RESOURCES FOR PRACTICE

Centralized resources for nurse practitioners: Common early experiences among leaders of six large health systems

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Leadership; nurse practitioners; organizational change; practice management; program development; administration; advanced practice nurse (APN).

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Abstract
Purpose: This article describes common experiences of institutions that have pioneered the work of integrating nurse practitioners (NPs) into complex hospital environments and addresses effective strategies in achieving a centralized leadership model.

Data sources: We conducted an informal, written survey and focus group discussions comparing experiences of leaders who were first in the position of centralizing resources and providing leadership for NPs in a hospital-based setting. Experiences were compared and common practices summarized.

Conclusions: The numbers of NPs required to provide patient care in an ever-growing, complex hospital environment are increasing rapidly. To meet the professional needs of these hospital-based NPs, a strong centralized leadership approach should be utilized. An organized and centralized approach to credentialing, program development, orientation, and evaluation processes will become necessary as hospitals continue to hire increased numbers of NPs.

Implications for practice: This article summarizes important considerations for formulating centralized leadership models for hospital-based NPs and provides a guide for administrators and NPs who are attempting to build similar models.

Factors such as increasing patient acuity, decreasing length of stay, patient safety, cost containment, requirements for continuous in-house coverage, physician shortages, and decreased resident work hours have led hospitals to reevaluate and modify their current staffing models (Bahouth, Esposito-Herr, & Babineau, 2007; Buchanan, 1996; Kleinpell, 1997; Larkin, 2003; Todd, Resnick, Stuhlemmer, & Mullen, 2004; Whitecomb et al., 2002; Wolf & Greenhouse, 2007). Over recent years, hospitals have utilized nurse practitioners (NPs) as a solution to models of care and these staffing problems. As a result, the number and impact of NPs in many organizations has dramatically increased. The outcomes of these revised staffing models have been positive with reports of increased patient satisfaction, increased bedside nursing satisfaction, and decreased length of stay (Kleinpell, 1997; VanOyen-Force, 2009; Whitcomb et al., 2002).

The successful integration of NPs into the hospital setting requires a strong centralized leadership model that provides advocacy, centralized planning, and coordination for hospital-based NPs (Ellis, Mackey, Buppert, & Klingensmith, 2008). This process can be challenging for institutions attempting to create hospital-wide resources for NPs without the designation of a single leader. Areas
of focus for the NP leader include: credentialing, compliance, centralized continuing education, program development, professional development, orientation, reimbursement, peer evaluation, and measurement of quality outcomes. We surveyed NP leaders about the experience of developing a centralized approach to managing hospital-based NPs without precedent to this approach. This article describes the common experience of developing centralized resources and implementing a leadership role for hospital-based NPs in six large academic medical centers.

**Background**

**Definitions**

NPs are the largest group of advanced practice nurses (APRNs) utilized within the academic medical center (APRN Joint Dialogue Group, 2008; Pearson, 2008). NPs diagnose and treat a wide range of health problems with a unique approach and emphasize both the medical approach to care and the nursing holistic approach to care. Besides clinical care, NPs focus on health promotion, disease prevention, health education, and counseling (American Academy of Nurse Practitioners [AANP], 2009). NPs are cost-effective providers who promote access to cutting edge health care, promote quality patient care, provide continuity in care, and enhance revenue generation for the service (Kleinpell, Ely, & Grabenkort, 2008; Knaus, Felten, Burtin, Forbes, & Davis, 1997; Mundinger et al., 2000; Safriet, 1992).

**The medical centers**

Several medical centers have experience in developing resources for hospital-based NPs. The authors of this article represent the leaders who pioneered work in developing the earliest resources for hospital-based NPs leading to the establishment of a formal centralized leadership structure for the support and oversight of NP practice within large hospital settings. These authors were among the first charged with the development of support resources, programs, and systems of care for the rapidly expanding group of NPs in their institutions.

