howard Hughes Medical Institute (HHMI); and other(s).
- Abstract of 200 words or fewer describing the main points of the article. If it is a research article, prepare a structured abstract describing (1) what was observed or investigated, (2) the subjects and methods, and (3) the results and conclusions. Also include 3-5 key words that describe the contents of the article like those that appear in the *Cumulative Index to Nursing and Allied Health Literature* (CINAHL) or the *National Library of Medicine's Medical Subject Headings* (MeSH).
- **Manuscript text pages should not include authors names** (for proper peer review)
- Clear indication of the placement of all tables and figures in text.
- Signed copyright transfer form with signature from all authors or U.S. Government Work form (see above).
- Completed article submission form for each contributor (see above).
- Written permission, including complete source, for any borrowed text, tables, or figures.

References

- References must be cited in text and styled in the reference list according to the *American Medical Association Manual of Style*, Ed. 10, Copyright 2007, AMA.
- References should not be created using Microsoft Word's automatic footnote/endnote feature.
- References should be included on a separate page at the end of the article and should be double spaced
- References should be numbered consecutively in the order they are cited; reference numbers can be used more than once throughout an article.
- Page numbers should appear with the text citation following a specific quote.

Here are some examples of correctly styled reference entries.

Journals: Author, article title, journal, year, volume, issue, inclusive pages.

Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay-for-performance: from
concept to practice. *JAMA*. 2005;294(14):1788-1793.
Arnold E. Managing human resources to improve employee retention. *Health Care Manag*. 2005;24(2):132-140.

Books: Author, book title, place of publication, publisher, year.

Liebler JG, McConnell CR. *Management Principles for Health Professionals*. 4th ed.

Boston, MA:
Jones and Bartlett; 2004.
Cox K, Huber D. Managing time and stress. In: Huber D, ed. *Leadership and Nursing Care Management*. 3rd ed. St Louis, MO: Elsevier; 2006;83-108.

For *multiple authors in journals and books*:

- If six or fewer, list all authors
- If more than six, list the first three followed by et al.

Figures:

A) Creating Digital Artwork

1. Learn about the publication requirements for Digital Artwork: http://links.lww.com/ES/A42
2. Create, Scan and Save your artwork and compare your final figure to the Digital Artwork Guideline Checklist (below).
3. Upload each figure to Editorial Manager in conjunction with your manuscript text and tables.

B) Digital Artwork Guideline Checklist

Here are the basics to have in place before submitting your digital artwork:

- Artwork should be saved as TIFF, EPS, or MS Office (DOC, PPT, XLS) files. High resolution PDF files are also acceptable.
- Crop out any white or black space surrounding the image.
- Diagrams, drawings, graphs, and other line art must be vector or saved at a resolution of at least 1200 dpi. If created in an MS Office program, send the native (DOC, PPT, XLS) file.
- Photographs, radiographs and other halftone images must be saved at a resolution of at least 300 dpi.
- Photographs and radiographs with text must be saved as postscript or at a resolution of at least 600 dpi.
- Each figure must be saved and submitted as a separate file. Figures should not be embedded in the manuscript text file.

Remember:

- Cite figures consecutively in your manuscript.
- Number figures in the figure legend in the order in which they are discussed.
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Practice Collaboration Perspectives among Ambulatory Care Nurse Practitioners in Virginia

Kimberly S. Bednar, MSN, FNP-C
Department of Family Medicine, University of Virginia

Kenneth White, PhD, APRN-BC, FACHE, FAAN
School of Nursing, University of Virginia

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Abstract

Introduction: Advanced Practice Registered Nurses (APRNs) have assumed more clinical practice responsibilities and are serving as population health leaders. In addition to clinical practice, the APRN's leadership involvement with their physician and administrator colleagues at the decision-making table is necessary for inter-professional collaboration and organizational alignment. Bridging the gap between administration and practice is complicated by historical antecedents, professional boundaries, and organizational cultures. Provider-specific leadership that supports scope of practice and defines institutional regulations may guide the APRN's path to the administrative table. This study examined how one group of APRNs, nurse practitioners (NPs), perceive leadership opportunities, define collaborative partnerships, and describe involvement in the non-clinical aspects of the practice organization.

Purpose: The constructs of partnerships, practice equity, accountability, ownership, and power as defined by the shared nursing governance model were used to develop a questionnaire that examined leadership characteristics and concepts utilized in NP ambulatory practice settings in Virginia.

Method: A twenty-five mixed method questionnaire was emailed to NP members of the Virginia Council of Nurse Practitioners.

Discussion: Data from 108 questionnaires were analyzed. Seventy percent of respondents do not have a shared governance model associated with their practice setting. The information from this research provides a platform for NP groups to open dialog with health care institution executives about accountability limitations within organizations as well as advocate for advanced practice provider-specific leadership.

Keywords: advanced practice registered nurses, shared governance, role development, Kanter's theory of structural empowerment.

Practice Collaboration Perspectives Among

Ambulatory Care Nurse Practitioners in Virginia

Introduction

In the latter part of the 20th century, great strides were made in developing the professional model of nursing practice (Cleland, 1978). Professional nursing practice is viewed as a collaborative approach with nurses making decisions about the various aspects of their practice, such as quality improvement, safety, professional development, clinical research, and communication with strategic partners. In the early 21st century, the numbers of advanced practice registered nurses (APRNs) began to grow in numbers and where characterized as "physician extenders" for selected patient care needs. In response to emerging confusion regarding APRN nomenclature and to clarify educational and certification requirements, the APRN consensus model was developed to delineate advanced practice roles in association to health care needs (NCSBN, 2008). As APRNs grew in number and became more visible in health care, various reports were issued to support APRNs providing patient care to the fullest extent of their educational preparation and statutory scope of practice (NCSBN, 2008; NONPF, 2013). These national nursing recommendations were further supported by the Institute of Medicine report entitled *The Future of Nursing: Leading Change, Advancing Health* (2013) and The Patient Protection and Affordable Care Act of 2010 [hereinafter referred to as the ACA] legislation which called for APRNs to practice at the top of their license and to assume a greater clinical and leadership role in primary care and population health, especially in underserved areas. What is not well-defined is how specific APRN specialty groups such as nurse practitioners (NPs) enact effective clinical and leadership roles with other NPs and physician colleagues to make clinical and non-clinical decisions related to their collaborative practice.

Shared Governance in Nursing

Shared governance was first described by Virginia Cleland (1978) as a governing model that addressed professional nursing employee and management relations in institutions where collective bargaining existed. Cleland (1978) noted components of shared governance that allowed the professional nurse to develop their full potential as a health care provider whereby they were able to develop structures that unified nursing control over practice. Since, the inception of shared governance, application of professional nurse-structured leadership has been limited to bedside nursing staff. In ideal structured nursing leadership environments, committees within a shared governance model include shared power, control and decision-making with the professional nurse (Anthony, 2004). The structure enables the professional nurse to be accountable for their own practice, include pathways for legislative authority to develop practice policies, and allows the professional nurse to be responsible for devising and implementing practice quality and standards (Cleland, 1978). The professional nurse is then responsible for, has authority for and is accountable for their practice. Active participation in the process allows the nurse to have a sense of practice ownership, and have power and control in the delivery of patient care (Porter-O'Grady, 2004).

Effective shared governance models foster professional responsibility, interdisciplinary partnerships, and commitment to the organization by expanding authority and accountability for practice (Porter-O'Grady, 1991). The process decentralizes management and creates an empowered work environment through principles of partnership, equity, accountability, and ownership (Scott & Caress, 2005; Swihart, 2011). The work environment, within a shared governance structure, promotes autonomy, provides authority for decision-making and defines accountability for outcomes (Porter-O'Grady, 1991).

The principles of shared governance in nursing may also be applied to the advanced practice registered nurses (APRN). APRNs are nurses that have completed graduate level education and have met clinical practice requirements to provide patient-focused health care services and to improve patient outcomes within a clinical specialty (Hamric, Hanson, Tracy, & O'Grady, 2014). For purposes of this paper, the discussion of APRN practice will be limited to nurse practitioners (NPs) who practice in ambulatory settings. The shared governance principles of practice autonomy, independence, and empowerment are particularly germane to nurse practitioners. Application of these principles include the ability to fully participate in shared decision-making processes that impacts patient care delivery; supports practice partnerships with other NPs, administrators and physician colleagues; and, provides a format for greater practice accountability and guidance as may be seen in Figure 1 (Swihart, 2011; Anthony, 2004).

Shared governance provides structure and resources that address challenges that NPs face in providing a longitudinal source of health care, increasing access to care and removing barriers to needed health care services (Healthy People 2020, 2014). Shared governance is a practice-empowerment process that fosters and builds sustainable support for the NP in the clinical setting (Porter-O'Grady, 2001). The ability to improve access to care and to be instrumental in institutional and practice policy changes relies heavily on knowledge and mastery of health-related leadership skills. Adoption of shared governance allows the NP to possess control over practice and improve quality of care provided through concepts of partnership, equity, accountability, and ownership (Swihart, 2011).