The demographics of the six academic institutions have many similarities in terms of the academic environment. Each has a mission of clinical practice, research, and education. Most have experienced enormous growth in the number of hospital-based providers warranting comparison of their historical perspectives. See Table 1.

NPs at the represented medical centers are employed by a variety of entities including the medical center, private physician groups, and the hospital. While paid by other entities, all NPs are credentialed for practice in the hospital by a common process following hospital bylaws for their practice. NPs practice in a variety of medical and surgical specialties across the institutions and work according to state practice regulations. NPs working within these medical centers function in a variety of patient care settings from outpatient clinics, procedure areas, inpatient services, critical care units, and emergency departments. Responsibilities are specific to the role and practice setting and usually include: delivery of direct patient care, conducting history and physical examinations, ordering and evaluating diagnostic tests, performing procedures, prescribing medications and therapies, educating and counseling the patient and the family, discharge planning, and directing the interdisciplinary team. Many NPs on each of the hospitals’ staffs have affiliate and joint faculty positions at the respective nursing and medical schools where NPs participate in teaching the next generation of patient care providers.

At the surveyed institutions, the NP leader is essential for the strategic utilization of this group of NPs in order to assure institutional alignment within a diverse group of specialists. The centralized leader also assists with enhancing interprofessional collaboration and communication.

**Common challenges**

With the rapid proliferation in both the number of employed NPs and in their expanding scope of practice within the hospital organization, several new challenges emerged at an organizational level. Common findings described by the authors prior to initiation of a centralized leadership role included: (a) fragmented reporting structures leading to inefficient communication to NPs and executive leadership; (b) lack of standardization in processes for hiring, credentialing, and orientation; (c) multiple entry points into practice within the clinical campus; (d) variable scope of practice amongst NPs with little structure to measure competencies; (e) inefficiencies in addressing NP professional issues because of lack of dedicated resources; (f) difficulty with retention of NPs; (g) underutilization of existing resources; (h) lack of mentoring to assist the novice NP to transition into their role; (i) continued confusion regarding the NP role, and (j) the presence of faculty and nonfaculty status creating a two class structure of NPs.

**Lack of formal reporting structure**

Lack of a formal reporting structure led to an ill-defined work group with little authority. This interfered with the ability of the practicing NP to be involved or effect changes related to patient care or their practice.
Because there was no centralized accountability, NPs were essentially functioning independently with the support of their collaborating physicians, but without any administrative structure to directly support them. NPs voiced feelings of isolation, often unaware of strategic initiatives, practice, and policy changes. Without a direct link to an NP leader, NPs felt that they were missing continuing education opportunities and lacked networking opportunities with other NPs. Annual performance reviews were often completed without nursing involvement and true feedback for professional development was often lacking.

Variable hiring processes and scopes of practice

NPs were being hired into practice through a variety of avenues and to meet a large number of diverse clinical needs (research, education, and direct patient care). NP orientation often followed the RN orientation programs or did not occur at all. Little guidance was provided to the new NP about key documentation needed prior to practice, nor access to key clinical resources making the start-up process inefficient. Job descriptions were generic and NP annual performance evaluations were developed and conducted by the individual service lines or the collaborating physician thus causing variability in standardizing expectations, timely completion, and overall performance ratings.

Changing paradigm for the delivery of patient care

Patient care delivery was evolving from one of resident predominance to one with increasing emphasis by NP providers. Continuity of care was seen as a priority and NPs were being hired as ideal providers to meet patient care needs on a consistent basis. However, there was rarely a coordinated plan for the hiring or implementation of the NP. Additionally, NPs described feeling out of the loop of communication often unaware of changes being made in the clinical arena. They described their role as falling somewhere in between the medical and nursing arenas, therefore missing important hospital communications. NP representation on key committees to influence change in the hospital setting was lacking. Resources for individual NPs were not formalized and therefore variable depending on departmental alignment. There was little support for the professional growth of the individual NP without a system for mentorship.

Senior leadership at each of our six institutions recognized these growing challenges and the need for resources to be developed for this growing group of NP providers. Collectively, the authors of this manuscript agreed that a centralized NP leadership approach was needed to meet these challenges. The first centralized NP leader was thus charged with developing NP resources, determining a logical approach to NP leadership, overseeing NP practice, addressing regulatory and administrative issues, defining appropriate scope of practice, achieving a better understanding of the NP climate of practice, assisting with hiring and orientation, allocating revenue, and managing budget considerations. With this individual charged as the visionary for NP practice, it was hypothesized that this enhanced strategic planning would lead to NP retention and improvement in the delivery of cost-effective, high-quality, safe patient care in the hospital setting.

Centralization of NP practice

The majority of institutions represented in this article began the centralizing process by developing a hospital-wide NP group that met on a monthly basis. This group was assembled for the purpose of networking, communicating about NP-specific hospital policies, state regulations, education, and developing a sense of community. Meetings were monthly and led by a senior NP. Key hospital leaders were invited to monthly meetings to discuss their strategic hospital-wide plan. Annual
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Table 2  Sample budget item requests prior to centralizing leadership

<table>
<thead>
<tr>
<th>Category</th>
<th>Item Requests</th>
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<tbody>
<tr>
<td>Salaries and benefits</td>
<td>• NP director</td>
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<tr>
<td></td>
<td>• Associate director</td>
</tr>
<tr>
<td></td>
<td>• Managers</td>
</tr>
<tr>
<td></td>
<td>• Assistant/Support staff</td>
</tr>
<tr>
<td>Office supplies</td>
<td>• Computers, phones,</td>
</tr>
<tr>
<td></td>
<td>• General supplies</td>
</tr>
<tr>
<td>Recruitment and advertising</td>
<td>• Calculated based on numbers of NPs and vacancies</td>
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<tr>
<td></td>
<td>• Print, web</td>
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<tr>
<td>Travel and education</td>
<td>• Hospital-wide conferencing</td>
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<tr>
<td></td>
<td>• National conferences</td>
</tr>
<tr>
<td>Facility expenses</td>
<td>• Office space, etc.</td>
</tr>
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</table>

reports were sent to hospital administrators summarizing work of the group and goals for the following year. This communication raised awareness of the contributions of the NP group and developed interest at the administrative level.

The decision to hire the first formal NP leader required a well-defined proposal, budget, and corporate support from key personnel such as the Chief Nursing Officer, Chief Medical Officer, and senior administrative leaders. A review of current processes with a gap analysis helped substantiate the need for the position. Often this was in the form of a SWOT (strengths, weaknesses, opportunities, and threats) analysis (Brandt, Edwards, Sullivan, Zehler, & Grinder, 2009). The SWOT analysis identified systems that were currently not optimized, opportunities for NP involvement/improvement, and any real or potential threats to the organization. The SWOT analysis incorporated objective supporting data such as an assessment of the internal and external environment, legislative restrictions, current resources, programs, equipment, and supplies as applicable. A clear job description with clearly identified role expectations, proposed implementation and communication plan, and required financial support were also developed.

All institutions began with allocated funding for a centralized NP leader but required additional funding and resources to expand to a fully functioning centralized leadership model. Several institutions represented began with part time funding for this new role (50% administrative time) but little else in the way of available budget dollars. The authors of this article recommend considering the following items when making an initial resource request. See Table 2 for a sample of initial resource requests when centralizing NP leadership.

Identifying an NP leader

The identification and hiring of the first formal NP leader to serve as a single point of contact, liaison, and expert for matters specific to NP practice was critical in this pioneering role. At all surveyed institutions, the first hired NP leader was well known to the institution for their clinical expertise, prior leadership experience, and efforts related to NP practice prior to the initiation of such a role. Table 3 summarizes key requirements for the individual recruited into the NP leadership role.