A specific goal of shared governance applicable to NP practice is to ensure a collegial practice with colleagues that foster a work environment that enables the team to work closely with patients in order to develop a patient-centered shared health care decision-making process.

Shared governance strengthens professional development so that the APRN is able to practice at the highest level of preparation and expand evidence based practice through interdisciplinary team work and improve quality of care (Scott & Caress, 2005).

Relevant Environmental Pressures

The passage of the ACA ensured that millions of Americans would have increased access to care (HHS, 2010). Increased patient care needs have provided opportunities for expanded utilization of APRNs as front line health care providers. The American Association of Nurse Practitioners (AANP) (2014) reports more than 200,000 nurse practitioners (NPs) are employed in the United States of which more that 87 percent provide primary care. Nurse practitioners represent the largest proportion of APRNs who are being utilized as a health care provider source in ambulatory patient care settings. The inclusion of NPs as ambulatory health care providers has expanded their visibility which, in turn, has created a flurry of legislative discussion and practice regulation changes in many states (AANP, 2015).

The Institute of Medicine (IOM) (2011) and the Federal Trade Commission (FTC) (2014) have proposed removing practice restrictions for NPs in order to increased access to care and meet the demand for primary care providers. State practice restrictions and barriers limit the NP's ability to perform at their highest level of preparation, prevent the NP from inclusion at the executive table, and prevent the NP from being actively engaged as an equal partner in health care practice decisions. Further, administrative policy within health care institutions and individual practice sites may also limit the NP from being actively engaged in role expansion and development that includes shared leadership or practice governance.

Promoting the expansion of NP practice and appropriate utilization has been recommended as an effective solution to increased health care access demands (AANP, 2015).

Expansion of practice would include accepting NPs as clinical and population health care leaders thus changing the dynamics of the NP professional relationships with physician and administrator colleagues. Strains in professional relationships can develop when NPs are not included in shared leadership and practice governance due to an unclear understanding of scope of practice and institutional regulations.

Each state board of nursing has the capacity to define NP licensure. However in some states, the board of medicine is joined with the board of nursing to provide NP licensure and scope of practice regulations. Scope of practice laws can include the need for collaborative agreements, physician oversight, patient care responsibilities, and prescriptive authority. The health care institution is then charged with the responsibility of regulating credentialing oversight and establishing practice privileges as can be seen in Figure 3 (Robert Wood Johnson Foundation [RWJF], 2009).

Variability in NP practice becomes increasingly problematic when attempting to match health care access demands to available providers within a convoluted and confused understanding of state licensure laws and institution regulations. Appropriate provider resource utilization has been considered an administrative clinical problem in that employers often rely on the physician as the primary focus of the ambulatory clinical setting and the NP as an adjunct to the physician (Cronenwett & Dzau, 2010). Opposed to employing NPs as a bridge, optimizing NP function in the ambulatory setting makes more sense in addressing patient care access. Building an environment that ensures NPs are practicing at the fullest extent of their preparation requires a clear understanding of the NP's capabilities, scope of practice and subsequent restrictions. Furthermore, the administrative environment that encourages full participation from the NP through processes of shared governance encourages the NP to have authority for and

ownership of their practice. Nurse practitioners are then able to have a voice in their practice development which improves job satisfaction and empower the NPs to perform at their highest level of preparation within their full scope of practice.

Nurse Practitioners in Virginia

In the Commonwealth of Virginia, NPs are required to have a practice agreement with a collaborating physician and are considered members of a care team (Virginia Board of Nursing [BON], 2016). By implementing effective components of shared governance, valuable information can be gleaned that ensures the NP is able to function at their fullest extent of preparation, reduce practice barriers, improve access to health care, and build a stronger care team. Clinical and credentialing standards can be established, NP specific practice policies can be implemented, and leveled leadership can be shared through collegial NP lead committees which are cornerstones of a shared governance process. Shared governance allows NPs to be full and equal partners with physician and administrative leadership in health care practice policy development and improvement. Defining specific roles within shared governance of authority, scope of responsibility, administrative structure, and gaps in NP practice, the NP workforce would be suited to lead health care change.

Literature Review

A systematic literature review was performed to identify and evaluate shared governance and leadership practices and the implications for nurse practitioner practice. The search included the electronic databases CINAHL, MEDLINE, PschyInfo, PubMed, and Google Scholar from January 2003 to October 2014. Due to the paucity of research on shared governance and NP practice, the time period for the search was extended to an eleven year period in order to expand the numbers of available publications. Studies included for review were those written in English

that addressed APRNs' leadership perceptions and included nursing administrative leadership. Studies performed outside the United States that including APRN leadership were also included for review. Key words of "clinical governance," "shared governance," "ambulatory care," "advanced nursing practice," "advanced practice nurse," "leadership," and "work environment" were used in various combinations when searching databases.

Centralized Leadership

A centralized leadership model has been shown to promote professional leadership opportunities and development. Key components of a centralized leadership model ensure that NPs are able to be effective health care providers and leaders by practicing to the fullest extent of their licensure and educational training.

Ackerman, Mick, & Witzel (2010) in an article describing "The Margaret D. Sovie Center for Advanced Practice" stated that establishing centralized coordination centers within healthcare organizations provide a well-managed resource for core advanced practice functions, definitions, and role descriptions. The authors (Ackerman, Mick, Witzel, 2010) describe an advanced practice provider-specific leadership model that focuses on continuing education, professional development, practice innovation, and regulatory oversight which provide positive support for the advanced practice provider and bridge the gaps between the physician provider model and the nursing model. These researchers concluded that centralized formal leadership development and support provides core resources for advanced practice providers within healthcare institutions.

Bahouth and researchers (2013) performed a qualitative study that focused on six large academic medical centers, in order to identify common experiences with developing centralized leadership structures that support and provide oversight for nurse practitioners in large hospital

settings. The results indicated that centralized nurse practitioner leadership provides resources that empower NPs to function at their highest level of preparation. The authors comment that centralized leadership can increase NP visibility through demonstration of contributions to the health care delivery system, and gives credence to the importance of organizational empowerment as it relates to professional practice development (Bahouth et al, 2013). Additionally, clarifying NP roles and developing standardized professional practice models supports expert NP practice and improves delivery of comprehensive health care. Bahouth and researcher (2013) also identified leadership characteristics that contributed positively to NP governance. These included being a champion of practice, knowledgeable of institutional systems and policies, being politically astute regarding philosophical issues, and becoming known for quality leadership within the health care organization.

Oliver (2006), in a professional issues article describing leadership in health care, expressed the opinion that individual leadership styles and skills fosters role development including empowering the practitioner to implement change, be expert clinical decision-makers, work independently, and be effective collaborators. The author noted leadership skill development improves delivery of patient care and increases the practitioner's visibility as a valued member at the administrative table.

Work Environment

Lankshear, Kerr, Laschinger, and Wong (2013), in a study of positive work environments, concluded that professional practice leadership (PPL) improved the professional environment by clarifying role perceptions and functions. These researchers (2013) described organizational support as the implementation of leadership tactics such as professional practice functions of role assignments and accountability. The researchers state the power of an

organization with a positive work environment relates directly to the PPL role and accountability (Lankshear et al., 2013).

Role Development

Poghosyan et al. (2013) performed a qualitative study examining nurse practitioners' perceptions of barriers and facilitators of scope of practice as primary care providers. The researchers concluded that work environments that include restrictive regulatory practices and government regulations, unclear administrative views of practice, and variations between organizations interfere with the NP's ability to improve or ensure quality of care provided (Poghosyan et al., 2013). The researchers noted poor infrastructure and relationships with administrators limit perceived NP role development and support (Poghosyan et al., 2013). Poghosyan et al. (2013) noted that NP role expansion and development is further restricted by non-involvement in administrative decision-making, lack of in-place organizational structures that support scope of practice, and absence of executive level inclusion.

Following a qualitative meta-summary that examined characteristics of advanced practice nursing, Hutchinson et al. (2014) concluded that advanced practice characteristics extended autonomous advanced nursing clinical practice, encouraged collaborative practice relationships with other health care professionals, and included opportunity for leadership external to the organization. The authors concluded that developing practice improves overall care delivery and promotes collaboration (Hutchinson et al, 2014).

Summary and Conclusion

Findings of this literature review supports the positive influence of centralized NP-specific shared governance on advanced practice development. Establishing a centralized NP leadership structure with clear and concise pathways enables the NP to address clinical concerns

and perform quality improvement projects that reduce barriers to access to care (Bahouth et al., 2013). Effective centralized leadership programs such as shared governance based on authentic leadership techniques (Lankshear et al., 2013) provides a positive work environment, improves NP organizational commitment, and improves NP visibility. Leadership structures that support autonomous practice, encourage collaboration, and encourage professional development promote advanced nursing practice (Hutchinson et al, 2014). Unfortunately, organizations that have poor leadership infrastructures that perpetuate unclear understanding of the NP role limit the NP's perceived opportunities for role development and support (Poghosyan et al., 2013).

Limitations of this literature review included a small descriptive report (Bahouth et al., 20130, a self-reported nursing survey which is subject to participant bias (Lankshear et al., 2013), and administrative articles (Ackerman, Mick, Witzel, 2010; Oliver, 2006).