Phases of implementation for the NP leader

When asked to reflect on their initial work to develop and implement a centralized leadership model, the authors agreed that work should be conceptualized in three phases. Phase I was the time for needs assessment and development of foundational resources. Integral to this phase of implementation was the prioritization of regulatory issues and review for current adherence to legal regulations within the institution (licensing, credentialing, and billing). Proposal of a fully funded, hospital-wide leadership model was critical for this phase of development. Phase II can be summarized as a time to fully operationalize the proposed leadership model, refine centralized resources, and gain traction. Specific NP practice models and individual issues can begin to be addressed across the institution. The impact of NP practice can be quantified. Phase III was the time for evaluation of impact/outcome and further refinement of programs. We describe common features in all six of our institutions as we undertook the challenge of centralizing our resources to support NP practice.

Phase I: Development

Common projects that all institutions found critical in Phase I focused on improving understanding of the NP role, developing orientation programs, developing and strengthening resources for NP practice, improving visibility of the contributions of the NP group, and implementing streamlined recruitment, hiring, and credentialing process. Phase I begins with the identification of all NPs in the institution and review of licensure and regulatory compliance.

Key to the successful completion of this phase is clear communication about the role and reporting relationships related to the NP leader. Most of the early leaders began in the role without individual NPs directly reporting to the NP leader as direct supervisor. The early role focused on resource development, increasing understanding about the NP role, and strategic planning for the future. This is a key time for the NP leader to establish relationships and gain support for the role, with the executive group, department leaders, human resources, and finance officers. Finally, this time period is critical in
establishing a relationship with the individual NPs across the institution and developing an understanding of the unique priorities and challenges in their roles and to gain credibility and grassroots support for the model.

A preliminary assessment about budget needs for a centralized leadership model begins in this phase. A critical question to consider is how to budget the cost of the NP work force, whether to establish a centralized budgeting for the work force or to continue to allocate the resource within the nursing, medicine, and practice budgets. It is important to determine whether all hospital-based NPs will be paid through one centralized budget or through individual departmental budgets.

Frequent meetings with key hospital administrators (monthly) are essential for building of rapport. All authors agree that an annual written report and verbal presentation to hospital leadership about the accomplishments during this phase are critical to successful progression to Phase II.

Table 4 summarizes the Phase I priorities summarized by the leaders at our institutions.

**Phase II: Implementation**

This phase carries three general goals: (a) expand existing programs; (b) identify and address individual practice problems; (c) establish a formalized leadership/reporting structure. The NP leader maintains a broad perspective for NP hospital-based practice but begins to focus onto more individual practice problems that require attention (i.e., a transition from macro to micro issues). Advanced projects related to billing, measuring individual NP productivity, and peer evaluation processes are a priority during this phase. Phase I activities are ongoing and should be gaining more traction while revised to meet the growing needs of the group. This phase focuses on the expansion of the centralized leader role and implementation of a formalized management model. See Table 5.

Implementing a formalized reporting structure is important in order to sustain hospital-wide NP activities and develop future NP leaders (succession planning). Budget allocations are needed to support the development and support of the formalized leadership role and function. Clarifying line authority within the budget is also key during this phase. Preparing NP managers and providing administrative training and mentoring is the goal of the NP leader during this phase of centralization.

For institutions with large numbers of NPs, it was important for the NP leader to obtain resources for additional lead NPs to serve as managers, cluster leaders, or team leaders for subgroups of NPs. At five of the institutions the NP managers have the majority of time devoted to administrative activities with a percentage of time devoted to clinical responsibilities in order to maintain their clinical skill set. Depending on the complexity of the clinical environment, the authors of this article agree that 20–25 direct reports per manager would be a reasonable goal when implementing a new centralized model.

For larger institutions, the leadership model may require a director, assistant directors, and team leaders who would have varying levels of clinical and administrative responsibilities. Once in place, the leadership team can enhance current resources/programs as well as implement a unified approach to performance evaluation specific to NP practice. Formalized leadership models at each institution responded to the unique priorities of their institution and individual needs of the hospital-based NPs (Ackerman, Mick, & Witzel, 2010; Ellis et al., 2008). Table 5 summarizes sample activities to increase chances for success during this phase of development.