The lack of literature specifically addressing shared governance and leadership involvement of NPs supports the research question of this capstone. Namely, there is a need to explore ways that NPs participate in shared governance and leadership with other NPs, physicians and administrator colleagues.

Methods

Introduction

The purpose of this study was to examine the impact of shared leadership concepts of partnership, equity, accountability and ownership as defined in the shared governance model on nurse practitioners in ambulatory care settings. The questions under examination are: Are NPs who provide patient care in ambulatory settings engaged, empowered, and involved in clinical and non-clinical decision-making with their NP, physician, and administrator colleagues? And if so, what are the characteristics that describe these shared leadership models?

Study Design

This study employed a mixed methods approach designed to describe shared leadership or governance processes within nurse practitioner ambulatory practice settings. The shared governance constructs of partnerships, equity, accountability, and ownership were assessed though dichotomous, multiple choice and open-ended questions. Questions addressed collaborative partnerships with physician and administrator colleagues, perceived barriers and perceived supports for NP practice, access to accountability measures through productivity reports and outcome measures, and involvement in practice progression and role development.

Survey Instrument

The questionnaire contained twenty-five dichotomous, multiple choice and open-ended questions that were crafted from the literature and adapted from nursing governance tools developed and validated by leaders in the field (see Appendices A). Kanter's theory of structural empowerment guided questions pertaining to perceived level of power regarding executive level decision-making and perceived practice barriers and supports. Permission to use questions from professional nursing governance tools developed by Hess (1998) was obtained. The questionnaire was validated through the Public Health Sciences resource available through the University of Virginia Health Sciences Library.

The electronic questionnaire was crafted using the University of Virginia, School of Nursing secure survey tool through SelectSurvey.Net.

Demographic information included gender, age, licensure, highest level of education in nursing, and years of experience.

Participants were asked if there are shared governance structures in place within their organization or practice site. Participants were also asked if they are involved in administrative

processes that address their role as a care provider and if they are included on administrative executive boards. Administrative processes included structured and non-structured meetings addressing practice partnerships, involvement in practice committees that address patient care access needs at practice sites. Scope of practice was evaluated by inquiring about billing practices, access to productivity and outcomes data, and patient care visit specifics. Billing practice questions inquired how the NP submits patient encounter bills: under their National Provider Identifier (NPI) number, through "incident to" billing, or shared billing. Accountability was examined by addressing access to productivity and outcomes reports and how that information was used to influence practice. Practice ownership was evaluated by inquiring about patient care visit specifics such as how patient visit are typically conducted: independent, tangential, or parallel.

Study Setting and Sample

There are over 8,000 APRNs in the Commonwealth of Virginia (VNA, 2014). Virginia APRN titling groups include licensed nurse anesthetists, licensed nurse midwives and licensed nurse practitioners. NPs represent the large proportion of the APRNs and account for more than six thousand licensed advanced practice nurses in Virginia (VNA, 2014). In order to gain insight into ambulatory patient practice, participant recruitment was limited to nurse practitioners.

The participants in this study were drawn from a convenience sample of NPs who are members of a state wide association, the Virginia Council of Nurse Practitioners (VCNP). There are over 1,700 licensed, retired, and student nurse practitioner members affiliated with the VCNP (VCNP, 2015).

The specific inclusion criteria for this study are: licensed nurse practitioners who are employed in ambulatory care setting.

The exclusion criteria are: nurse practitioner student status, retired status, NPs who provide more than fifty percent in patient care services, and nurses who are not licensed as nurse practitioners.

Protection of Human Rights

The proposal was approved on June 22, 2015 by the University of Virginia Health Sciences Institutional Review Board (IRB). Data was stored in the University of Virginia School of Nursing survey tool and on a personal computer with password protection. Information will be destroyed after completion of the capstone project and the publication of results. There was no compensation provided for participation in this study.

There were no direct risks or benefits associated with study participation. However, study participants may have indirectly realized strengths and weaknesses within their current practice setting.

Procedures

After Institutional Review Board approval and designation as an exempt study in the University of Virginia, the state president of the VCNP and administrative assistant were contacted in person and via email to inquire about permission to distribute the questionnaire to active members. The VCNP did not require a fee for the two separate email distributions.

The survey was distributed to 1,716 NP email addresses maintained by the VCNP. There were three new email addresses added following the initial distribution list. Group email allowed distribution of the questionnaire to NP members throughout the state simultaneously. The questionnaire was accessible to VCNP nurse practitioner members for a thirty day survey access time period. For reminders and follow up, there was one membership group email sent fourteen days after the initial email distribution.

Active members received the initial survey email on July 2, 2015. The reminder email was sent on July 16, 2015. Eight hundred active VCNP members opened the initial email following the July 2nd distribution. There were fourteen "bounce-back" emails at that time. Six hundred and forty-two active VCNP members opened the reminder email following the July 16th distribution. There were twelve "bounce-back" responses following the reminder survey email.

Informed consent was attached to the questionnaire. Participants were asked to acknowledge consent prior to proceeding to questionnaire. In order to limit participation to NPs who primarily practice in ambulatory care, an initial question inquiring ambulatory or in-patient care provider status was asked. NPs with more than 50% of their patient care time allocated towards in-patient care services were asked not to complete the survey.

Data Analysis

One hundred seventy-four responses were returned following the distribution of the survey to 1,716 NP email addresses. This is a 10% return rate which was within the expected return rate of 5 to 20% (Fan & Zhegn, 2010). One hundred and eight completed questionnaires were considered for final analysis. Thirty-seven questionnaires were excluded from final analysis due to participants providing "no" to informed consent but submitted a completed questionnaire. An additional twenty-four returned questionnaires were excluded as participants answered "yes" to clinical responsibilities include more than 50% inpatient care. Five more completed questionnaires were excluded as participants did not provide an answer regarding inpatient care responsibilities. One hundred and eight questionnaires were reviewed for completeness. An additional twenty-five questionnaires were excluded as participants failed to complete the survey beyond answering demographic information. A total of 83 questionnaires were used for the final analysis. Figure 3 illustrates questionnaire inclusion decision-making.

Statistical analysis was performed using IBM SPSS Statistics for Windows, Version 22.0. Descriptive statistics was performed to describe total sample using percentages of gender, age, years' experience as a NP, highest level of nursing education, and licensure. Chi – squared analysis was performed on categorical variables to determine if there were statistical differences between NPs who have shared governance structure in place and NPs who do not. Qualitative responses were analyzed by the author and capstone committee chair. Common themes were summarized in a narrative description (Sandelowski, 2000). Cronbach's alpha was performed on qualitative questions to determine internal reliability between questions. The Cronbach's alpha for questions addressing practice partnerships, involvement in partnerships, interactions with professional colleagues, and opportunity to discuss role development was 0.855. The Cronbach's alpha was 0.779 for questions addressing contributions to decision-making at the executive table, perceived practice barriers and perceived practice supports. A Cronbach's alpha suggests inter-relatedness between question items with results of 0.75 – 0.95 as acceptable values (Tavakol & Dennick, 2011)

Findings

Demographic Characteristics

Demographic information included age as recorded in year of birth, gender, NP credentials, highest level of education, years of experience, and VCNP regional affiliation (see Table 1).

There were eighty-one (81) female participants and one (1) male participant. Ten-year age groups up to age sixty-nine were determined from reported year of birth. Ages greater calculated to be greater than seventy were grouped together as seventy plus (+) age group. The majority of participants (32%, n= 26) were fifty to fifty-nine years old. Seventy-five percent (n

= 75) of the participants stated they are licensed primary care nurse practitioners. Additionally, 77 % (n = 64) of participants state their highest level of education is a master's degree. Years' experience was calculated in ten-year intervals. The majority of participants have either zero – ten (34 %, n = 24) or ten – twenty (37 %, n =31) years' experience.

Council Affiliation

There are twelve regions affiliated with the VCNP within the Commonwealth of Virginia into twelve regions. The VCNP members in Northern Virginia and Richmond regions provided the majority of completed responses accounting for 21.7 % (n = 18) and 18.1 % (n = 15) respectfully (see Figure 5).

Practice Site Demographics

Practice site questions included identifying number of NPs at practice site, whether or not the practice site is part of a larger system and the estimated number of NPs in the larger health system (see Table 2). Forty-eight percent (n = 40) of respondents stated they were the sole NP at the practice site. An additional 42.2 % (n = 35) of the respondents stated there were two to five NPs the at practice site. Sixty-six percent (n = 55) of the respondents' practice site is part of a larger health system with 31.3 % (n = 26) having more than 50 NPs included in the larger health system.

Presence of shared governance or leadership model

In response to whether there is a NP specific leadership or shared governance model present in the practice site, 58 respondents (69.9 %) indicated no and 25 respondents (30.1 %) answered there is a shared leadership model in place (see Table 3).