**Phase III: Measuring the impact**

The majority of our institutions are in Phase II or just entering Phase III after years of early organization. The centralization of resources for NPs is a process that takes time and persistence. While evaluation is ongoing, we propose that this phase is the time to formally analyze the impact of an organized/centralized NP leadership model. It is important that the NP role is evaluated to measure its impact on patient access to care, quality,
Table 4  Recommended phase I critical activities

<table>
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<tr>
<th>Goal</th>
<th>Activities</th>
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| Regulatory compliance | ■ Review and revise medical staff office and nursing bylaws  
■ Verify credentialing and privileging of each NP consistent with scope of practice, institution, and statewide regulations  
■ Review Joint Commission, Nursing Care Quality Initiative (NCQI) standards, and Magnet forces to assure compliance (American Nurses Credentialing Center, 2010).  
■ Assure the good standing of each NP provider according to state and federal guidelines  
■ Review and assess billing and reimbursement practices  
■ Develop searchable databases and reporting mechanisms |
| Credentialing         | ■ Revise/develop compliant credentialing and privileging process (Kleinpell, Hravnak, Hinch, & Llewellyn, 2008).  
■ Establish delineation of privileges for core and noncore privileges  
■ Develop consensus on competency thresholds and measurement |
| Role clarification    | ■ Review current roles and responsibilities of individual NPs (Bahouth & Esposito-Herr, 2009; Cummings, Fraser, & Tarlier, 2003).  
■ Create standardized job description(s)  
■ Conduct campus-wide education about the NP role  
■ Increase numbers of communications about NP contributions  
■ Develop innovative practice models designed to meet patient care needs  
■ Formulate plan to shift line authority |
| Role transition       | ■ Develop formal orientation programs (Bahouth & Esposito-Herr, 2009; Sorce, Simone, & Madden, 2010; Yeager, 2010).  
■ Develop mentorship programs for professional support  
■ Collaborate with schools of nursing  
■ Serve as the contact resource for graduating NPs as they transition into NP practice  
■ Develop tools for managers to smoothly integrate NP into practice |
| Recruitment           | ■ Evaluate compensation and benefits structure  
■ Conduct market analysis to assure equity  
■ Establish hiring criteria  
■ Develop recruitment tools  
■ Participate in recruitment and interview process  
■ Align with marketing and human resources department |
| Continuing education  | ■ Evaluate current resources for continuing education of NPs in institution  
■ Identify funding mechanisms for hospital-wide NP continuing education  
■ Develop programs as indicated—mandatory education, journal clubs, grand rounds  
■ Collaborate with School of Nursing |
| Self-governance       | ■ Utilize consensus recommendations  
■ Develop a leadership/executive council (NP led) for self-governance  
■ Assure NP representation at hospital-wide decision-making committees |
| Communication         | ■ Develop communication tools for discussion or hospital and statewide policies effecting NP practice (website, newsletter)  
■ Develop marketing and PR materials specific to NP practice  
■ Celebrate NP successes within the institution to underscore NP contributions (publications, awards, advancements in patient care delivery models)  
■ Establish Town Hall meetings or other forums for communication  
■ Participate in key administrative meetings: Liaison to all hospital partners  
■ Advocate for NP practice locally, statewide, and nationally  
■ Submit/present annual report of accomplishments to hospital-wide leaders |
| Professional advancement and retention | ■ Develop processes for and standardize annual performance review  
■ Measure and analyze NP satisfaction survey data  
■ Evaluate salary/benefit structure and institution position in the market  
■ Advocate for legislative changes to promote NP role  
■ Collaborate with human resources to monitor and evaluate turnover issues |

safety, service, and reimbursement. Thus, the impact of the NP-driven patient care model can be communicated during leadership and budget allocation meetings. Several indicators important to the success of the NP program and to hospital finances include NP turnover, productivity, communication improvements, employee engagement, and adherence to The Joint Commission (TJC) and the Centers for Medicare and Medicaid.
Service requirements (CMS) core measures. This phase is a good time to reassess the needs of the group and revise the strategic plan for NP utilization as appropriate. Communication regarding achieved outcomes and successes is critical to validate the return on investment for the NP leader role. It is also important to evaluate the investment being made to develop leaders from within the NP group for the purpose of professional growth, retention of staff, and succession planning.