Compensation

Participants were asked to select a response that best defined how they are compensated: salary, base salary plus incentive, base salary plus incentive for volume, base salary plus incentive for quality or other. Unfortunately, the questionnaire format failed to allow participants to write in answers therefore responses marked as "other" were excluded from descriptive analysis as there is no way to define what "other" means. The majority of respondents or 61.4 % (n = 51) selected salary only. The second most prevalent answer identified base salary plus incentive for volume accounting for 15.7 % (n = 31) of responses (see Table 4 and Figure 6).

Accountability Measures

In response to access to productivity and outcome reports, 44 % (n = 37) of respondents stated they received reports on a regular basis. The participants were given the opportunity to provide a choice of several pre-specified responses to how productivity and outcome reports are used in the practice setting. The most common responses on how the information from productivity and outcome reports are used were "affects salary" and "used for practice decision-making". Over 14 % (n = 12) of respondents stated reports affect salary, 24 % (n = 18) stated reports affect billing practices, and over 9 % (n = 8) of respondents stated reports are used for practice decision-making (see Table 5).

The survey included two questions assessing how patient visits are conducted (see Table 4) and how patient visits are most likely billed (see Table 6). Ninety-five percent (n = 79) of NP respondents conduct patient visits independently or parallel to physician colleague. Whereas 5 % (n = 4) conducted shared patient visit with physician provider. Nearly, 46 % (n = 38) of respondents replied they are most likely to bill under their own national provider identifier (NPI)

number. Twenty-one percent (n = 18) of participants bill as "incident to" by using the physician's NPI number.

Chi-squared Results

Chi-squared testing was performed to determine if a relationship exists between a nurse practitioner-specific collaborative leadership or shared governance model and NP credentials, education level, years' experience, VCNP regional affiliation, compensation, practice site size, access to productivity and outcome reports, billing practices, and how patient visits are conducted. A two-sided pre-set alpha of 0.05 was used.

In order to perform a two by two comparison, credentials were grouped into acute and primary care sub-groups. Acute care NPs and adult-gerontology acute care NPs were combined into the acute NP group. Adult NP, adult-gerontology primary care NP, family NP, psychiatric-mental health NP, gerontology NP and pediatric primary care NP were included in the primary care group.

Highest level of education was combined into two groups with master's degree representing one group and doctor of nursing practice (DNP) and doctor of philosophy (PhD) degrees were combined to represent the second group.

Due to the multiple answers provided regarding how patient visits are conducted, the responses were combined into two responses. The final two comparison groups were identified as those that conducted shared visits with the physician provider or those visits conducted independently.

In order to evaluate billing practices, responses were combined into two groups. The groups used for Chi-squared analysis were those that billed under their own NPI numbers and all other responses.

Chi-squared test results indicate there was no statistically significant difference between NPs who have a shared leadership structure in place and NPs who do not. Furthermore, there was no relationship found when comparing NP demographics that included credentials, level of education, years' experience and VCNP regional affiliation. Chi-squared tests failed to demonstrate a relationship between shared governance and practice site as part of a larger institution. There were no Chi-squared statistically significant differences in patient visit specifics of how visits are conducted and billing practice. Results are seen in Table 6.

Qualitative Results

Seven open-ended questions were included in the questionnaire. Participants were asked to describe their involvement in practice partnerships, their involvement in practice committees, their relationship with their collaborative physician and administrator colleagues, their opportunities for role development, their contributions to decision-making at the executive level, their perceived barriers that limit ability to function at highest level of preparation, and perceived supports that enables them to function at their highest level of preparation. Common themes were identified for each question.

Involvement in practice partnerships. There were four common themes identified from self-reported responses to the question "Practice partnership includes involvement with physician colleagues and executive administrators to address patient care needs…….describe your involvement in practice partner activities." The themes identified were no involvement, limited involvement, collaborative and independent to practice (see Table 8). Twenty-eight respondents stated there is no involvement due to part-time employment status, lack of formal practice partnership within organization, practice site is a "corporate setting", or the participant has decided not to participate. Nine participants stated there is limited involvement due to

"limited administration over rules decisions despite great MD NP collaboration" and "we have very little input into the decisions that have been made about the direction the group has taken over the years." Thirty-four respondents stated there are collaborative partnerships which include weekly, bi-weekly and monthly team meetings that address concerns the NPs have, patient care coordination needs, and program development. One participant states "Actively involved in any policy changes, pilot studies, or administrative changes that deal with my job on the unit" and "equal involvement with MD and BOD for all practice concerns." Two participants identified themselves as functioning independently or in a solo setting. These participants noted "I practice fairly independently in a very small practice run by NPs" and "physician consultation occurs infrequently."

Practice committee involvement. Participants were asked to describe their involvement in practice committees. The two themes identified in the comments made by participants were no/none and yes (see Table 9). Forty-seven participants stated there no practice committees within the organization or they do not attend meetings. One participant noted "physician practice committee but no interaction nor do they have any role in what I do on a daily basis." Twenty-one participants noted some level of involvement in practice committees that were described by participants as quality improvement, interdisciplinary teams, patient access, continued medical education, and clinical leadership. One participant stated they are involved in "ACO, PCMH committee, NP workforce group," and multidisciplinary quality improvement committee" at their practice site.

Practice partnerships descriptions. Three themes were identified when reviewing participant's descriptions of practice partnerships with collaborating physician and administrator colleagues. Description themes are rare interactions, close collaborative and supportive

interactions, and formal agreement. Eighteen participants noted there are rare or very infrequent interactions (see Table 10). One participant stated "none. I rarely talk to either of them. I see them at monthly staff meetings where they talk at us." Another participant stated "I rarely see my collaborating physician. I ask questions about 4 times a year." Twenty-seven respondents state they have close, collaborative and supportive practice partnerships with their collaborating physician and administrator colleagues. The participants who noted collaborative and supportive practice partnership expressed positive collegial relationships. One participant stated "excellent rapport and complete trust in my abilities/skill set." Another stated "I have a close relationship with my collaborating physician and with the Vice President of the two sites where I work. The CEO of the organization and I frequently use email to communicate and have quarterly meetings." Four participants stated they have formal agreements. The participants who stated they have formal agreements also stated they function independently or had an autonomous role. One participant stated "I see patients independently." Another participant answered "I have an independent practice partnership. I see my own patients and utilize my collaborative physician on an as needed basis."

Role development. Participants were asked to describe practice site opportunities to discuss role development. The four common responses identified were: 1. Yes, there are opportunities; 2. practices are autonomous settings and participants were unable to identify opportunities; 3. there are no opportunities; and 4. there are limited opportunities (see Table 11). Forty-five participants responded yes and noted opportunities to expand leadership roles, where encouraged to obtain new skills to improve patient care, and had many opportunities to expand clinical services. One respondent answered "yes, we are now implementing a strategy so that I can obtain new skills to serve the patient population better." Another stated "yes, all providers in

my practice have the opportunity to expand clinical skills which helps further autonomy." Three participants responded they practice in an autonomous setting. These participants were unable to identify opportunities to be more independent. One participant stated "I am already in a very autonomous role – I am not sure that I could be more independent." Twenty participants provided a simple no or N/A response. However, one participant explained "they generally are not open to the NP expanding their skill set." Another responded "no, I do everything that the other physicians in the group do in the office setting without exception." Seven participants noted there are limited opportunities to discuss role development. One participant in this group stated "the focus is on keeping up with the patient load and EMR" and "expectation is that NPs function autonomously and see more and more patients." Another NP stated "I feel like I am too burdened with day to day tasks to pursue any additionally responsibilities."

Decision-making at the executive level. Nurse practitioner participants were asked if they contribute to decision-making at the executive level. Responses were categorized into no, yes, and minimal involvement (see Table 12). Forty-three respondents answered no. Rationale for no responses included lack of need; decisions are made by owners or directors, and size of institution as prohibiting factors. One participant wrote, "no b/c [sic] the institution is so big and decision-making so cumbersome. I have no interest in this." Another participant responded "No. This is a very disjointed institution, with lots of NPs/PAs (physician assistants) practicing in a variety of roles." Finally, a participant responded "no… We have an APP Director, but she usually makes the decisions in our name. We feel it is not by our proxy….." Twenty-eight participants provided direct yes responses. Several responded yes with no further descriptive information. However, a participant answered yes and noted "I have direct communication with administrators," and "very open communication can express opinion if needed." There were five

participants who responded minimal involvement. Responses from this small group included "I feel I could if there was something that needed to be changed," and "if asked for my input or if I feel that my input would be useful."

Perceived practice barriers. Participants were asked to describe practice barriers. Forty-two participants described barriers and twenty-seven respondents answered there are no barriers (see Table 13). Barriers described by participants included lack of role clarity, Medicare regulations, state scope of practice restrictions, organizational restrictions, lack of structured leadership at practice or within organization, and lack of insurance credentialing. Lack of role clarity included "lack of understanding/knowledge about DNP", "there is not much experience with NPs working with general surgeons in ambulatory setting……The surgeons don't seem to have a good idea of how I can function independently", and "at our institution PAs and NPs are treated in exactly the same manner and have very little, if any, leadership roles."

One participant noted "Medicare rules and lack of insurance credentialing require patient encounters to be billed under the physician, NPs as a whole are not being credentialed by certain insurance companies, which necessitate billing those patients under my MD's NPI…" and "….Medicare rules that say a physician must sign home health face to face reports."

Organizational restrictions included productivity demands with a focus on volume alone, restrictive guidelines that hinder the NPs ability to practice at full capacity, and practice restrictions that are opposed to state practice laws. One participants stated "demand for increased productivity and maintaining EMR, office manager is not supportive of NPs and MDs defer to her," and "financial pressure…..This means there is a pressure to see more patients constantly". Other organizational barriers included inability to advance to "assistant professor position" and "lack of support for DNP."

State scope of practice restrictions requiring physician collaboration as required by Virginia state law were noted by several participants. One participant stated "I feel I am able to practice at the highest level my education allows. State laws are somewhat restrictive."

The 27 respondents who denied barriers or restriction for their practices described themselves as functioning independently. One participant stated "I work at a level where I am very comfortable."

Perceived practice supports. Participants were asked to list supports that enabled their ability to function at their highest level of educational preparation or promoted their desired professional role development. Supports were defined but were not limited to structured leadership, structured committees or councils, and educational opportunities (see Table 14). Fifty-four participants provided descriptions of practice supports. Supports listed by these participants included educational opportunities, continued medical education, reimbursement, organizational wide supports, structured leadership, professional membership, and peer interactions. Other common themes identified were organizational and collaborative support; continuing education opportunities; and peer interaction within organization and professional organization membership.

One participant answered "I believe that the medical director that I work with supports me and allows me to function at the highest level of my education." Another wrote "I am allowed to function independently with support of practice manager and supervising MD."

Continue education opportunity support included annual funding or allowance for continuing medical and nursing (CME/CNEs) educational opportunities which included tuition reimbursement and financial support, paid time off to attend professional conferences and licensure and credentialing fees.

Several participants noted membership to VCNP and AANP provide professional support. One participant wrote "AANP guidelines and networking at meetings are helpful in areas I'm not clear about." Another participant wrote "active role in local VCNP, communicate regularly with physicians and PAs, feel I have the support of my medical director…,participate in monthly committee meetings to discuss and improve patient care."

Result Summary

The majority of respondents were Master's-prepared female nurse practitioners ranging in age from twenty to fifty with fewer than five years' experience participated in this survey. The majority of these NPs provide ambulatory care in settings that are part of a larger health system. Unfortunately, 70 % of the participants do not have or are unaware of a shared leadership model within the institutions in which they are employed. Interestingly, there was no statistical difference in NP practice between those that have a shared governance model in place and the NPs that do not.

Findings from the open-ended questions suggest most of the participants practice in a close collaborative setting that supports continued professional growth. Unfortunately, institutional and state practice regulations limit the NPs to practice at their perceived highest level within their scope of practice.

Discussion

Nurse practitioners are being utilized in health care systems to provide primary ambulatory patient care. This has prompted federal practice recommendations and has encouraged practice change legislation within many states. As autonomous NP practice evolves, organizations that employ NPs would do well to establish an effective shared leadership model that considers varying NP roles, incorporates patient care responsibilities, and

acknowledges professional alliances. This model would serve to bridge the leadership gap between nursing and medical administration and to be a collaborative platform for NPs and their physician colleagues (Ackerman, Mick, Witzel, 2010). The goal of shared leadership is not to isolate NPs in a sole NP leadership model but to empower the NPs to maximize their role and function in health care through strategic leadership processes.

The literature suggests that centralized shared leadership empowers NPs to be health care leaders who are able to practice at the full extent of their education and preparation. Furthermore, shared leadership promotes positive work environments that foster maximum professional function and accountability. Infrastructures within institutions can extend autonomous practice that encourages collaborative partnerships.

This study indicates that the majority of participants do not have or are unaware of an advanced practice provider-specific shared governance leadership model within the institutions in which they are employed. However, the majority of the participants noted they see patients independently of their collaborating physician partners and believe they provide patient care autonomously. These findings suggest the presence of shared leadership models may not impact how the NP practices as much as how it empowers them to control their practice or possess power within the organization. This is exemplified in participants' comments regarding their collaborative interactions and opportunities for decision-making. Although participants stated they have a supportive collaborative relationship with their physician colleagues and other health professionals, over half of the responses indicated there was no opportunity to be engaged in the decision-making process. It is unclear if the NPs who participated in this study have tried to be engaged in the decision-making process and met resistance or if they do not assert the importance of NP presence in the process.

The questionnaire included opportunities for the NP participants to describe practice supports and barriers. However, specific questions inquiring about perceived hierarchical relationships and professional socialization were not included. More research is needed to investigate how power is distributed between nurse practitioners and their physician colleagues and how that impacts the NP's sense of professional empowerment. As described by Kanter (1977), the distribution of perceived formal and informal power is vital to promoting empowerment and fostering leadership skill development, promoting the sense of accountability, and encouraging professional engagement in others.

Lack of empowerment affects the NP's independent function by limiting their ability to engage in non-clinical aspects of their role−especially when they do not have access to accountability measures, such as billing practices, and are not included in administrative decision-making. These finding point to an inconsistent connection between accountability and engagement in NP practice. For example, the respondents clearly communicated they were accountable to their clinical and patient-related responsibilities. However, they were less engaged with the strategic and business aspects of their practice. These findings suggest there is a lack of structural support through decreased access to resources and information that provide a heightened sense of practice autonomy (Orgambidez-Ramos & Borrego-Ales, 2014). This is further supported by Kanter's (1977) theory as she describes people with low structural support with decreased opportunities as those who tend to be task oriented and do not actively seek out more responsibility or participation.

Lack of power and opportunity (Kanter, 1977) is exemplified when respondents stated they were treating patients independently but without using their own NPI number for billing purposes. It is unclear if billing practices reflect personal choice or institutional policies. The

institution may require the NP to forward patient encounter bills to their collaborating physician to be co-signed. The co-signature would allow the institution to submit the encounter bill under the physicians NPI number resulting in a higher reimbursement rate. Billing under the NP's NPI number would mean less reimbursement for the institution but would increase engagement as a collaborative partner in the practice. Billing practices do not allow the NP to bill under their own NPI number may cause a sense of powerlessness and may devalue the NP role. This process is counter-productive in promoting accountability through access to information as further described by Kanter (1977). It is important to note that participants were not asked to describe specific types of institutional or administrative policies or how those policies restrict or affect their practice.

This study provided some insight into how NPs perceives their practice, leadership functions and their professional relationships. Again, it is unclear whether or not the NP possesses power within these relationships or chooses not to be involved. The concepts of formal and informal power as it affects the NP's ability to produce an outcome within the confines of available resources may explain perceived barriers and supports (Kanter, 1977). NP respondents in this study who perceived organizational wide support reported being more engaged in their role and saw themselves as valued team members. Positive support may also contribute to a sense of increased professional opportunity and role commitment (Kanter, 1977). Conversely, NPs who identified institutional regulations, state scope of practice requirements and insurance credentialing issues may perceive limited formal and informal power which negatively impacts their commitment to their professional role. The inability to exert power limits practice equity and ownership which prohibits the NP to function at the highest level of their preparation.

Variability between institutions and clinical sites may reflect individual differences in perceived access to accountability, practice equity, and involvement in leadership opportunities. Participants that work in solo practices or are employed in a corporate setting, such as retail clinics, may not have the ability to be involved in leadership opportunities. In practice settings where there is a solo NP there may be limited opportunity to build a NP-involved leadership structure that fosters practice ownership, accountability, collaborative partnerships, and equity. Furthermore, NPs who are employed in a corporate setting may see themselves as paid employees that function within preset administrative guidelines, without an option for involvement in higher level strategic non-clinical decisions.

Findings of this study suggest there is a lack of NP engagement which may negatively impact the likelihood of individual NPs who actively pursue a seat at the administrative table. This may suggest how the NP is acculturated to practice within the institution and by colleagues. Lack of engagement may reflect the NP's perception of exclusion from or lack of knowledge about the business aspects of health care. Formal educational curricula and continuing education courses focusing on the business aspects of health care may need to be included during entry into the profession and throughout practice in order to expand knowledge of and reinforce the importance of the business and leadership aspects of advanced practice.

Shared leadership and governance may be a new concept for many nurse practitioners in the advanced practice role. Although NPs may have been exposed to the shared governance model as staff nurses, they likely have not extended its usefulness and applicability to the advanced practice role and how it can promote NP practice. A limitation of the survey instrument is that it did not investigate which practice model, nursing or medicine, the NP felt aligned most with their clinical practice. Allegiance to one administration over the other may

impact responses regarding leadership involvement, institutional supports and barriers, and professional partnerships. Shared governance is one way to enhance the ambulatory NP role and may be part of the solution addressing full collaborative practice. Forming leadership structures that supports collaboration that extends from the clinical setting to the board room can ensure the NP voice is present at the strategic and operational decision-making table.