**Strategies for success and avoiding obstacles**

Several issues became obvious within all institutions during the evolution of the individual NP leadership roles. The majority of the authors on this article reported directly to the Chief Nursing Officer (CNO), whereas among other known models, NP leaders report directly to the Chief Medical Officer (CMO). All authors agree that direct reporting to chief administrators with final decision-making capacity is critical as real-time practice and budget decisions will need to be made. Mentorship for the NP leader as the role formalizes and develops, allows for the leader to transition from an expert clinician to an expert administrator. There are potential benefits of reporting to the Chief Executive Officer (CEO) with indirect lines to both the CMO and CNO because the NP role straddles both disciplines and development of NP programs requires the support of both medicine and nursing leadership. Both the NP leader and the CMO/CNO need to share the same vision regarding the NP leader position throughout the implementation of the role. Frequent meetings were cited as helpful to the development of the NP leadership role.

Identification of key stakeholders in the hospital environment was important early in the development of the NP leader. These individuals were critical as multiple system-wide NP issues were addressed in a variety of settings and their support cannot be emphasized enough. Next, close collaboration with both the School of Nursing and the School of Medicine are important relationships and offer high yield as programs develop. This allows the interface with NP graduate students and affords the NP leader the ability to influence curriculum decisions to best prepare NP students for the reality of hospital-based practice.

Many delays described by these early leaders stemmed from early NPs requesting insufficient resources for the development of such a leadership model. Minimally, the early NP leader needs administrative support and discretionary budget to implement activities key to phase I development. We recommend considering the following critical areas when developing resources and considering centralizing a leadership model for the organization of NP practice: allotment of adequate support resources, early determination of budget authority, decision-making authority, and opportunity to participate on clinical decision-making committees such as Medical Executive Councils, Medical Staff Offices, Nursing Executive Committees. Preplanning in each of these areas will increase the chance for success of this essential position. Table 6 summarizes strategies to consider when initiating plans for a centralized leadership model.

**Discussion**

This survey of NP leaders from our six institutions revealed one clear finding: establishing a centralized
leadership approach for NPs within the organization is not only logical but essential. This leader is charged with facilitating and inspiring a dynamic environment for NP practice. The process involves identifying needs, developing resources, creating physician partnerships, removing existing barriers, encouraging and implementing (championing) needed changes, performing ongoing program evaluation, and celebrating existing foundational successes. These authors agree that this centralized support, communication, and advocacy promotes the provision of expert advanced and holistic nursing practice.

On review of our collective experiences, we identified several areas challenging to the implementation of a centralized approach to NP leadership. One is the inclusion of both physician assistants (PAs) and NPs under the same centralized leader. While the path of education and experience for the NP and PA are usually quite different, the hospital-based role looks very similar. Therefore, it has been logical for all of these institutions to include PAs and NPs under the same centralized leadership model. Caution must be exercised to fully understand the differences in supervision requirement for the PA and the unique needs of both the PA and NP provider.

Next, providing leadership to NPs employed by a variety of entities (hospital, physician practices, school of nursing) but performing a similar hospital-based role can be a challenge. We suggest that the NP leader is responsible for the delivery of NP care within the hospital setting and therefore the leadership work should include all NPs providing care. This can be especially complex when dealing with issues of salary, billing, and orientation but should not limit the NP leader from including these NPs in their system of communication and professional development. Open lines of communication with the hiring managers from these other entities is essential as the NP leader focuses on influencing change for all NPs working in the hospital system.

A third issue common to the early leaders charged with resource development was the “slow slide” into leadership authority. When this occurred, the formal NP leader was charged with the task of centralizing approaches to recruitment, education, role development, and advocacy without the formal budget authority to implement immediate changes. While eventually corrected, this provided the early leaders with implied authority but no direct line authority for the NPs whom they were creating programs. A clearer line of authority will avoid friction between the NP staff and their non-NP manager as changes in the NP practice are being made.

Therefore, the authors of this article agreed that several potential barriers to success should be addressed early in the development of a centralized leadership model:

- Ambiguous reporting structure.
- Lack of true decision-making authority.
- Budgetary restrictions.
- Lack of dedicated resources and infrastructure for program development.
- Ill-defined scope of work.

Review of experiences and approaches in developing the first centralized leadership role for NPs at six large academic centers were similar. Challenges encountered were common. Each leader prioritized early start-up activities in slightly different order, but all agree that certain key activities are essential to success. See Table 7 for key start-up activities to consider as the new NP leader develops the first centralized role.

As healthcare delivery models continue to develop, NPs will continue to provide answers for changing patient care needs. The preparation and knowledge base of the NP is well suited to direct patient management and to navigate the complex healthcare system. The impact on the patient care experience and customer satisfaction is great with a well-organized group of NPs providing continuous care in this ever changing environment. Therefore, we anticipate continued increases in the numbers of NPs hired into the hospital setting over the next decade.

With mounting pressure to maintain hospital costs, an efficient system for managing large groups of providers will be increasingly important. Using the lived experiences of our institutions to find appropriate solutions in a variety of hospital settings will expedite the process for some systems and may provide foundational support for needed change. We authors agree that future challenges of the centralized leadership role will include measurement of patient outcomes correlating with NP practice, demonstration of continued compliance with core measures, and the description of the impact of NP practice on continuity in patient care. Further, the NP leader should
Table 7  Summary of key start-up activities for the NP leader

<table>
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<tr>
<th>Checklist of start-up activities for new NP leader</th>
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<tr>
<td>Identify all NPs within institution</td>
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<tr>
<td>Meet with individual NPs to evaluate roles, contributions, and issues</td>
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<tr>
<td>Identify and meet key stakeholders: Administrators, Directors</td>
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<tr>
<td>Establish standing meeting with CMO and CNO (monthly)</td>
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<tr>
<td>Review state regulations and institution bylaws related to NP practice</td>
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<tr>
<td>Meet with compliance and medical staff officers to review NP files for adherence to regulations</td>
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<tr>
<td>Review credentialing and privileging process</td>
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<tr>
<td>Assess salary structure</td>
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<tr>
<td>Determine budget allocation for implementation of centralized leadership model</td>
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<tr>
<td>Develop NP position description</td>
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<tr>
<td>Review recruitment and hiring process</td>
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<tr>
<td>Develop tools for NP managers (recruitment, tools, evaluation, etc.)</td>
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<td>Develop orientation programs</td>
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<td>Develop mentorship programs</td>
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<tr>
<td>Develop mechanisms of communication (e.g., website development, newsletter, etc.)</td>
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<tr>
<td>Advocate for NP role—locally and nationally</td>
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<tr>
<td>Provide continuing education opportunities</td>
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<tr>
<td>Collaborate with Schools of Nursing (visibility, preceptorship, postgraduate hiring)</td>
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<tr>
<td>Develop NP leadership councils (shared governance)</td>
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<tr>
<td>Develop and modify innovative practice models</td>
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<tr>
<td>Develop NP credentialing and privileging process (peer review)</td>
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<tr>
<td>Establish competency requirements for individual privileges</td>
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<tr>
<td>Establish a formalized leadership model</td>
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<td>Develop outcome/productivity measures</td>
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quantify the NP contribution to an enhanced patient safety environment and demonstrate NP impact on improved nursing satisfaction resulting in decreased nursing turnover.

Conclusion

The experiences of the leaders of these six institutions were similar—all experienced common challenges as the leadership role was developed including prioritizing resources, identifying stakeholders, securing authority, and garnering support for the model. Comparison among our six institutions demonstrated that a centralized approach to organizing NP leadership is essential. Future study will demonstrate the outcomes of implementing such a model of administrative oversight.

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References


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