Overall, this study raises more questions than provides answers. The lack of shared governance and leadership detracts from the ability for partnerships, equity, accountability, and ownership in NP practice in ambulatory settings from the respondents of this survey. Surprisingly, patient care dynamics such as how patient visits and billing practices are organized and conducted do not seem to be affected by the absence of NP shared governance or other collaborative leadership models. More research is needed to define and describe best practices of shared leadership within the setting of NP practice and the benefits of a NP-guided governance model.

Strengths

The findings of this study demonstrated that there are no statistically significant relationships between NPs who have a shared leadership structure in place and how the NP practices. This study also provided insight into views regarding NP practice supports and barriers in the Commonwealth of Virginia. The results showed peer interactions and organizational support were positive practice supports and practice barriers included lack of role clarity, scope of practice restrictions, and credentialing limitations.

Limitations

Limiting the sample to ambulatory care NPs underrepresents APRN specialty roles and limits generalizability. A convenience sample limited the ability to compare APRN specialty

groups with practice settings and role descriptors. Self-reporting of information may have contributed to participant bias and over- or under-reporting.

The author did not inquire if NP participants in this study were familiar with shared governance. Therefore, prior knowledge of concepts may have contributed to participant bias in thinking about leadership and subsequent responses.

Asking individuals whether shared governance promotes the NP role and practice development is subjective in that self-reported evidence by NPs may not be the best method in determining whether NPs are practicing at the highest level of their preparation or are involved in administrative decision-making. Furthermore, evaluating health care systems that have shared governance policies in place does not guarantee NP practice optimization.

Nursing Practice Implications

Information from this Capstone may be used to develop further research examining shared leadership roles and functions. Schools of nursing may use this information to examine advanced practice program curricula to include more content in the business aspects of APRN practice and the importance of being advocates for their voices being represented at the practice-setting table. Institutions and researchers may want to investigate the level of NP engagement in their practice and the reasons for what may hinder the NP's sense of professional engagement. Administrators and NPs can use this information to model work environment change, become involved in interdisciplinary leadership counsels, advocate for inclusion at the executive table, and be empowered to direct role expansion.

Professional organizations can use this information to argue for practice authority change, influence insurance companies to expand credentialing for NPs so that health care services provided are perceived as equivalent to their physician counterparts. The information from this

research can provide platforms for nurse practitioner groups to open dialog with health care institution executives about accountability limitations within organizations as well as advocate for advanced practice provider-specific leadership.

Institutions interested in addressing advanced practice provider-specific shared governance may want to learn from best practices, such as the Margaret D. Soviet Center for Advanced Practice at the University of Rochester to learn more about exemplar organizational support processes and structures. Using established models may assist in standardizing NP practice within organizations and clinics and can provide benchmark data on established accountability and outcomes reporting.

Nurse practitioners can use this data to inform institution administrators about the contributions NPs make in directly influencing health care access demands. The individual NP can use this information to bolster the argument for inclusion as a partner in practice and policy decision-making. Nurse practitioners who serve as student mentors can use these findings to educate NP students about the professionalism and the importance of being involved as a partner in the business of providing health care.

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Table 1
Demographic Information

Gender (n = 82)		
	Frequency	Percent
Female	81	97.6
Male	1	1.2
Calculated Participant Age (n = 81)		
	Frequency	Percent
20 – 29	2	2
30 – 39	14	17
40 – 49	18	22
50 – 59	26	32
60 – 69	18	22
70 +	3	4
Credentials (n = 83)		
	Frequency	Percent
No response provided	2	2.4
Acute Care NP	3	3.6
Primary Care	75	90.3
Psychiatric	3	3.6
Highest Level of Education (n = 83)		
	Frequency	Percent
Master's	64	77.1
DNP	13	15.7
PhD	6	7.2
Years' Experience (n = 83)		
	Frequency	Percent
Missing	1	1.2
0 – 10	34	40.9
10 – 20	31	37.4
20 +	17	20.5

Note. NP = nurse practitioner, DNP = Doctor of Nursing Practice, PhD = Doctor of Philosophy. Age was calculated from reported year of birth and categorized into decade intervals. Acute care category includes acute care nurse practitioners and adult gerontology acute care nurse practitioners. Psychiatric nurse practitioner category includes adult, family and psychiatric nurse practitioners. Primary care nurse practitioner category includes adult gerontology, adult, family, and pediatric nurse practitioners. Reported years' experience was combined into ten year intervals.

Table 2
Nurse Practitioner Site Census

NPs at Practice Site (n = 83)		
	Frequency	Percent
1	40	48.2
2 – 5	35	42.2
6 – 9	3	3.6
>10	5	6.0
Practice Site Part of Larger System (n = 83)		
	Frequency	Percent
No	28	33.7
Yes	55	66.3
Number of NPs in Larger Health System (n = 83)		
	Frequency	Percent
0 – 10	32	38,6
10 – 20	17	20.5
20 – 50	8	9.6
>50	26	31.3

Note. NP = nurse practitioner. Respondents who noted they were part of a larger health system where asked to identify total number of NPs employed within the system.

Table 3
Shared Governance

Response	Total Number (n = 83)	Percentage
Yes	25	30.1
No / I don't know	58	69.9

Note. Don't = do not. No and I don't know responses were combined into a single category.

Table 4
Nurse Practitioner Accountability Measures

Access to Productivity and Outcome Reports (n = 83)		
	Frequency	Percent
No response	1	1.2
Not at all	26	31.3
No, not on a regular basis	11	13.3
Yes, but not on a regular basis	8	9.6
Yes, on a regular basis	37	44.6
Type of Patient Visit (n = 83)		
	Frequency	Percent
Independent or Parallel Visits	79	95.2
Shared Visits	4	4.8
Type of Compensation (n = 83)		
	Frequency	Percent
No response	1	1.2

Salary	51	61.4
Salary plus incentive	31	37.3

Note. Compensation responses were categorized into two groups of salary and all other responses. Types of visits were combined into two groups. Responses that noted independent or parallel visits separate to physician visits were combined. Patient visits where NP and physician both see the patient were combined into the second group. Participants were allowed to provide multiple responses.

Table 5
How Productivity and Outcome Reports Affect NP Practice

How information is used	Frequency (n = 83)	Percent
No Response	18	21.7
Other	21	25.3
Affects Salary	12	14.4
Changes Daily Schedule	6	7.2
Affects Billing Practice	18	24
Affects Decision-making	8	9.6

Note. Results that included more than one response were combined to reflect first choice made by the participant.

Table 6
Billing Practices of NP in Ambulatory Care

Bill Type	Frequency (n = 83)	Percent
Other	18	21.7
Under my NPI	38	45.8
Incident to	18	21.7
Shared Billing with MD	9	10.8

Note. NPI = National Provider Number. Responses that included multiple responses were combined into shared billing category. Other responses did not include explanation for billing practice.

Table 7
Chi-squared Results

Question	Degrees of Freedom	Number	Value	X^2
Shared Leadership in Place	3	82	0.24	0.24
Credentials	12	83	2.05	0.36
Highest Level of Education	1	83	1.68	0.20
Years' Experience	12	83	6.84	0.87

Regional Affiliation	11	83	7.34	0.77
Compensation	3	82	0.24	0.97
Part of Larger Institution	1	83	0.08	0.77
How Patient Visit is conducted	6	83	0.42	1.00
Bill Under Own NPI Number	1	65	0.11	0.75

Note. Chi-square was used to compare practice characteristics between NPs who have a shared governance or leadership structure in place and those that do not.

Table 8
Involvement in Practice Partnerships

Themes	Number of Participants (n = 78)	Exemplars
No involvement	28	No formal practice partnership due to employment status (part-time employment), no formal practice partnership within organization, or the participant has decided not to participate
Limited involvement	9	"Limited administration over rules decisions despite great MD-NP collaboration" and "we have very little input into the decisions that have been made about the direction the group has taken over the years"
Collaborative	34	Weekly, bi-weekly and monthly team meetings that address concerns the NPs have, patient care coordination needs, and program development
Independent or solo	2	Function independently or in a solo setting and physician consultation occurs infrequently

Note. Themes were compiled from seventy-three written responses. Direct quotes were used when no other explanation was available.

Table 9
Practice Committee Involvement

Themes	Number of Participants (n = 78)	Exemplars
No or none	47	No practice committees within the organization or study participant is not involved
Yes	25	Committees included quality improvement, interdisciplinary teams, patient access, continued medical education, and clinical leadership

Note. Themes were compiled from seventy-two written responses.

Table 10
Practice Partnership Descriptions

Themes	Number of Participant Responses (n = 75)	Exemplars
Rarely	18	Rare or very infrequent interactions
Closely, collaborative and supportive	26	Positive collegial relationship
Formal agreement	4	Participants that noted a formal agreement where more likely to function independently or had an autonomous role

Note. Themes were compiled from forty-eight written responses. Participants provided single word responses.

Table 11
Role Development

Themes	Number of Participant Responses (n = 78)	Themes
Opportunities	45	Participants that noted opportunities to expand leadership roles, where encouraged to obtain new skills to improve patient care, and had many opportunities to expand clinical services.
Autonomous	3	Participants that noted having

		autonomous practice did not identify opportunities to be more independent
No or not applicable	20	Participants provided a simple no or N/A response
Limited	7	Several participants noted limited opportunities to discuss role development explaining that the main focus is on keeping up with the patient load and EMR. Expectation is that NPs function autonomously and see more and more patients."

Note. Themes were compiled from seventy-five written responses. Participants that answered "autonomous," "no or not applicable," or "limited" did not provide further explanations.

Table 12
Decision-making at the Executive Level

Themes	Number of Participant Responses (n = 76)	Exemplars
No	43	Rationale for no responses included lack of need, decisions are made by owners or directors, and size of institution as prohibiting factors.
Yes	28	Several participants provided direct yes answers with no further descriptive information. Responses included direct communication with administrators, open communication, and can express opinion
Minimal	5	Participants felt they could voice opinion if needed or asked

Note. Themes were compiled from seventy-six written responses. Participants answered "no," "yes," or "minimal" without further explanation.

Table 13
Perceived Practice Barriers

Themes	Number of Participant Responses (n = 71)	Exemplars
No Barriers	27	No barriers or restriction for their practices. Several participants noted that they function independently.
Barriers	42	Lack of role clarity, Medicare rules, state scope of practice restrictions (MD supervision is required), organizational restrictions, lack of structured leadership at practice or within organization, and lack of insurance credentialing.

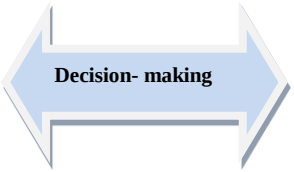
Note. Themes were compiled from sixty-nine written responses.

Table 14
Perceived Practice Supports

Themes	Number of Participant Responses (n = 64)	Exemplars
Organizational and Collaborative Support	16	Organizational and collaborative support.
CME/CEU Allowance and Reimbursement	8	Participants have a specific amount of annual funding for CME/CEUs which includes tuition reimbursement, financial support, paid time off and licensure and credentialing fees.
Continuing Education	15	Continuing education, attending professional conferences, technological support and on line tools such as “Up To Date”.
Peer Interactions within Organization and Professional Organization Membership	4	VCNP and AANP provide support; “state laws and AANP guidelines”; networking at meetings are helpful in areas I’m not clear about.”

Note. Themes were compiled from forty-three written responses.

Figure 1
Self-governance vs. Shared Governance



Centralized Interactions (Self-Governance)	**Decentralized Interactions (Shared Governance)**
Position-based	Knowledge-based
Distant from point of care/service	Occurs at point of care/service
Hierarchical communication	Direct communication
Limited staff input	High staff input
Separates responsibility/managers are accountable	Integrates equity, accountability, and authority for staff and managers
We/they work environment	Synergistic work environment
Divided goals/purpose	Cohesive goals/purpose, ownership
Independent activities/tasks	Collegiality, collaboration, partnership

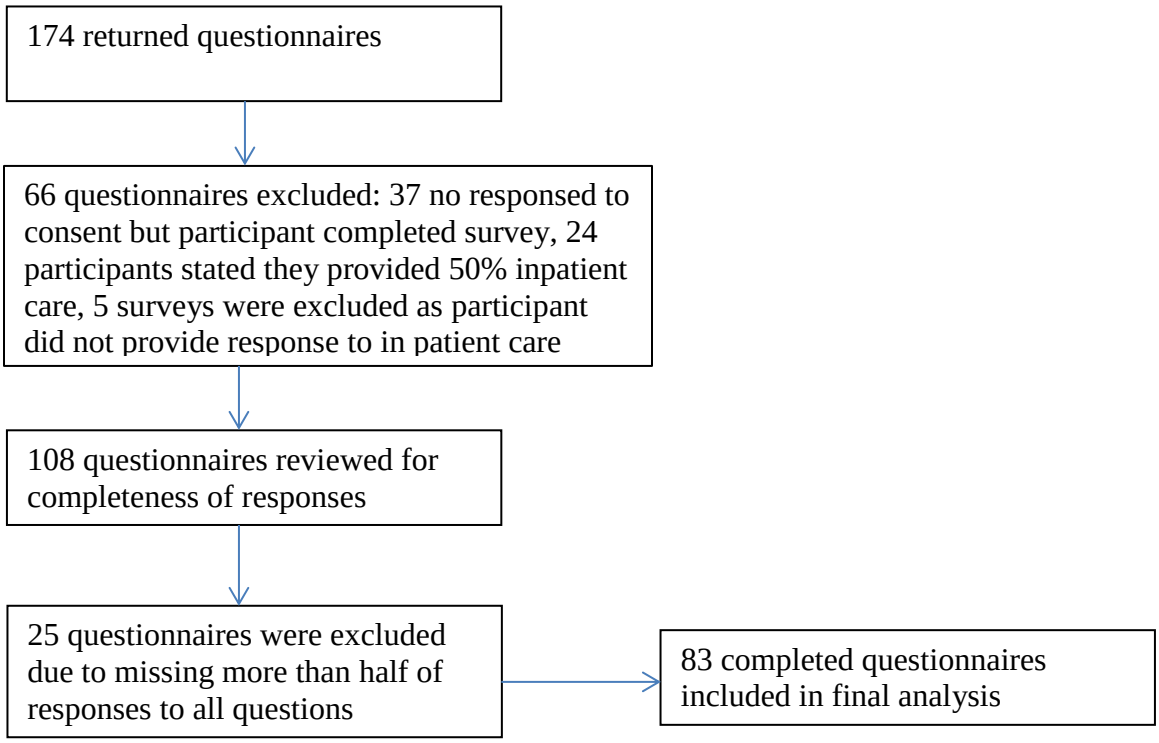
Note. Illustration of basic differences between self and shared governance behavior and traits. Adapted from Shared Governance: A Practical Approach to Transform Professional by D. Swihart, 2011, p. 8. Copyright 2011 by HCPro, Inc. Retrieved from *http://www.hcmarketplace.com/prod-9581/Shared-Governance.html.*

Figure 2
From Hierarchy to Relational Partnership

From HIERARCHY	to	RELATIONAL PARTNERSHIP
Independence		Interdependence
Hierarchical relationship		Collegial relationship
Parallel functioning		Team functioning
Medical plan		Patient's plan
Resisting change		Leading change
Competing		Partnering
Indirect communication		Direct communication

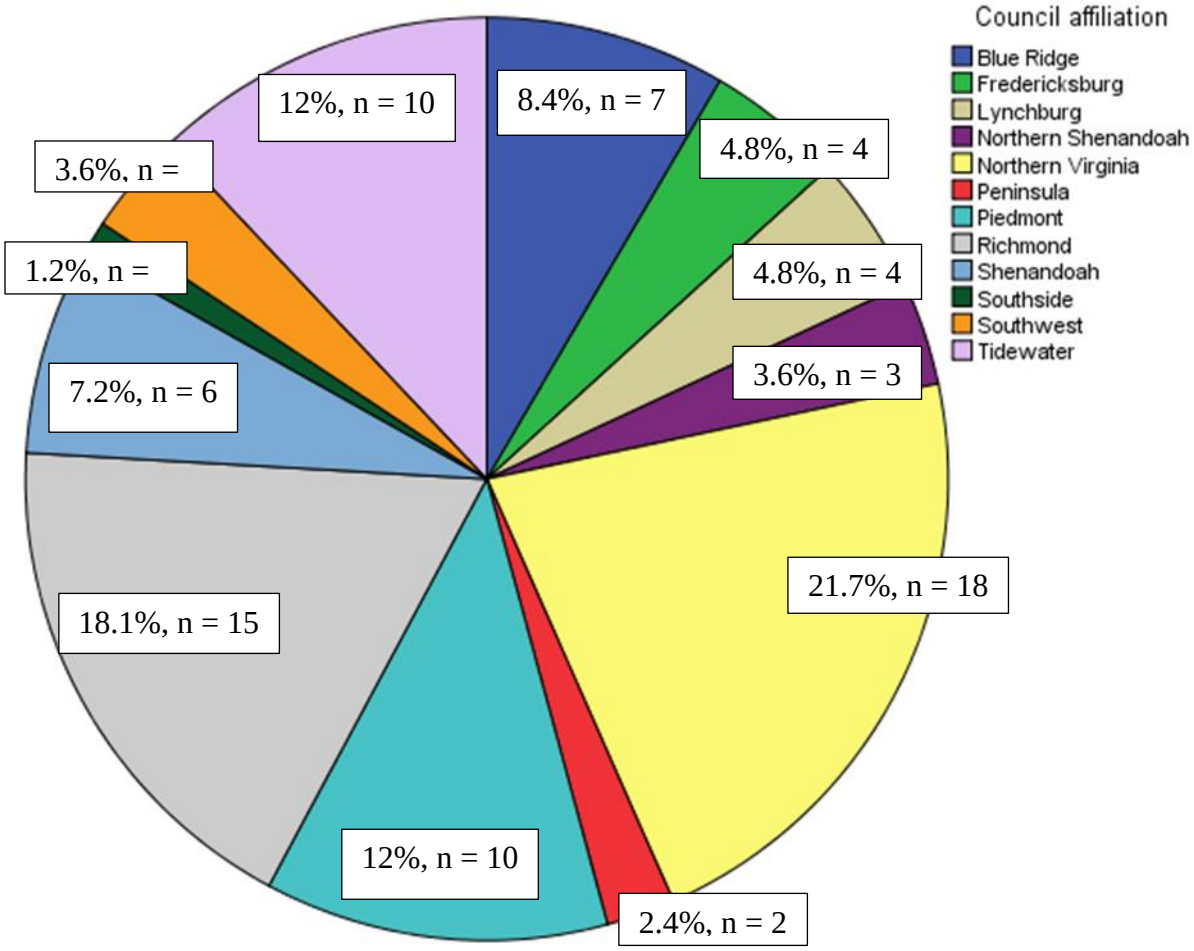
Note. Professional Partnership Relationship Structure within Shared Governance. Model describes professional relationship change between healthcare providers, team members and patients. Adapted from Shared Governance: A Practical Approach to Transform Professional by D. Swihart, 2011, p. 11. Copyright 2011 by HCPro, Inc. Retrieved from *http://www.hcmarketplace.com/prod-9581/Shared-Governance.html*

Figure 3
Questionnaire Inclusion and Exclusion Decision Diagram



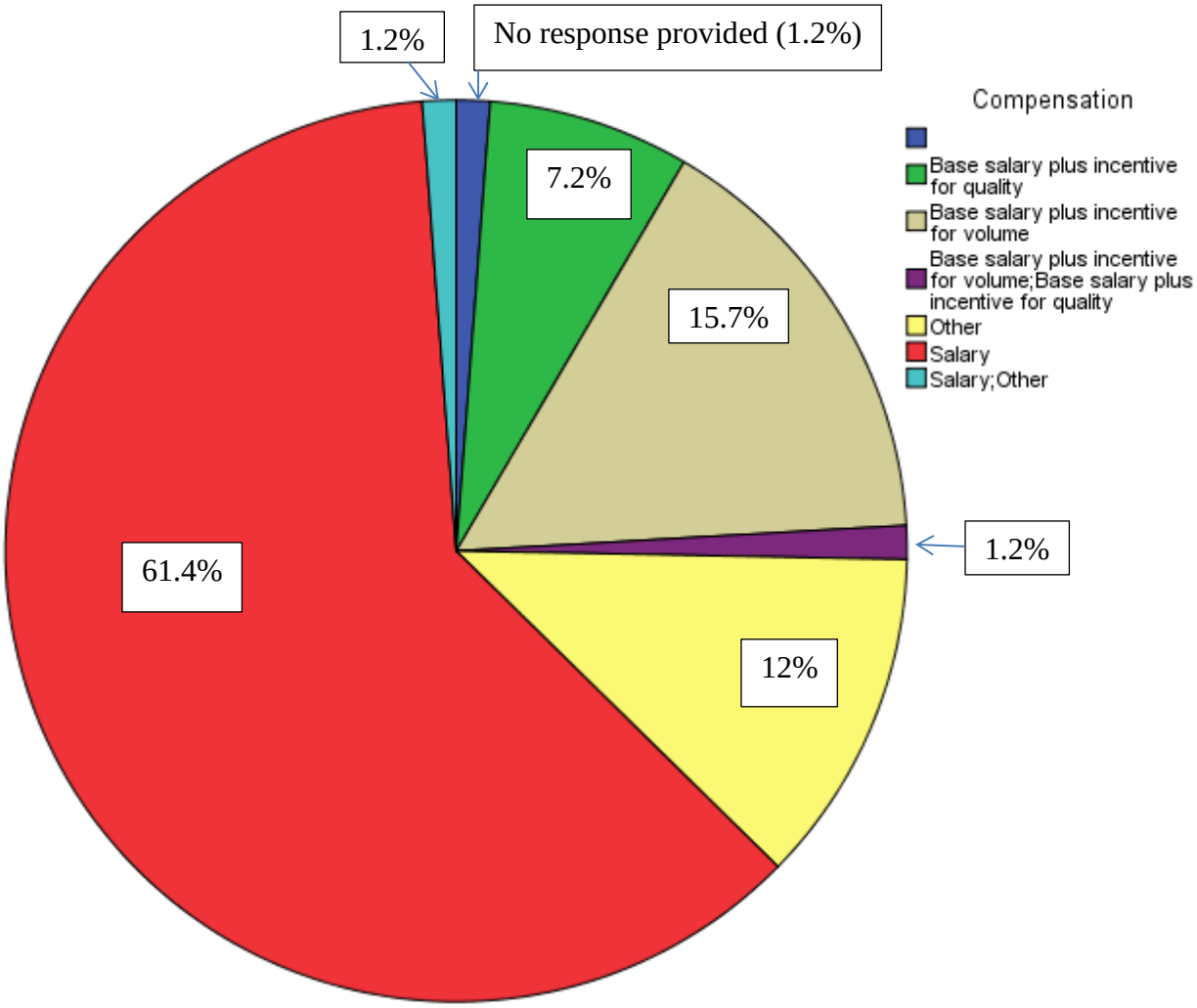
Note. Decision diagram explaining inclusion and exclusion of submitted questionnaires.

Figure 4
Participant Council Affiliation



Note. Pie chart diagram illustrates percentage and number of participants' VCNP regional affiliation.

Figure 5
Compensation Prevalence



Note. Compensation pie diagram illustrates percent of participants that responded to salary question.

Appendix A

Shared Governance Survey Questionnaire

APRN shared collaborative leadership supports APRN role maximization through well-defined institutional policies and procedures that are APRN driven, provide professional guidance, and enable APRN role development. APRN role maximization includes measures for accountability, supports professional partnerships with collaborating physician and executive administrators, and encourages practice equity through shared decision-making, and role ownership by inclusion of the APRN in practice policy and procedure development and adoption.

This questionnaire is aimed at answering whether or not APRNs are involved in collaborative practice model leadership?

20. Year of birth:

21. Gender:
    - ☐ Male
    - ☐ Female

22. What is your Nurse Practitioner Credential?
    - ☐ ACNP (Acute Care NP)
    - ☐ ANP (Adult NP)
    - ☐ AGACNP (Adult-Geriatric Acute Care NP)
    - ☐ AGPCNP (Adult-Gerontology Primary Care NP)
    - ☐ FNP (Family NP)
    - ☐ PMHNP - Psychiatric- (Mental Health NP)
    - ☐ GNP - (Gerontological NP)
    - ☐ PNP - (Pediatric Primary Care NP)

23. What is your highest level of education?
    - ☐ Master's Degree
    - ☐ DNP
    - ☐ PhD

24. Years of experience as nurse practitioner?
    - ☐ 0 – 5
    - ☐ 5 – 10
    - ☐ 10 – 15
    - ☐ 15 – 20

□ 20+

25. In your practice setting is there a dedicated APRN centralized collaborative leadership or shared governance?
    □ Yes
    □ No

26. How would you define your compensation policy?
    □ Salary
    □ Base salary plus incentive for volume
    □ Base salary plus incentive for quality

27. Which best describes the number of NPs in your practice?
    □ 1 - 5
    □ 6 – 9
    □ Greater than 10

28. Is your practice site part of a larger system?
    □ Yes
    □ No

    If yes, how many NPs are in your institution?
    □ 10 – 20
    □ 20 – 50
    □ More than 50

29. Practice partnership includes involvement with physician colleagues to address patient care needs such as access to care and provider availability. Practice committees can include wide organizational efforts (i.e. NP focus practice group) or site specific interdisciplinary groups (i.e. QI committee). Describe your involvement in practice committees:

30. Describe your professional partnership with your collaborating physician and administrative colleagues (i.e. chief executive officers)?

31. Are there opportunities to discuss role development (i.e. expanding clinic skills, leadership opportunities, or furthering autonomy)?

32. Do you receive productivity and outcome reports on a regular basis (monthly, quarterly)?
    □ Yes
    □ No

33. How is the information from the productivity or outcome report used? Check all that apply.
    - ☐ Determine billing practices,
    - ☐ Change daily schedule,
    - ☐ Effect salary,
    - ☐ Used for practice decision-making
    - ☐ other:_____

34. How are you most likely to submit you patient encounter bills?
    - ☐ Under my NPI number,
    - ☐ Incident to under the MD's NPI number,
    - ☐ Shared billing process
    - ☐ Other:_____

35. How do you conduct your patient visits?
    - ☐ Independent, without close or direct MD supervision
    - ☐ Parallel to MD provider (in office with collaborating MD but have separate patient visits)
    - ☐ Tangent to MD provider (shared patient visits)

36. Do you make decisions at the executive level that effect NP practice within your institution or practice setting?
    - ☐ No
    - ☐ Yes: Please describe with title and function:

37. Practice barriers can include but are not limited to organizational restrictions, lack of administrative support, lack of role clarity, and lack of structured leadership.

    Please list any barriers that prevent your ability to function at the highest level of your preparation or limit your desired professional role:

38. Practice supports can include but are not limited to structured leadership, structured committees or counsels, and educational opportunities.

    Please list supports that enable your ability to function at the highest level of your preparation or promote your desired professional role development: