2-2022

Nurse Practitioners' Adjustment to the Hospitalist Position: A Grounded Theory Study

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By

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A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the dissertation for the degree of Doctor of Philosophy

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ABSTRACT

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Hospital based medicine is the fastest growing medical specialty in the United States. While most hospitalists are internal medicine residency graduates, most of these new internal medicine medical graduates are choosing not to enter hospital medicine, resulting in a growing hospitalist workforce shortage. To fill this staffing gap, nurse practitioners (NPs), some with no previous NP experience, are assuming hospitalist positions. As more NPs assume hospitalist positions, they face challenges adapting to the prevailing physician-based hospitalist model, such as attaining requisite medical knowledge and skills and establishing credibility and rapport with other care team members. Through a series of semi-structured interviews, this qualitative research study explored how NPs working at hospitals in New York State adjusted to the hospitalist position and dealt with various challenges. Findings from this study highlight the need for the development of new and enhanced initiatives, orientation programs, and policies to better support current and future NPs in their hospitalist position.

Keywords: nurse practitioner, hospitalist, and hospital medicine

ACKNOWLEDGMENTS

I would like to acknowledge and thank each NP participant who contributed to this study. Your hard work and commitment to high quality patient care does not go unnoticed. I am in awe of what each of you accomplish in your work.

Dr. Steven Baumann is a true academic leader who I have had the pleasure of working with professionally and as my dissertation chair. His commitment to nursing science is palpable and his support of students is unparalleled. I could not have accomplished this work without his guidance, support, and expertise. I am forever grateful.

Dr Martha Whetsell is one of the kindest people I was honored to meet during my academic experience. Her compassion for students inspires and promotes confidence. I am thankful for her support during this journey and appreciate her serving as a committee member.

Dr. Juan Battle was a late addition to my academic path, however, in the short time I have known him, he has been supportive and encouraging. His words pushed me forward and his wisdom propelled me to think larger and about next steps in research. I thank him for serving as a committee member for my work.

Dr. Tricia Lewis, our paths crossed before this journey, but this adventure cemented a deep bond. Thank you for always lending a listening ear and keeping me grounded. Dr. Corrine Settecase-Wu, your support throughout this journey kept me going. You always knew what I needed to hear, and you propelled me forward with your kindness. I admire each of you for your wisdom, perseverance, and commitment to the wonderful profession of nursing. I am grateful to call you both my friends.

Dedication

This work is dedicated to my family. Their support was unmatched, and I could not have accomplished it without them. You each make my life complete. I am truly blessed.

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Chapter One: Introduction to the Problem

With approximately 325,000 licensed nurse practitioners (NPs) in the United States (American Association of Colleges of Nursing [AACN], 2019), NPs play a critical role in healthcare provision across primary and acute care settings (Andregard & Jangland, 2015, Bruce & Steinke, 2006; Scheurer & Cardin, 2017). To maintain disciplinary standards and regulate their own profession, practicing advance practice nurses (APRN), nurse educators, and constituent organizations formulated a regulation model, the Consensus Model for APRN Regulation (National Council of State Boards of Nursing [NCSBN], 2008). The Consensus Model was developed to standardize APRN regulations including licensure, accreditation, certification, and education. (Mack, 2018). The model provides guidelines for NP roles that include primary care and acute care specialization. In addition, it is recommended that NPs who are employed in acute care settings should be educated and certified as acute care NPs (NCSBN, 2008; Hamric et al., 2009). Despite the recommendations and guidelines, NPs continue to pursue primary care and family educational tracks, but then seek employment in acute care settings (Haut & Madden, 2015). Although 40 organizations have endorsed the model and at least 50% of the model's components have been integrated in 46 states in the US, not all institutions have integrated the guidelines in their practice environments (NCSBN, 2008).

The growing number of NPs and the specialties in which they practice are examples of how the advanced practice roles and specialties are emerging. These workforce changes are due to several factors including NP education, clinical expertise and experiences, population changes, the positive outcomes of NP care, gaps in availability of other health professionals such as physicians in specific specialties, and health care agencies attempts to fill emerging practice

gaps. Acute care settings employ both primary care and acute care NPs in a variety of specialties including critical care and an emerging specialty, the NP hospitalist.

A hospitalist, which provides general medical care to hospitalized patients, has primarily been a practice area for physicians (Howie & Erickson, 2002; Marinella, 2002). The Association of Academic Medical Colleges (AAMC) predicts that a significant physician shortage will persist through 2025, with acute care settings experiencing the greatest service provision gap (Furfari et al., 2014). Consequently, the demand for NPs in hospitals will continue to increase in the coming decades (Bruce & Steinke, 2006; Kleinpell & Hravnak, 2005, Scheurer & Cardin, 2017). NPs employed as hospitalists include NPs with primary or acute care education.

Until the early 1990's most NP programs focused on preparing primary care providers (Hanson & Hamric, 2003). As opportunities for NPs expanded beyond primary care, acute care NP educational programs began to emerge, although relatively few in comparison to primary care programs such as family nurse practitioners and adult-gerontological primary care nurse practitioner programs. Part of this problem is that higher education fails to keep up with changes in healthcare and an acute shortage of nurse practitioner educators, particularly those who can teach acute care NPs. Before the introduction of acute care nurse practitioner (ACNP) educational programs and currently in states where ACNP programs are scarce, NPs educated in primary care were hired to work in hospital settings (Haut & Madden, 2015). Although the Consensus Model guides NP education with NP practice, some hospitals continue to employ NPs with primary care education for positions in acute care (Haut & Madden, 2015; Litchman et al., 2018; Rounds et al., 2012).

Emerging in the late 1990's as a new approach to care management for hospitalized patients, the hospitalist model of care was introduced (Howie & Erickson, 2002; Marinella,

2002). As the fastest growing medical specialty in the US, hospitalists are widely used, fifty-five percent of hospitals that have 200 beds or more employ hospitalists to provide inpatient care (Lindenauer et al. 2007). With the demand for hospital care expected to increase by thirty-five percent by 2025 (Furfari et al., 2014), the need for hospitalists will only continue to grow (Parekh & Roy, 2010).

While the majority of hospitalists are internal medicine residency graduates, many new internal medicine graduates are choosing not to enter hospital medicine, resulting in a growing hospitalist workforce shortage. As a result, twenty-three percent of hospitalist positions are currently filled by NPs (Furfari et al., 2014). In addition to addressing the hospitalist workforce shortage, the employment of NPs as hospitalists is also cost effective for hospitals, as the average NP salary is approximately 45% less than a physician's salary and hospitals can bill 85% of the MD rate for NP care (AANP, 2018; Parekh & Roy, 2010). As an emergent specialty for NPs, the hospitalist role provides NPs opportunities for professional development and growth, which in turn may contribute to positive outcomes for patients, providers, and organizations. NPs are independent practitioners who are educated with advanced nursing and medical clinical knowledge and skills to provide direct patient care. As hospitalists, they provide care to inpatient-hospitalized patients with a multitude of complex issues. Yet, NPs who become hospitalists may face challenges associated with this new professional path that range from developing a new set of competencies to navigating their relationships with others on the healthcare team (Brown & Draye, 2003; Bruce & Steinke, 2006: Scheurer & Cardin, 2017). Despite the increasing number of NPs that are becoming hospitalists, there is little known about how these NPs adjust to this new position and the challenges that they may face as providers in

this new specialty previously dominated by physicians. This grounded theory study explored how NP hospitalists adjusted to the hospitalist specialty.

History of Nurse Practitioners

Historically, nurses have filled the voids left by physician colleagues and other medical personnel (Haut & Madden, 2015; Mack, 2018; Roux & Halstead, 2017). Nurses have consistently occupied positions that reflect the unmet needs of the patients served by the healthcare system when physicians are either unavailable or find the work undesirable (Hanson & Hamric, 2003). NP educational programs were established in response to the lack of primary care physicians in the 1960's especially in ambulatory, occupational and rural settings (Kelly & Mathews, 2001; Rich et al., 2001). In addition to providing much-needed services, NPs offered a holistic approach to care provision, regularly integrating preventative care and health maintenance into their practice (Hamric et al., 2009; Litchman et al., 2018; Mahoney–Siccardi, 1999).

AACN (2019) reports that 47.9% of all nurses in graduate programs are enrolled in NP programs versus other graduate nursing programs such as education or administration. Nurses seek this educational track because it expands their scope of practice, enhances their professional growth, and provides them further autonomy in nursing (Price et al., 2014). However, some authors suggest that NP students are unaware of the Consensus Model and the link of NP educational track to scope of practice. These NP students subsequently seek primary care NP education despite their interest in acute care positions, including the NP hospitalist position (Doherty et al., 2018).

There are currently more opportunities for NPs as hospitalists due to both an increase in patients who are hospitalized and critically ill and the lack of internal medicine residents seeking

hospitalist positions post residency (Dillon et al., 2016). As shortages in acute care positions have expanded, a growing number of new graduate NPs are employed in a variety of hospital units, including critical care and other specialty units (Bruce & Steinke, 2006; Kleinpell & Hravnak, 2005).

With this expansion of the NP role, some NPs have described the challenge of adjusting to their new role (Barnes, 2015). Often NPs are employed in acute care settings regardless of the educational track they pursued: primary care or acute care. If the track in which NPs are educated does not match closely with the area in which they are employed, they may experience knowledge gaps, thus the guidance from the Consensus Model (AACN, 2008; Hamric et al., 2009). This challenge may be especially true for NP hospitalists because of its emergent status. As a result, NPs have reported experiencing low confidence in their ability to execute the responsibilities of their new positions (Barnes, 2015; Dillon et al., 2016). NPs who have become hospitalists may face a particular set of challenges adjusting to their new positions, attributable largely to the complex care needs of patients seen by hospitalists in the acute care setting. In addition to the experience needed to perform hospitalist duties, when an NP becomes a hospitalist, they must also adapt to organizational and process functions of their new position. For example, hospitalists engage in specific tasks, such as admitting and discharging hospitalized patients, which are not typically part of the NP educational focus (Scheurer & Cardin, 2017). Furthermore, as integral members of the healthcare team, NP hospitalists must navigate new or altered dynamics with other providers in a prevailing physician-based hospitalist model.

Development of the Hospitalist Specialty

Shifting healthcare organizational and delivery trends led to the creation of the hospitalist specialty during the 1990's (Howie & Erickson, 2002). Prior to this decade, internists and family

medicine physicians were providing care to their community patients in their offices before and after scheduled hospital rounds (Marinella, 2002). In the 1990's workload demands on physicians increased following changes in reimbursement rates for primary care visits. The result: physicians needed to see more patients within their designated office hours to maintain their income (Marinella, 2002). As a growing number of primary care physicians found it difficult to provide efficient and timely care to both their community patients and their hospitalized patients, the hospitalist practice model for inpatient care emerged (Marinella, 2002). This model allowed physicians in the community to transfer the care of their hospitalized patients to physician hospitalists. It has shown improved efficiency and patient outcomes (Auerbach et al., 2002). Today, as the demand for hospital-based medicine continues to grow while the supply of physician hospitalists dwindles, there is a critical need for other healthcare professionals, such as NPs, to assume the hospitalist position and provide safe and efficient care.

Statement of the Problem

NPs are being employed as hospitalists to fill service gaps created by an undersupply of physician hospitalists (Furfari et al., 2014). As hospitalists, NPs need to demonstrate their competence and value as a contributing member of the healthcare team. Their skills of collaboration and interdisciplinary practice are essential to promote patient safety through communication and teamwork (Hamric & Hanson, 2003). NP hospitalists may face barriers to successfully integrate into the hospitalist model. For example, as the hospitalist model is physician-focused, physician hospitalists have limited exposure to the components of NP education, NP skills, and NP scope of practice, which can create challenges in the mentorship of NPs who assume hospitalist responsibilities (Furfari et al., 2014). Additionally, primary care NP, the most common educational track (AACN, 2019); focuses on health promotion and

chronic disease management, predominantly in the outpatient setting. NPs who are not educated as acute care NPs and assume a hospitalist position may need further education and training specific to the inpatient setting. Despite these potential challenges, there has been very little research exploring the experiences of NPs adjusting to the hospitalist position. Since the NP hospitalist is a relatively new, albeit growing specialty, investigation of NPs' experiences adjusting to this position is essential to identify ways in which current and future NP hospitalists can be better supported in their adjustment to their professional responsibilities.

Significance

The emerging specialty practice of NP hospitalists requires study, and in particular the process of NP adjustment to the hospitalist position is neither well understood nor documented. Despite the implementation status of the Consensus Model in the US, hospitals are employing NPs educated in primary care as hospitalists. The projected increase in the demand for NP hospitalists makes a clear understanding of the process more important. The on-going professional practice changes for NPs, together with the increasing focus of the healthcare industry on interdisciplinary teams, positions NPs for increased opportunities in the hospitalist specialty (Hurlock-Chorostecki et al., 2014). To date, there has been very little research investigating the processes employed by NP hospitalists as they adjust to this position. Thus, this qualitative research study, in the tradition of grounded theory, can provide critical insight into how NPs adjust to the hospitalist position.

Definitions

Acute Care Setting: Inpatient hospital setting.

Acute Care Nurse Practitioner: An advanced practice registered nurse (APRN) that provides care for acute and chronically ill patients in an inpatient setting (Bruce & Steinke,

2006). The Consensus Model (2008) recommends education and certification as an acute care nurse practitioner (ACNP)

Primary Care Nurse Practitioner: An APRN that provides care to patients in a variety of primary care settings: physician practices, ambulatory urgent care centers, and NP directed clinics (Kelly & Mathews, 2001). The Consensus Model (2008) recommends education and certification as a primary care nurse practitioner (PCNP). This category can include family nurse practitioners (FNP) and adult-gerontology nurse practitioners (AGNP).

Nurse Practitioner Hospitalist: A nurse practitioner whose primary focus is the general medical care of hospitalized patients. Their activities include patient care coordination and management, teaching, research, and leadership related to hospital medicine. (Pantalat, 2006)

Purpose of the Study and Primary Research Question

The purpose of this qualitative research study was to explore how NPs adjusted to the hospitalist position in the acute care setting. The primary research question this study aimed to address is: *How do NPs manage their adjustment to the hospitalist position in the acute care setting?* A substantive theory was generated from the derived data using grounded theory to illustrate the phenomenon of the NP's adjustment to the hospitalist position in the acute care setting (Birks & Mills, 2015).

Methods

This research relied on grounded theory, an inductive qualitative research method that involves constantly comparing, coding, and identifying patterns in participant data to explore a specific phenomenon. Ultimately, this iterative process resulted in the identification of a basic social process that was a culmination of the data and themes and explained the phenomenon under study (Glaser & Strauss, 1967).

Biases and Assumptions

A constructionist paradigm assumes that processes invoked when facing a challenge are best understood through reports of interviewees who have experienced it and can be represented by an identifiable social process (Glaser & Holton, 2005). Constructionism supposes that all meaningful reality depends on human practices and reality is constructed out of interactions between human beings (Andrews, 2012). Additional assumptions include: 1) the analysis will focus on an adequate understanding of the participants' experiences and actions, 2) the participants will be capable of responding with honesty and accuracy of their personal experiences and, 3) the participants have all experienced a similar phenomenon: adjusting to the NP hospitalist position.

As a nurse educator for over 25 years, I believe that expert nursing practice such as that expected of an APRN is attained by increased technical skills, experience, and education. With the guidance of my chairperson, I was open to disconfirm this bias and aimed to provide a holistic analysis of the data. Additionally, I interviewed NPs that reported minimal RN experience prior to attending graduate school and recognized that my personal beliefs could be a potential source of bias.

Summary

Hospital-based medicine is a fast-growing specialty in US hospitals. As demand for hospitalists increases while fewer physicians enter this specialty, greater opportunity has emerged for NPs to assume hospitalist positions. To ensure their successful integration into the care team and execution of their responsibilities, a better understanding is needed of facilitators and barriers faced by NPs as they adjusted to the hospitalist position. Research and the development of a substantive theory explaining these processes can lead to the development of a

roadmap for future educators, administrators, and healthcare team members to guide NPs as they embark on this new career path.

Chapter Two: Review of the Literature

The hospitalist position is an emerging area of NP practice, with the number of NP hospitalists growing in the US. However, few studies have probed the NP hospitalist role and the NPs' adjustment to this position (Clark & Paul, 2012; Spychalla et al., 2014). This chapter provides an overview of the literature surrounding NP practice across primary and acute care roles, with a focus on the hospitalist model of care and the role of NPs in this domain.

NPs in Primary Care Settings

The experiences of primary care NPs are well documented in the literature. Initially, nurse practitioner education and practice focused on preparing primary care clinicians who were willing to work in remote locations, in areas where MDs were in short supply, and with underserved populations. Thus, the experiences of NPs in primary care have been a central focus of much empirical investigation (Brown & Draye, 2003; Brown & Olshansky, 1997; Heitz et al., 2004; Kelly & Mathews, 2001). Numerous studies have revealed the myriad challenges faced by NPs in primary care regarding perceived performance and integration into the healthcare team. For example, studies have found that recent NP graduates experience feelings of inadequacy when they enter practice settings and discomfort when they transition to unfamiliar nursing roles within or across organizations (Brown & Draye, 2003; Brown & Olshansky, 1997; Heitz et al., 2004, Kelly & Mathews, 2001).

Additionally, NPs have reported difficulties forging collegial relationships with physicians, which NPs attributed to the physicians' poor understanding of the NP role in primary care provision (Brown & Draye, 2003; Brown & Olshansky, 1997: Heitz et al., 2004, Kelly & Mathews, 2001). A retrospective study by Brown and Draye (2003) underscored the difficulty NPs have encountered building relationships with physicians and NPs' perceived need to explain

and advocate for their role in primary care since the very inception of the profession. Brown and Draye found that physicians who were unclear about the NP position would undermine NPs to the degree of rendering them invisible. NPs who projected confidence were able to define their new positions and advocate more aptly for their integration in decision-making processes, and those who projected less confident tended to assume prior RN-level responsibilities, failing to reach their full potential as an NP. While this study by Brown and Draye recounts the experiences of the first NPs, similar challenges with regards to NPs being compelled to clarify their role to non-NP colleagues and NPs demonstrating their expertise and value in care provision have been reported by NPs in contemporary times (Hurlock-Chorostecki et al., 2013; Lowe et al., 2011).

In a similar vein, studies have illustrated that many NPs experience a lack of confidence in their abilities when entering their new role. One such study by the team of Brown and Olshansky (1997) explored the first year of transition from NP student to practicing NP in a sample (n=35) of new NP graduates from the University of Washington's nursing program. Using grounded theory tradition, the research team conducted interviews and focus groups with NPs during three time points: at one, six, and 12 months after the NP began their new position. Four themes were identified: 1) "laying the foundation" - the NPs finished school and worried about finding employment, 2) "launching"- newly graduated NPs confronted the anxiety of the new position, felt like imposters, and just tried to get through each day, 3) "meeting the challenge" - NPs engaged with physician colleagues to describe their responsibilities and their confidence increased as they gained experience and 4) "broadening the perspective" - NPs were integrated into healthcare, physicians better understood the NP role and MD collaborations were strengthened. Furthermore, participants reported feelings of professional "legitimacy" after

working in their role for approximately 1 year. While insightful, the Brown and Olshansky study had several limitations. The themes skewed towards categorical analysis rather than interpretative analysis. Moreover, the investigators did not adequately explore how circumstantial factors shaped participants' experiences, resulting in a simplified interpretation of findings.

Research by Heitz et al., (2004), and Kelly and Mathews (2001), explored the transition of the primary care NPs (PCNP) to their new roles. Findings from the studies largely resembled those from previously discussed studies, such as the finding that PCNPs experienced a lack of confidence and had difficultly forging collaborative relationships with colleagues when they first assumed their new position. Several additional themes emerged from these two studies: 1) PCNPs described experiencing a lack of time for personal commitments during school and as they transitioned to the NP role, 2) PCNPs described that physicians expected them to see the same number of patients as them, despite the fact that PCNPs are educated to provide socially oriented care (i.e., to address socio-economic concerns and family concerns, as well as physical clinical care), an approach that is more time intensive, and 3) PCNPs described that patients seemed ambivalent toward their role in care provision and possessed a lack of confidence in being cared for by an NP (Heitz et al., 2004; Kelly & Mathews, 2001).

Despite these challenges, both studies found that PCNPs described being able to eventually establish collaborative relationships with their patients and physician colleagues. For example, PCNPs reported that, as they established bonds with their patients, the patients would request to be seen specifically by the PCNP when a health issue arose instead of seeking an appointment with a physician (Kelly & Mathews, 2003). Interestingly, the researchers found that, as the PCNPs gained experience, they became more efficient in their interactions with their

patients, which gradually allowed them to see more patients, which in turn resulted in their physician colleagues being less critical of their workload (Kelly & Mathews, 2003).

The NP position has now existed for over 50 years, and PCNPs have made great strides in establishing their credibility and contributions to patient care (Aiken et al., 1993; Sackett et al., 1974; Schultz et al., 1994). Studies comparing NP care to MD care in primary care and acute care settings found that NPs provided patient care at levels equal to, and in some cases higher than their MD colleagues (Carter & Chochinov, 2007; Mundinger et al., 2000; Schultz et al., 1994). These studies also underscored the critical role NPs play in the provision of high quality healthcare and that the NP role should be fully incorporated into the healthcare system. During recent years, as systemic changes to the US healthcare system resulting from the Patient Protection and Affordable Care Act of 2010 have promoted interdisciplinary care, NPs have been integrated into many more healthcare environments (Spychalla et al., 2014). Although research about NP hospitalists in acute care is emergent, there have been studies exploring the NP role in specific units in the acute care setting.

NPs in Acute Care Settings

As the NP role evolved and medical residents' hours were decreased to promote work-life balance and improve patient safety in the 1980's, hospitals began employing NPs in specialty units, such as critical care, pediatrics, and the emergency department to fill service gaps (Dillon et al., 2016; Hoffman et al., 2004; Williamson et al., 2012). In these roles, NPs are responsible for the care management of patients during their hospitalization on a specific unit. As the prevalence of NPs working in acute care has grown during the past several decades, researchers have sought to assess their relative contributions to care provision and their impact on patient care (Dalton, 2013; Hoffman et al., 2004). A study by Hoffman et al. (2004), for example,

explored the ways in which NP contributions were perceived by other members of the medical management team, including respiratory therapists (RT) (n=28), physicians (MD) (n=13), and day shift staff RNs (n=111) working in the intensive care unit (ICU). Participants were asked open-ended questions and to invited to list the advantages and disadvantages of having NPs in the ICU setting. The overall response rate was 35%, with 262 comments received. Three investigators coded qualitative responses and conducted comparative analysis to generate a list of themes. Overall, findings revealed that NPs are perceived by their colleagues as accessible, competent, and collaborative ICU team members that provide high quality, cost effective care. Many respondents expressed that NPs should have more autonomy as care team members, such as not requiring NPs to have orders co-signed by MDs.

While Hoffman et al., found that the role of NPs was largely viewed favorably, some critical feedback was provided as well. Forty percent of the participants critiqued that the NPs only worked during daytime hours which suggested to the authors that the NPs were perceived to be competent members of the care team whose contributions were needed during ***all*** shifts. Additionally, despite NPs' holistic education and experience, participants viewed them as less skilled than critical care fellows in performing medical procedures (Hoffman et al., 2004). This perception is potentially attributable to the fact that the education of critical care fellows allots them more opportunities to practice procedures, such as hemodynamic line insertions, and perform invasive interventions, such as chest tube insertion, compared to the medical procedure opportunities afforded to NPs. While these findings convey the importance of NPs in critical care, the study did not explore how NPs adjusted to their positions nor did it identify the processes they employed to integrate into the healthcare team and system.

Recent research on NPs within the acute care setting extends to the United Kingdom (UK), where NPs are employed in acute care settings. One ethnographic study in the UK examined the impact of NPs on the quality of patient care in the ICU (Williamson et al., 2012). Qualitative data was collected through interviews with NPs, staff, and patients, as well as through observation. The researchers coded descriptive data to identify prevailing themes, patterns, and processes. Triangulation, a qualitative research strategy through which various coders reach consensus on a final set of themes, was employed to ensure inter-rater reliability (Carter et al., 2014; Fain, 2017). Additionally, member checking was used, whereby initial results were shared with the NPs and the unit RNs to assess the accuracy of the findings (Birks & Mills, 2015). Overall, findings revealed that NPs were perceived to be skilled practitioners who served a pivotal role in providing high quality patient care. One prominent theme that emerged was the NPs as the "lynchpin". The NPs facilitate all aspects of patient care, including on-going symptom management and coordination of interdisciplinary care. NPs were also viewed as role models, serving as a clinical resource for staff RNs, junior physicians, patients and families. Williamson et al. (2012) shared an excerpt from one staff RN participant that, "NPs were like a bridge between doctors and nurses," (p. 1583) and as this bridge, NPs facilitated open communication among the interdisciplinary care team to expedite patients' discharges from the ICU. A primary strength of the Williamson et al. study was that each interview and field note was reviewed and interpreted independently by each researcher and then triangulated, producing more robust, reliable findings. While the study shed light on the vital role that NPs have on ICU patients' coordination of care, many insights were not from NPs themselves, but from other staff and patients. The study did not explore the experience of NPs' adjustment to working in acute care.

More recently, in the US healthcare context, Dillon et al., (2016) explored the transition from student to NP in the acute care setting. This transition period has been documented as a time of stress. Dillon et al. (2016) published well after the Consensus Model (2008) was created. All 34 participants in the study held certification as an acute care NP (ACNP) and each participant worked in a critical care unit as an NP. This descriptive, correlational study modified, with permission, the Casey-Fink Graduate Nurse Experience Survey to apply to the ACNP experience. The variables studied included personal resources, community resources (including organizational support), successful transition, and retention in their first NP position. Findings revealed that leadership support to the NPs, specifically support from an assigned NP or physician mentor, directly affected successful NP transition. The correlation between communication with leadership and confidence in their NP role was statistically significant (r= 0.68; P<.01), as was the correlation between leadership support and professional satisfaction (r= 0.72 P<.05). Both confidence levels and professional satisfaction were found to assist in successful NP transition, increase NP retention and decrease the costs associated with on-going replacement of NPs. This study also assessed the differences among NPs with more and less RN critical care experience before becoming an NP and how each fared during their transition. To do so, the researchers compared results from NPs that had 0-4 years (n=8) prior critical care experience to those NPs with greater than 4 years critical care experience (n=26) before becoming an NP. No statistically significant differences were found between these groups of NPs, which the researchers noted might be attributable to the low sample size of the NP group with 0-4 years of prior experience (n=8).

Although each of the above-discussed studies reported positive outcomes of NPs in critical care, the findings offered little information about the processes NPs employed while adjusting to

the position of an NP in acute care. More specifically, none of the NP participants were employed as NP hospitalists. The NP hospitalist position differs significantly from the NP in a critical care unit within a hospital because of the NP hospitalist's responsibility of managing the complex care of medical patients throughout their entire hospitalization, as opposed to the NP in a critical care unit providing care solely while a patient is in the critical care unit (Marinella, 2002). Thus, it is critical to gain a deeper understanding of the experiences of NPs as they adjust to, and assume the position of hospitalist, especially given the growth of the hospitalist specialty across US hospitals during recent years.

Hospitalists

The hospitalist position emerged during the 1990's as internists and family practice physicians in private practice found it increasingly difficult to effectively manage their community-based practice in addition to the care of their hospitalized patients (Marinella, 2002). The concept of "hospitalist" was first proposed in 1996 to describe a physician who devotes their practice to the care of patients throughout their hospitalization (Wachter & Goldman, 1996). Since the inception of this care model, studies have evaluated the impact of hospitalist care provision on patient outcomes (Auerbach et al., 2002: Lindenauer et al., 2007, Pantalat, 2006).

Auerbach et al., (2002) conducted one of the first studies to examine the mortality rates of hospitalists' patients through a retrospective chart review in an urban community teaching hospital. The study examined length of stay (LOS), readmission rates, inpatient mortality, and mortality post discharge at 30 and 60 days. The study compared results of patients cared for by hospitalists and non-hospitalists. Over 5,300 patient records were reviewed at year one and year two after the implementation of the hospitalist service. Patients assigned to hospitalists (24.8%) and non- hospitalists (75.2%) were identified prior to analysis. Length of stay, cost per patient

and overall mortality rate were similar in both groups at year one. However, the data at year two suggested that adjusted mortality rates were lower for patients cared for by the hospitalists versus those who were cared for by the non-hospitalists during hospitalization and 2 months following discharge. Patients cared for by the hospitalists showed a statistically significant reduction in mean LOS (0.61-day reduction, $P< 0.001$) and a decrease of $822 incurred cost per patient admission ($P < 0.001$). The adjusted mortality rates were calculated using the Cox Proportional-Hazards Model, which is used to relate several risk factors, considered simultaneously, to survival rate (Cox Proportional-Hazards model, n.d.). While this study uncovered positive outcomes of the hospitalist model on patient mortality, the study had several limitations. The study relied upon a homogenous and small sample of five hospitalists in one community hospital in California, which limited exploration of how cost savings and decreased LOS were achieved.

Another retrospective study that examined the clinical and financial outcomes of the hospitalist model of care used a larger and less homogenous sample (Lindenauer et al., 2007). The researchers conducted a retrospective review of over 76,000 adult patient charts for patients admitted to 45 hospitals due to seven specific disease processes during a 3-year period. Patients received care from various providers during their hospital stays: hospitalists cared for 32% of the patients, primary internists cared for 43% of patients, and family practice physicians cared for 25% of patients. The researchers compared outcomes for patients cared for by hospitalists versus the other two specialties, using multivariable modeling to assess the LOS, cost per admission, and rate of readmission (Lindenauer et al., 2007). Interface between the physician's specialty and diagnosis was evaluated based on categorizing the annual volume of each physician group. In addition, all regression models were repeated to assess if the effect of the physician's specialty varied according to the hospital teaching status (Lindenauer et al., 2007). Findings revealed that

patients cared for by hospitalists had a statistically significant shorter LOS (0.4-day shorter LOS, P< 0.001) and a statistically significant lower cost per patient (adjusted difference $268, P= 0.02) than those who were cared for by the primary internists. Hospitalists' patients also had a statistically significant shorter LOS (0.4-day, P< 0.001) than those patients managed by the family practice physicians. However, the adjusted difference in cost of admission per patient was not statistically significant (Lindenauer et al., 2007). Inpatient mortality rates and 14-day readmission rates for all groups were similar. Strengths of the study include the large patient and hospital sample and the use of multivariable models to assess the effect of the three different physician groups. Yet, the study did not examine ***how*** the hospitalist model of care was implemented in each hospital. Thus, outcomes may have varied depending on whether the hospitalists were employed by the hospital or by an external physician group.

The studies by Auerbach et al., (2002) and Lindenauer et al., (2007) highlight the areas where hospitalist care may yield favorable patient outcomes and reduce hospital expenditures. However, there were several notable limitations in these studies. Importantly, all the hospitalist study participants were physicians. NP hospitalists face unique challenges as non-physicians working within a physician-based hospitalist care model. Understanding how the NP hospitalists adjust to the challenges can illuminate opportunities to enhance the transition period for NP hospitalists in acute care settings.

NP Hospitalists

The body of literature on NP hospitalists is largely limited to descriptive narratives regarding the increasing prevalence and expectations of the NP hospitalist. A study by Clark and Paul (2012) explored the experiences of NP hospitalists, focusing on the use of NPs on the hospital at night service (HaN) to manage the care of inpatients overnight. This quantitative

study, which was conducted in a 710-bed acute care facility in the UK, employed a comparative, descriptive, method. During a 12-week period, a validated survey containing Likert scale responses and a free-text comment box was distributed to 110 practitioners (55 physicians and 55 nurses), to assess their perceptions of the HaN NP function. Ninety-eight of the 110 questionnaires were returned, for a response rate of 89%. Physician (n=52) and RN (N=46) responses were compared using the Mann-Whitney U test, which translated each group's response to rankings. Researchers then compared whether the ranks differed significantly, using a priori probability. Statistically significant differences were found between physician and RN responses regarding the understanding of the NP role (P= 0.03). Interestingly, physicians demonstrated a better understanding of the NP role in the HaN service than RNs, suggesting that even though the RNs and NPs share the RN title, staff RNs have a different perception of the NP role. This finding is a departure from the findings of studies previously reviewed in this chapter, which reported that physicians possessed a poor understanding of the NP role. Other notable findings of this study included that staff RN participants perceived NPs to be readily available for advice and teaching and physicians viewed NPs as less capable of performing advanced physical assessments due to less training (Clark & Paul, 2012). While this study provided insight into the role of NPs on the HaN service, it also had several notable weaknesses. The researchers did not use a theoretical framework to guide the study, nor did they provide the survey tool that they used. The study did not address how NPs on the HaN service adjusted to their position. In terms of transferability of findings, because the study was conducted in only one hospital setting in the UK, its results may not be comparable to NP practice in US hospitals.

This literature review provided insight into different NP roles in various healthcare settings. As well this literature review described the benefits of hospitalist care. Specifically, the review

highlighted the experiences of NPs as they transitioned into primary care, how other medical disciplines perceived NPs working in acute care, and various benefits of hospitalist care on outcomes of patients and organizations. However, there has been no investigation of how NPs adjusted when they are first employed as hospitalists—a role that differs markedly from NPs on critical care units in a hospital or in primary care. As NPs become further integrated in the hospital environment as hospitalists, exploring their adjustment may contribute an enhanced understanding of the facilitators and barriers to this emerging NP specialty.

Chapter Three: Methodology

Introduction

This chapter provides an overview of the methodological approach that was undertaken to explore how NPs adjust to the hospitalist position. Specifically, an overview of the traditional underpinning and processes of grounded theory tradition and a description of the sample, data collection procedures, data analysis, and human subject protection approaches are reviewed.

Grounded Theory Tradition in Qualitative Research

Grounded theory is one of the most widely used qualitative research methods employed by nurse scientists. Developed by sociologists Barney Glaser and Anselm Strauss in 1967, grounded theory uses an inductive approach to examine qualitative data with the ultimate objective of creating a substantive theory to understand a specific phenomenon in a particular situation (Glaser & Strauss, 1967). Grounded theory is distinct from other qualitative research methods in that the creation of a theory is informed directly by the data obtained through participant interviews and the researcher's observations during data collection (Corbin & Strauss, 2015). Generally, grounded theory is used in qualitative research when little is known about a particular phenomenon to develop a foundational theory that can guide future research (Glaser & Strauss, 1967). As Glaser noted, grounded theory allows a researcher to discover what ***is*** happening rather than assuming what ***should be*** happening (Glaser & Strauss, 1967; Fain, 2017). As such, studies utilizing grounded theory do not involve a priori hypothesis development. Rather, inductive methods were used to uncover prevailing themes and meanings from the data to address a social process or problem.

Grounded theory is predicated on the tenets of pragmatism and symbolic interactionism (Birks & Mills, 2015; Heath & Cowley, 2004). Charles Peirce (1905) introduced pragmatism in the 1870's, defining it as an "inseparable connection between rational cognition and rational purpose" (p 163). Pragmatism posits that people generate their own meaning about the situations they face and then adjust their behaviors accordingly (Charmaz, 2014). The second underlying philosophy of grounded theory is symbolic interactionism, an approach developed by George Mead and Herbert Blumer to study human behavior (Blumer, 1980; Olshansky, 2015). Symbolic interactionism suggests that people create meaning about their experiences based on the interactions they have with others (Blumer, 1969). People react to situations based on the actions of those around them, and based on those interactions; they create meaning in their lives (Blumer, 1980; Fain, 2017; Olshansky, 2015). Symbolic interactionism also assumes that when individuals are faced with specific experiences, their behaviors can be predicted based on previous behaviors and the meanings of those behaviors (Charmaz, 2014). The principles of pragmatism and symbolic interactionism are integrated into the grounded theory framework. They provide a foundation to understand how individuals behave and react to events and to the actions of those around them, which ultimately facilitates the development of a theory to predict future behaviors and interactions.

In this grounded theory study qualitative data was obtained from semi-structured interviews with NP hospitalists (described below). Data from these interviews was simultaneously coded and analyzed throughout the interviewing process using the constant comparative analysis process to identify connections, differences, and variations in the data (Glaser & Strauss, 1967). This iterative process enabled the researcher to develop categories that were then grouped into

themes. From these main themes, a theory grounded in the data was developed that provided an overarching interpretation and explanation for the themes.

Sample and Recruitment

NP hospitalists were recruited and engaged to gain insight into the process by which NPs managed their adjustment to the hospitalist position. Initially, convenience sampling was planned, which was supplemented by a purposeful sampling technique known as snowballing, as participants were engaged (Naderifar et al., 2017). Approximately 20 participants were identified from the membership of the New York State Nurse Practitioner Association (NYSNPA). Participants were employed as NP hospitalists in an acute care setting when they participated in this study. The anticipated sample size for the study was based on experts' varied estimates for grounded theory studies and recruitment was stopped when saturation of data was obtained (Munhall, 2012; Polit & Beck, 2018).

In terms of participant recruitment, the researcher submitted the documentation to the NYSNPA Board of Directors outlining the research study and requested that a researcher-developed recruitment flier be distributed to the NYSNPA constituents by email. The researcher also attended a local NYSNPA dinner meeting and shared information about the research study with the attendees. NPs who expressed interest in participating were invited to speak with the researcher privately to determine if they met inclusion criteria. To be eligible to participate in this study, participants were RNs that hold NY state professional licensure as an NP and NPs who are employed full or part-time as an NP hospitalist for at least 1 year but not more than 5 years. If an individual met the inclusion criteria and volunteered to participate, an in-person interview was scheduled at a mutually agreed upon time and location. Apart from assessing eligibility, this initial meeting facilitated rapport between the participant and the researcher,

which was further developed during the interview. As interviews were completed, the researcher began snowball sampling, asking participants to recommend potential participants who may meet inclusion criteria. To ensure that a small circle of NPs who were known to each other did not represent the complete sample, the researcher randomly selected participants that had been suggested by other participants.

Data Collection

Data collection involved in-depth interviews and the administration of a brief demographic survey. In-depth interviewing allows the researcher to obtain more comprehensive knowledge about individual experiences that are relevant to the phenomenon of interest (Brinkmann, 2013; DiCicco-Bloom & Crabtree, 2006). The researcher scheduled in-person, semi-structured interviews at a mutually agreeable location convenient to the participant and the researcher. The semi–structured interviewing technique involved the use of a limited number of prepared questions to enable the participant and researcher to co-direct the interview (DiCicco-Bloom & Crabtree, 2006). Prior to beginning the interview, the researcher explained the study to the participant and obtained written consent, including permission to audio record the interview. Each interview began with the general question, "Tell me about being an NP hospitalist?" to focus the conversation. Throughout the interview, the researcher listened intently and used interviewing techniques, such as periods of silence, gesturing, and restating the participant's comments to clarify and obtain in-depth descriptions of the participants' experiences. Following each interview, the researcher wrote memos with their personal observations from the interview (Brinkmann, 2013). Each participant also completed a brief survey to provide general demographic information (Appendix A). After review of the first few interviews and discussion with the researcher's faculty, the grand tour question was changed to "Tell me about becoming

an NP hospitalist?" Interviews continued until theoretical saturation was achieved, when data no longer offered new ideas or reflections to the categories or themes identified (Charmaz, 2014).

Data Analysis

Consistent with grounded theory tradition, data analysis involved the simultaneous coding and analysis of transcribed interview data (Glaser & Strauss, 1967). The coding process involved line-by-line analysis of each transcript, and the researcher initially categorized pieces of data into interpretations of low-level meanings. As analysis proceeded, data continued to be compared to previously identified codes in order to develop higher-level meanings (Birks & Mills, 2015). As the comparative analysis continued, commonalities, differences and themes, which explained the experiences of the participants, became apparent (Glaser & Strauss, 1967). Further analysis of the categories and themes identified the basic social process, which was built around a core category (Glaser & Holton, 2005). The content and context of participants' comments regarding their experiences as NP hospitalists were assessed throughout. After the codebook was finalized, the researcher engaged in extensive memo writing to identify crosscutting themes among codes and trends within the data. A core category was identified through analysis of the data and the commonalities within the themes (Glaser & Holton, 2005).

Rigor

The researcher sought to ensure the fidelity of the data collection procedures and validity of the findings in multiple ways. Lincoln and Guba (1985) suggest that trustworthiness of a research study directly relates to the worth of the research. To ensure trustworthiness, the researcher documented their thoughts by memo writing and journaling throughout the data collection and analysis. These memos were referenced to contextualize findings from the qualitative analysis.

Rigor in grounded theory research can be attained by: 1) allowing the participant to guide the process, 2) checking the theoretical construction against the participants' meanings, 3) using participants actual words in the codes, themes, and finally if appropriate, the theory, 4) communicating the researcher's personal view about the phenomenon being explored, 5) stating how and why the participants were selected, 6) defining the scope of the research, and 7) describing how the literature relates to the categories and themes that emerged in the theory (Chiovitti & Piran, 2003). These approaches were employed in this study. Additionally, maintaining credibility, transferability, dependability, and confirmability supported the rigor of the study (Lincoln & Guba, 1985). Credibility demands that the findings were accurate descriptions or interpretations of the participants' experiences. Similarly, confirmability guaranteed the data and analysis, were true depictions of the participants' experiences. (Fain, 2017; Glaser & Strauss, 1967). Transferability assured the results of the study could be generalized to participants in similar settings who experienced similar conditions (Lincoln & Guba, 1985). Lastly, dependability occurs when the findings are consistent and can be repeated.

Protection of the Participants and the Data

Institutional Review Board (IRB) approval was obtained from the City University of New York (CUNY) prior to study commencement (Appendix B). A written description of the study was submitted to the NYSNPA, as required by their bylaws.

Documented informed consent was obtained from each research participant before each interview. Additionally, participants were informed that their involvement in the research was voluntary; that they may stop participation at any time, and that failure to participate would not have any effect on their affiliation with the NYSNPA. Participants were provided an opportunity to ask questions or raise concerns about their participation prior to beginning the interview. With

the consent of participants, interviews were digitally recorded. Data collected during interviews (e.g., audio files and field notes), as well as demographic survey responses, were stored in a secure location only accessible to the researcher. Each participant was assigned a unique code during data analysis to ensure confidentiality, and all findings were presented using this coding scheme (i.e., P1-P17) to protect participants' identities. Transcriptions were shared solely with the researcher's mentor to ensure accurate coding.

Summary

This chapter provided an overview of the qualitative methods that were used to explore NP hospitalists' experiences acclimating to, and performing, their role. As described above, grounded theory was used to uncover a theory that relates to the NP hospitalist adjustment experience, as this is a growing area of research. Convenience and snowball sampling were used to recruit potential participants, and semi-structured interviewing probed NP hospitalists' experiences. Rigorous data analysis methods were employed to ensure that findings were reliable and valid. Finally, the researcher adhered to the highest ethical standards throughout recruitment, data collection, and data analysis to safeguard participant privacy and confidentiality.

Chapter Four: Findings

The findings of this grounded theory study are an analysis of the codes and themes of the participants' comments about their experience of becoming a NP hospitalist. Grounded theory tradition provides a perspective on human behavior and develops a theory from the data collected and analyzed. This chapter begins with a brief introduction of symbolic interactionism, which is the underpinning of grounded theory tradition. It then describes the demographics of the participants and then outlines the categories and subcategories, which represent the findings of this study. Actual interview quotations are immersed throughout the discussion section and pseudonyms for the participant names were used to protect the actual contributors. The data were analyzed using constant, comparative analysis, which identified categories and subcategories. The results of the data analysis led to the uncovering of the abstract categories that define the basic social process, *Seeking Recognition as an Advanced Practice Nurse in the Hospitalist Position.*

Symbolic Interactionism and the NP Hospitalist

Symbolic interactionism is a fundamental element of grounded theory, which was developed by George Mead and Herbert Blumer (Blumer, 1969). Symbolic interactionism focuses on processes through which events, social conditions, things, people, and the environment take on meanings (Blumer, 1969). Based on the actions of those around them, people respond, and based on those responses, meaning is generated in their lives (Blumer, 1969; Fain, 2017; Olshansky, 2015). Symbolic interactionism also assumes that when individuals are faced with specific experiences; their behaviors can be predicted based on the meanings of those behaviors (Charmaz, 2014). Understanding the meaning behind people's behavior, interactions, and responses helps the researcher understand the experiences of the participants within a specific context. (Jeon, 2004).

In their interactions with physicians, registered nurses (RNs), and other advanced care providers (NPs and PAs) within shared space, the NP hospitalists engage in behavior and use language, which constructs social meaning. Each interpersonal interaction elicited a different response from the NP hospitalist. Overall, the NP hospitalists described their interactions with physicians as interactions in which they were treated as subordinates rather than colleagues. One participant verbalized that interactions with MD hospitalists led him to *"feel like I exist in a permanent second-class status."* As he articulated this to the researcher his facial expressions became passive and subdued and his voiced lowered in tone. As stated by many of the participants, the responsive interactions from the MD hospitalists displayed a lack of recognition of the NP hospitalists as advanced practice nurses. Instead, many participants described being treated as assistants to the MDs. "Andrew" (participant 1) stated he depended on the MD hospitalist to *"delegate which patients I saw and mostly I did the discharges and admissions which [the MDs] didn't like to do."*

"Dawn" (participant 4) became upset as she reported, "[*The MDs] think I'm just there to do admissions and histories, not do what I'm trained to do which is total care of the medical patient in an advanced nursing role."*

Describing their interactions with RN colleagues on the clinical units the NP hospitalists reported that, their RN colleagues *"*felt the NP hospitalists were helpful to the staff nurses because [the NPs] are still nurses.*"* Again, this reported consensus additionally indicated a lack of a clear recognition of the NPs as advanced practice nurses**.** Recounted interactions with their NP or PA hospitalist colleagues described acknowledgement of the NPs advanced practice status. However other NP or PA hospitalists reported their function was to "assist" the MD hospitalists. This caused them to function in a secondary role. "Quinn" (participant 17), a PA hospitalist interviewed,

casually stated, "*By nature of my title as a physician assistant why would I expect anything different?"*

Demographics of the Participants

Demographic data was collected before each interview**.** Sixteen NPs participated in one-on-one personal interviews. All NP participants were employed as NP hospitalists for at least one year; 10 worked in community hospitals and 6 in tertiary hospitals. Thirteen participants were female and three were male. Eleven were non-Hispanic White, two were Black, two were Asian, and one was Hispanic. Participant ages ranged from 27 – 65 years old. All NP participants held a graduate degree in nursing. Nine NPs were certified as Acute Care NPs (ACNP), four were certified as Family NPs (FNP), and three were certified as Adult-Gerontology NPs (AGNP). Overall, the participants reported 4 to 35 years of RN experience before becoming an NP. Eight participants had NP experience before beginning the hospitalist position: three ad worked as an NP in outpatient primary care settings and five had worked as an NP in cardiology inpatient care settings. The remaining eight participants stated their current position of NP hospitalist was their first NP position since graduating. To protect their anonymity, all names in the discussion of findings are pseudonyms. Additionally, to add rigor to the study, one non-Hispanic White male PA hospitalist was interviewed. He reported this was his first PA position and he had been working as a PA hospitalist for 3 years. He was certified as a physician assistant. (See Appendix E).

Seeking Recognition as an Advanced Practice Nurse in a Hospitalist Position

Three categories emerged from the data, which led to the overarching social process identified in this study: S*eeking recognition as an advanced practice nurse in a hospitalist position*. Participants described behaviors consistent with trying to distinguish themselves as NP hospitalists. The three categories identified to support the basic social process are: 1) reducing

the workload of the MD hospitalists, 2) building partnerships, and 3) becoming a provider. Subcategories were identified to support each category.

Category 1: Reducing the MD Hospitalists' Workload

As NPs enter the genre of hospital medicine, they are faced with delegation from the MD hospitalists to the tasks that the MDs view as menial or "less" satisfying. Most participants in this study verbalized this perception, although three participants who had previous NP experience, did not experience the feeling of being "subordinate" They believed that the MD hospitalists delegated to the NP hospitalists to leverage their own availability for patients that are more complex: much of what the NP hospitalists were assigned were tasks that the MDs said "tied them up"

Subcategory A: Picking up the Slack

The participants shared the feeling that the NP hospitalist role was in place to "pick up the slack" and "fix things quickly." "Carol" (participant 3) stated,

"Our job is to take the excess work away from the MD hospitalists like discharges, admissions, and medication reconciliation. All things they usually do not like to do."

Most NP hospitalists described being assigned their patients by the MD hospitalists based on what *"lightens the MDs' patient load."* "Helen" (participant 8) shared, *"I'm looped in with the docs but I'm primarily doing whatever will free them up."* The overwhelming similarities cemented the overarching social process that the NP hospitalists were seeking recognition as an advanced practice nurse in the hospitalist position. The NPs expected to function as an advanced practice nurse; however, they felt that they were neither working to their full scope nor able to develop to their full potential as advanced practice nurses. Each NP interviewed shared the frustration and desire that Dawn stated,

"*I want to do what I know I can do and am trained to do- total care for hospital medicine patients."*

Instead, their role was dictated by what the MD hospitalists did not deign to do themselves. To further support, this premise "Fran" (participant 6) described it as

> *"We get our patients to help alleviate the load from the MD hospitalists. It's like we bridge the gap between what we are able to do and should be doing as an NP and what they want us to do so they don't have to do it"*

Helen further explained how during interdisciplinary rounds she was included, however,

> "*The MD gave the orders, and I entered the orders into the EMR [electronic medical record. I could add my opinion but generally the MD called the shots and then looked to me to enter the orders, I sort of felt like a scribe."*

Subcategory B: Bridging the gap

Often the bedside RN staff sought the NP hospitalists to "fix" things that were either not completed or not completed correctly by the MDs. Andrew related how certain MD hospitalists *"conveniently forgot to order things and when called told the bedside RNs to call the NP to do that for them."* Despite the overall sentiment of functioning in a subordinate status, participants took pride in their sense that they still "made a difference" with the patients. Andrew remarked that he was able to focus on the *"problem patients- the patients that usurp a great deal of time from a psycho-social perspective, so it frees up the MDs".* Of note by many of the NP hospitalists, was that the NPs excelled at the psychosocial and complex community issues whereas the MDs did not usually address these concerns. "Mallory" (participant 13) explained, "*I was often assigned the patients and families that had complex issues and would require many hours of interactions."*

She smiled and stated she was happy to assess and address these issues because they made a real impact on patient outcomes and she felt she was well versed in dealing with these issues. The MD hospitalist working with her would tell her "*A doctor isn't needed to work on those issues*". The participants reported many different scenarios where they had to work hard to be "recognized." "Gloria" (participant 7) stated that often she had to coordinate the MD consults, contact the patients' families, and ensure the testing was done. *"Very different than the skilled assessments I was capable of or the clinical decision making I was trained to do".*

The participants were clear that NPs are educated to assess and treat patients at an advanced practice level. The NP hospitalists who had NP experience before becoming a hospitalist reported that in their previous NP position, they had been recognized as an advanced practice nurse and they had developed skills associated with that position. The NPs had cared for a select group of patients, and although the focus may have been on a specific physiological system such as cardiac, they were able to assess, diagnose, and treat their patients completely. They reported a sense of advanced practice recognition and autonomy working in those previous NP positions. Conversely, in the NP hospitalist position, these participants reported a lack of distinction and recognition of their abilities and the frequent experience of being assigned tasks well below their full scope of practice. Carol reported, "*We don't do the same work as the MD hospitalists; they are in charge of the patients and we are in charge of taking excess work away from the MDs."*

Most participants commented that there is an extreme focus on discharging patients and most MDs are "not strong" with paperwork, therefore discharges are usually assigned to the NP hospitalists. Helen described her position as the *"gatekeeper"* for the MDs. She was responsible for keeping track of what was going on with their patients and reporting to the MD at the end of the shift.

"I help with the overall management of the patients so the MDs can triage their day around what they've assigned me to do."

The common thread throughout all those interviewed focused on receiving offloaded work from the MD hospitalists and being assigned the tasks and duties that were least satisfying to the MDs. This precluded the NP hospitalists from being recognized as the advanced practice nurses they were, and thus resulted in a general dissatisfaction among these NP hospitalists in the expectations and experiences of the hospitalist position.

Subcategory C: Tackling the broadness of medicine

Each participant noted that the hospitalist position focused on broad aspects of patient care, specifically hospital medicine. Different from a specific physiological emphasis, hospitalists are expected to cover every aspect of care. Participants recounted that because of the broadness of hospital medicine, they had a greater learning curve to feel prepared. Yet the MDs assumed that the NP curriculum prepared them for working in hospital medicine, many participants explained. "Ellen" (participant 5) pointed out that as a bedside RN she had been unaware of the scope of the hospitalist position.

"A lot goes on behind the scenes and [NP] school doesn't adequately prepare you for the position. They [the MDs] don't actually understand what our curriculum covers. One MD actually said to me, didn't you learn that in school?"

"Beverly" (participant 2) shared that she has learned a great deal as a hospitalist,

"As a hospitalist I can now handle the whole patient, it's like having a few different positions. I took my knowledge [from primary care] and now apply it to inpatients. Being a hospitalist is one of the best roles- it lets you see everything because of the broadness."

Many of the participants felt that the hospitalist position would be difficult for a newly graduated NP. Dawn voiced her concern,

> *"I worked in medicine as a bedside RN then became a cardiology NP. I think when you have one focus you can become very good at that- Medicine is too broad, it's everything, and requires a lot of self-learning."*

However, the participants that had become hospitalists as their first NP position felt the broadness of hospital medicine enhanced their learning. Ellen and Fran explained their experience as analogous to starting bedside nursing as a medical surgical nurse. The hospitalist position provided them the opportunity to gain foundational experience before entering a specialty NP position with one specific focus. "Jane" (participant 10) stated that working as a hospitalist expanded her knowledge base,

> *"I'm glad I became a hospitalist. After doing this I feel like I can do anything."*

*"*Kevin" (participant 11) concurred, *"It's broad-based but the best way to learn".*

All NP participants described that their learning was self-motivated and that the MD hospitalists believed that the NP curriculum included the many aspects of hospital medicine. Yet, different from this belief, little focus was placed on hospital medicine in the NP curriculum. "Paul" (participant 16) explained,

> *"[School was] very textbook-based. It didn't prepare you for the NP hospitalist position. It looked at what could happen and didn't focus on the overall process of providing comprehensive care to all types of patients."*

All the study participants emphasized that previous bedside experience was so critical prior to becoming an NP. They each reported relying on prior bedside experience, electronic

applications, textbooks, and journals to research knowledge needed when caring for their patients.

Category 2: Building Partnerships

The NP hospitalists explained that a large part of their positions relied on building partnerships. They stated they accomplished this by communicating with authenticity and clarity and maintaining a focus to center the patient in all work that they do. This strategic communication and patient focus contributed to more confidence in the NP hospitalist position as these partnerships strengthened.

Subcategory A: Partnering with the Bedside Nurses

Many of the participants described the need to create a strong bond with the bedside nurses on the clinical units. Carol described her relationship with the bedside nurses as *"reciprocal."* She commented that once the bedside nurses understood the NP hospitalist position, they looked up to her. They sought her out to ask questions and valued her input. She went on to say,

> *"Once they saw I could manage the patients' needs the trust started to develop. Since I'm still a nurse. I trust them, and they trusted me."*

Since this was Carol's first NP hospitalist role, she recalled explaining her newness to the position to the bedside nurses. She reported that the charge nurse told the others "She's still learning, go easy on her it's her first hospitalist position." Carol felt that opened easy communication with all the bedside nurses because *"nurses always want to help other nurses."*

Whenever the NP hospitalists were assigned to specific units the bedside nurses became very familiar with them. Gloria explained,

"Since we're on the floor they have immediate satisfaction of being able to have someone there when something goes wrong. That's the way our relationships develop because we see them every day."

Jane characterized her relationship with the bedside nurses as strong. "*In the beginning I pitched in with care- since then they really engaged with me."* She felt that helping with some tasks really cemented her partnership with the bedside nurses. *"I know the nursing stuff, so I figured I'd help. I know what it's like to be busy with a lot of patients."*

Although each participant believed it was critical to build a partnership with the bedside nurses, some of the participants expressed that their NP hospitalist position was not always understood by these colleagues and therefore was not recognized as an advanced practice position. Paul stated,

"Although I'm there to support the bedside nurses I'm really there to handle the acute episodic care that arises with the patients and sometimes the nurses call the docs even when I'm on the unit".

Paul expressed that he felt undervalued when this happened and not recognized as having an advanced nursing degree. Paul went on to discuss how he worked towards the bedside nurses understanding he was on the unit to handle episodic care and support them. Yet still, he said, *"Sometimes I felt it was a losing battle. I continuously stepped in to handle problems, but many bedside nurses still wanted the MDs called. They didn't really see us as able to handle it."*

Subcategory B: Partnering with the Patients and Families

Another key aspect of the NP hospitalist position was taking on the responsibility of dealing with the psychosocial issues of the patients and their families. The participants shared their belief that as nurses they were well trained to interact closely with patients and families.

Many patients said they did not understand the hospitalist position nor why an NP would be caring for them in the hospital. Carol recounted that she had a patient ask, *"Why is an NP taking care of me? I came to the hospital to have a doctor take care of me".* Carol explained to the patient her position as part of the care team, but generally found most patients were exposed to the NP position only in the outpatient settings. Likewise, Gloria detailed a situation she experienced with a difficult patient who could not understand the hospitalist position nor her NP position. She explained it to the patient as, "*The MD hospitalist is the captain of the healthcare ship and I'm part of his crew."* During her interview, Gloria recounted that her own statement to this patient supported a secondary position to the MD and did not distinguish herself as an advanced practice nurse. Gloria went on to clarify that at times the bedside nurses described the NP hospitalists as *"a physician lead."*

> *I would correct them by explaining I was a mid-level provider, but that always seemed condescending to me. Mid-level of what? This also seemed to confuse the patients".*

As Gloria recounted these representative instances, she became exasperated and angry stating, *"It makes me so angry when people don't understand what I'm trained to do. I get so tired of explaining it."*

As part of Beverly's daily routine, she rounds on the patients that are assigned to her by the MD hospitalists. Prior to the COVID -19 pandemic, she would arrange for the patients' families to be present during rounds. Throughout the pandemic Beverly instead began speaking to the family members via video sessions. She explained,

> *"Patients cannot always remember everything I say – it's important for the family to be involved. They depend on me to explain all aspects of their hospital care to them. Sometimes my plan may be starting a new pattern in their lives*

and I want to make sure they are aware of all the risks. It allows the patients and family to be active partners in the hospital plan of care".

Each of the participants confirmed the critical need to keep patients and families involved. Kevin noted,

"The partnership between me and the patient is so important- getting buy in and making sure they understand the plan across the continuum of care".

Paul summed up the purpose and value of an NP hospitalist partnering with patients and families, *"I want them to know what I do and why I'm doing it. I need them to trust me as their provider of care and understand that I'm educated and am able to take complete care of them."*

Category 3: Becoming a Provider as an NP Hospitalist

When the NP hospitalists were assigned a patient versus tasks such as admissions, discharges, and medication reconciliations, each NP participant voiced different feelings related to the responsibility associated with becoming the provider for the total care of patients. They voiced concern for developing the plan of care, ordering medications and diagnostic testing and procedures, and *"calling the shots"* during acute episodes. Beverly shared,

"I was available to the nurses in real time when things went sour with a patient. It was easy for them to reach me because I was housed on the unit. If they became worried about a patient, I was there. It was a lot of responsibility for me, but I did it".

Subcategory A: Relying on Previous Bedside Experience while Exploring a New Position as NP Hospitalist

Beverly explained,

"Although I always felt I was a provider of care as a bedside nurse, this position

was very different. I found myself depending on my knowledge base when I was at the bedside, but I really needed to build on that knowledge. There were some days early on, I felt there were nurses on the unit that probably knew more than me, so I had to bring on my game."

Andrew explained that he often felt he had to "prove" himself. He needed to work to the scope of the MD that assigned him his patients at the same time that the bedside nurses expected him to cover everything the patients needed.

"I felt I was independent yet still very dependent. The docs told me who to care for but then it was on me to accomplish whatever was needed. My NP license allowed me to order things, but I needed to get back to my bedside nursing knowledge".

"Laura" (participant 12) had worked as a bedside nurse for 35 years before becoming an NP. She had also worked as an NP in primary care before becoming a hospitalist. Laura explained,

"Bedside nursing is at the core of all I do as an NP. I use it as my foundation and then built on it as an advanced practice nurse. I find myself constantly thinking about what I did when I was at the bedside and then figuring out how to incorporate my NP knowledge into the patient's plan of care".

As a bedside RN for 20 years before becoming an NP, Kevin reported that he also relied on what he did as a bedside nurse and his critical thinking skills when he started his NP position.

"*My assessment skills were key. I felt like I would be held to the same standard as an MD however, there is always an MD willing to point out you are not at their competency level. There is a subtle implication to know your place. That's*

why I focused on what I did best and used my assessments and critical thinking skills".

Beverly agreed with Kevin's dependence on previous bedside nursing skills. She remarked,

"[Bedside] nursing counts. You need good nursing skills before going into this role. Because of my ICU skills, I am able to see the whole picture. I knew critical situations and that was a huge part of the [NP hospitalist] position. I believe if you have a great nursing background half the job is done for you, the other half is researching and figuring out the patient's situation. Assessment is a huge aspect of any kind of care you provide".

Dawn also believed her bedside skills helped make her a strong NP hospitalist.

"The [10] years of nursing I had at the bedside added to my assessment and overall skills. My basic RN skills helped me become a strong hospitalist. I am the one who knows the patients because that is what I did as an RN. Now I'm the main person, responsible for figuring out what to do. Overall great assessment skills help me do that."

Ellen added her own perspective on the relevance of bedside nursing experience to her position as an NP hospitalist.

"I knew what I could do as a nurse. Our nursing background helps us see the patient as a whole. I incorporate my nursing background with the medical aspects of being a hospitalist. Just like when I was a bedside nurse I sit and listen to my patients, I talk to families. The MDs do not do that and either do the PAs. It is not part of who they are. Once a nurse always a nurse".

Subcategory B: Different than Expected causing fear and uncertainty

The study participants that had NP experience before becoming a hospitalist each verbalized how the NP hospitalist position was very different than they expected. "Irene" (participant 9) started her career as an ED nurse and after completing her NP education, she had worked as a cardiology NP for 5 years. She then became an NP hospitalist. As a cardiology NP she stated she had more autonomy and could maintain her nursing focus. She was responsible for managing only the cardiology aspect of her patients' care.

> *"As a hospitalist I felt like there was no room for my nursing focus I was expected to see a patient, diagnose and treat: it was really a medical model. The nurses looked to me to solve things. I was not prepared. I had to retrain my brain to think broad. I thought I would manage a set of patients as an advanced practice nurse. The MDs expected me to follow the medical model completely. I wondered if I could do it. It wasn't what I expected, and it made me feel very uneasy initially."*

Most of the participants expressed feeling uncertain and fearful as they were beginning their new position as an NP Hospitalist. Carol felt like she was "in the dark" as she began her new position.

> *"As a new NP, I didn't know how to treat patients. They would come in, have a CXR and I did not know what I was looking for. Because I was assigned my patients from the MD [hospitalist], I was not prepared for what I would see. It was just like, these are yours. There was so much uncertainty. Even with the admissions. I had done them as a bedside nurse but now I needed detail. I really*

felt the pressure of the responsibility that now I was the one making the decisions."

Kevin added,

"When I first transitioned [as an NP Hospitalist] I was kind of excited, but within my first shift that quickly changed to nervousness. I really struggled initially because I was on my own. How could I be in charge of people's lives? I was too scared to be challenged. This was a completely new ballgame for me. I didn't trust myself or my decisions because I had to keep looking things up, but as I developed my skills, I became more confident, but it took a while."

Ellen and Beverly concurred with Carol and Kevin. Ellen and Beverly both verbalized that initially they were overwhelmed and uneasy. They relied on their prior knowledge and built upon it while they were not confident in the beginning. As they gained experience, they both grew into solid NPs.

Subcategory C: Mentoring and Orientation

Throughout each interview the participants remarked on the lack of orientation to the NP hospitalist position. Many of the participants compared their experience of becoming an NP hospitalist to when they first became RNs and commented that the transition to the RN role was more structured and comprehensive. They characterized the orientation process for an RN role as one more focused on facilitating learning, with a strong resource person beside them. Conversely, as they became NP hospitalists, they explained, "*it was more on the job training. No real focus"* Andrew made the following analogy,

"*When you're in school there's always a second pair of eyes, you're always a student so they expect you to be learning. As an NP, it is like OK you are a nurse*

so here are your patients and get to it. There was no real preceptor side by side. The MD [hospitalist] would answer questions but they had their own patients. If I asked, they would explain things, but it wasn't built into the transition."

Kevin added,

"As nurses, we got an actual orientation. We were with a preceptor; we were shown the ropes even where things were kept like supplies. As an NP hospitalist, it was like - OK here is your first shift. I did feel supported by my MD hospitalist, but they expected and promoted me working autonomously even in the beginning. I had to figure things out and look things up. It was overwhelming; not only did I need to know what I was doing, but also why I was doing it. There was no one next to be guiding me."

Gloria remarked that what helped her in becoming a solid NP hospitalist knew her roots as an RN.

"As a bedside RN, I was the one other nurse came to with questions. Now I needed that someone, but it wasn't available. I would ask the MDs or other NPs, but I had to ask; there was no one assigned to mentor me into becoming an NP hospitalist. I just kept on asking questions."

Jane described a situation where she stepped up to mentor a new NP recognizing the importance of a mentor when beginning a new position.

"I tried really hard to support a new NP hospitalist, because I knew how it felt to be floundering. The main difference was that he went right into graduate school and never worked as a bedside RN, so he had absolutely no frame of reference for even simple things. Although my mentoring helped, I could not

teach him what he would have learned as a bedside RN. You just need that experience."

Paul recounted,

"As a new NP hospitalist, I knew who my MD buddy was, but I was on my own. Different from others, I was assigned an NP preceptor for 2 shifts, but I was expecting at least 2 months with a preceptor. At least I was kept on days in the beginning. There are more resources available on days. When I finally moved to nights, it was I with two other NP hospitalists and two MD hospitalists covering the whole house. I needed to know what I was doing. I really bonded with the other two NP hospitalists and we relied on each other. We definitely tapped into the MDs when we needed to, but we became a tight threesome on nights. It was great; we picked each other's brains, and I am proud to say I think we are strong in our positions. But the issue is we had to make it happen. It wasn't set up for us."

Quinn who is a PA hospitalist described his experience coming on board as a PA hospitalist.

"PAs are trained in the medical model just like MDs, so we assimilate to the model easier. When I first started, I was not assigned a preceptor I just started. This was my first real healthcare job, so I guess I didn't know any better. I was sort of thrown into the position. I did ask questions, but I was definitely expected to hit the floor running. Because my notes and orders have to be signed by an MD, I did have to run my decisions by the MDs first, so I guess it was sort of like a mentor."

Many of the NP hospitalists interviewed reported that since they felt they had lacked a structured orientation when they began the role, they worked with new NP hospitalists informally to help them during the initial transition period. They explained that they felt this was their professional responsibility in growing new NP hospitalists. Both Andrew and Jane hold "lead" positions as NP hospitalists and have developed some formalized structure and training for new NP hospitalists. They also both informally mentor each new NP starting. Both Andrew and Jane believe this mentorship is critical to the development and satisfaction of the new NP hospitalists as they *Seek Recognition* as advanced practice nurses.

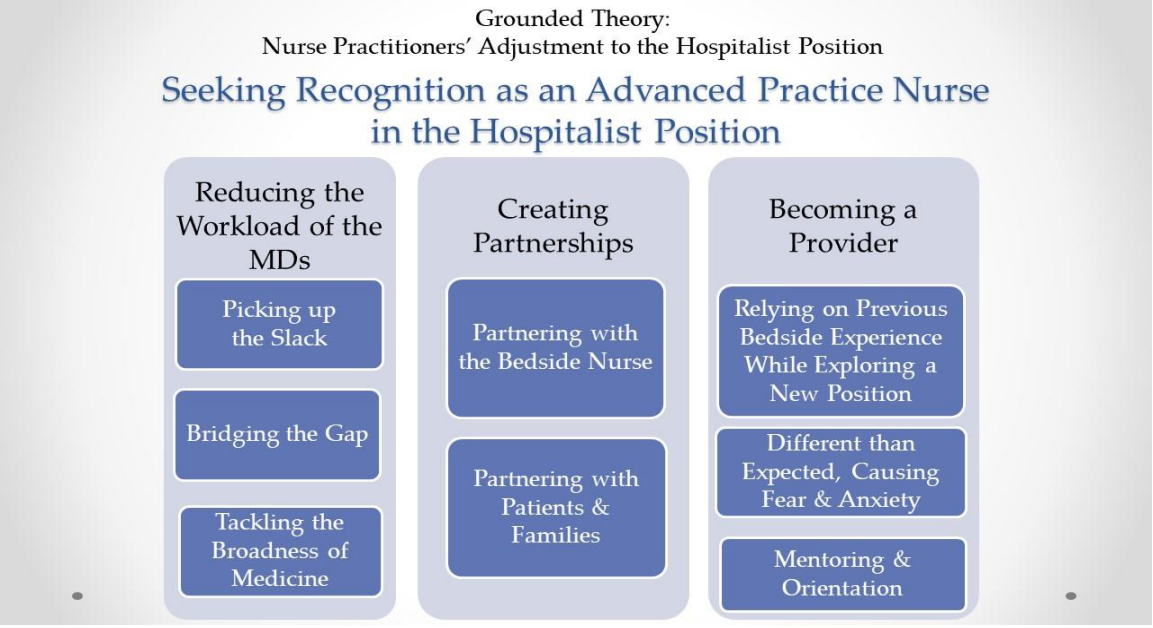
Summary

The findings from this grounded theory study focused on the experience of NPs as they are *seeking recognition as an advanced practice nurse in a hospitalist position*. Various themes were consistently embedded within the individual responses, which led to the development of the categories and subcategories. Each NP hospitalist shared his or her personal experiences. The researcher clarified and encouraged further information during the interviews as appropriate.

Demographic data collected did not reveal any significant trends in responses based on gender, ethnicity, or age. All participants responded strongly that bedside experience prior to becoming an NP was critical to succeed in the NP hospitalist position. This was identified in the subcategory "Relying on Previous Bedside Experience while Exploring a New Position as NP Hospitalist." There were some marked differences in the subcategory of "Tackling the Broadness of Hospital Medicine" when comparing NP hospitalists who began their NP career as a hospitalist versus those who held NP positions prior to becoming an NP hospitalist. Overall, NPs with prior experience believed that new NPs should not begin their career as an NP Hospitalist; however, those that became NP Hospitalists directly out of graduate school believed the

broadness of hospital medicine served as a solid foundation for their learning. Figure 1 represents the basic social process developed from the grounded theory study of *seeking recognition as an advanced practice nurse in a hospitalist position*.

Figure 1: Seeking recognition as an advanced practice nurse



Chapter Five: Discussion and Conclusions

This chapter includes a summary and discussion of th**e** grounded theory study, which explored the meaning and process of becoming an NP hospitalist. The discussion section focuses on the data, which supports the substantive theory *Seeking Recognition as an Advanced Practice Nurse in the Hospitalist Position.*

Summary of the Findings

Hospitalists provide care to acutely ill patients when hospitalized. As the demand for hospitalists continues to grow while the supply of physician hospitalists dwindles (Furfari et al., 2014**)** and cost containment pressures mount, there is a critical need for other healthcare professionals, such as NPs and PAs to provide safe, efficient, and cost-effective care in the hospitalist position. The purpose of this study was to investigate and explain the processes that NP hospitalists employ as they adjust to the hospitalist position. Grounded theory tradition was used for this study because it provides a structured approach to discovering information about a process.

Sixteen NP participants were included and interviewed. Recruitment continued until data saturation was obtained. Memo writing by the researcher occurred during each interview. The researcher transcribed each interview, and after the first four interviews, the researcher began line-by-line coding together with the faculty advisor. The researcher identified phrases and developed a list of raw codes also shared with the faculty advisor. The researcher began to categorize the raw codes and eventually decided on three key categories with subcategories that supported each category. The substantive theory that was generated from the data analysis is *Seeking Recognition as an Advanced Practice Nurse in a Hospitalist Position*. The three core categories that led to the substantive theory were identified as: 1) reducing the workload of the

MD hospitalists, 2) developing partnerships, and 3) becoming a provider. Each of these categories includes sub-categories that relate to the core categories.

Interpretation of the Findings

This study focused on how NP hospitalists adjusted to the hospitalist position. Through the analysis of the data the overarching theme: *Seeking Recognition as an Advanced Practice Nurse in a Hospitalist Position* was identified. The central theory of *Seeking Recognition* shares some common facets with other phenomena in the literature. These facets include, but are not limited to, social stratification, role transition theory and liminality.

Social Stratification

Social stratification refers to social orders. In the US, social order is most often associated with income and wealth (Cole, 2019). Additionally, level of education is positively associated with income and wealth. Physicians' educational levels, typically greater than NP educational levels, may contribute to their access to power and privilege (Cole, 2019, Maclellan et al., 2016). This could relate to the NP hospitalists' perceptions described as "second class status."

A qualitative study conducted in Brazil focused on the power relationships between physicians and nurses in an Intensive Care Unit (ICU). The data analysis revealed the following three categories: professional identity, discipline, and circularity of knowledge (Mattar et al., 2020). Although the nurses participating in the study were not NPs, the study's findings are similar to the findings of this NP hospitalist study. The study found that physicians believed that their role was to alleviate suffering and promote healing and the nurses' role was to provide hands-on care. Nurses stated they wanted better recognition of their abilities and felt that overall, society and other healthcare colleagues undervalued the nurses' roles. (Mattar et al., 2020).

Transition Theory and Liminality

Transitions have been studied in many disciplines including but not limited to, sociology, psychology, education, and nursing. All transitions are complex, occur over time, and cause changes to identity (Meleis et al., 2000). In transition literature in nursing, transition is defined as "a process of convoluted passage during which people define their sense of self in response to disruptive life events" (Kralik et al., 2006, p. 321). Redefinition is the development of replacing the old self with the new self in a new social environment. This redefinition of self is what defines the transition process. Although traditionally Meleis' theory is associated with patients transitioning through the course of illness (Meleis, 20150), the NPs in this study reporting they were not recognized or defined as advanced practice nurses in the hospitalist position can be recognized as transition. Their transition to the position included asserting themselves as advanced practice nurses and not simply "assistants" to the MD hospitalists. Redefining themselves became part of the NPs adjustment to the hospitalist position and was challenging because the MD hospitalists did not recognize them as such. The life event, which in the case of this study was the adjustment to the NP hospitalist position, may create a sense of disconnectedness and loss of security. This sense of disconnectedness and loss of security disrupts the stability of the transition and may leave the person unsatisfied with the changes occurring in the new position. New environments and positions within those environments require acquisition of skills. A study on the experience of role transition in ACNPs, reported that the NPs felt that their academic preparation in knowledge and skill acquisition was inadequate (Chang et al., 2006). Both the NP hospitalists interviewed for this study and the ACNPs in the aforementioned study, reported the need to educate themselves in the new skill set required to solve the overwhelming knowledge deficit they felt within the domain of hospital medicine.

The notion of liminality is often related to a transition process. Liminality focuses on movement from one space to another (Turner, 1987). Turner created the idea of liminality based on Van Gennep's second phase of transition in rites of passage, "margin" (Van Gennep, 1975). Turner describes "margin" as the limited period of ambiguity with few features of the preceding or forthcoming states. The NP hospitalists interviewed described similar qualities as they adjusted to their positions as hospitalists.

Reducing the MD Hospitalists' Workload

The NP participants described being assigned the tasks that the MDs found tedious, challenging, or undesirable. Many stated that a major focus of their NP hospitalist position was admitting patients and discharging patients. They voiced concerns that their skills and abilities as an advanced practice nurse were not recognized, and therefore many felt they were not working to their full capacity and scope. This led to feelings of dissatisfaction, and more deeply discontent, associated with a lack of autonomy in the hospitalist position. They verbalized their APRN position was not recognized as such. Some NP participants shared that the bedside nursing staff depended on them to "fix things quickly" when an MD hospitalist was not available. They were often called for routine orders or when an MD hospitalist told the bedside nurse, they were "too busy, call the NP." The NP hospitalists who worked the night shift felt they were better utilized when there was an acute episode with a patient because fewer MD hospitalists were available during this shift. The NP hospitalists on the day shift felt those events were more often reported only to the MD hospitalists.

The participants also verbalized the impact of the broadness of hospital medicine. Many felt ill prepared for the hospitalist position and needed to educate themselves by using on-line resources and conferring with other NP hospitalists when available. All of the study participants

felt that the NP education curriculum did not adequately prepare them for the hospitalist position particularly if they were trained as FNPs (Kaplan & Klein, 2021). Of the study participants, four were trained as FNPs, however after reviewing their interviews and comparing them to the interviews of the other NPs that were trained as ACNP or AGNPs, there was no indication that the FNPs felt more ill prepared than the others. Most reported that the MD hospitalists believed that the NP curriculum prepared them to work in hospital medicine and were surprised when they struggled acclimating to the position. The NPs that began their NP career as a hospitalist felt that the hospitalist position enhanced their ability to learn, and some compared it to starting as a bedside RN on a medical/surgical unit. They felt that the broadness of hospital medicine allowed for a more holistic patient focus versus simply a specific physiological disease focus.

Although many of the NP hospitalists veered towards a lack of true autonomy, all still believed the care, they provided, at any level, contributed to the well-being and positive outcomes of the patients. While focusing on admissions they sought to understand the often-complex psychosocial issues associated with the patients, often overlooked by the MD hospitalists. Additionally, when discharging patients, the NP hospitalists were certain to educate about new medications, reconcile all medications, and provide instructions on follow-up visits. Each of these scenarios contributed to the overall feeing of being held in a "second class status" and a lack of recognition of their advanced practice nursing degree.

Building Partnerships to Enhance Recognition of their Position

The NP hospitalists discussed the need to forge strong partnerships with both the bedside nurses and the patients and families. Bedside nurses often do not embrace the position of NP hospitalists, and many feel that becoming an NP suggests leaving nursing (Hoffman et al., 2004). Developing a strong relationship with the bedside nurses allowed the NPs to engage in patient care

with the bedside nurse and reinforce that becoming an NP was still "being a nurse." Overall, the NPs described that it was necessary to work alongside the bedside nurses to develop a trusting relationship. The bedside nurses gradually grew to trust the NPs and often sought them out to clarify patient status once trust was developed. However, some of the NPs were frustrated that the bedside nurses continued to contact the MD hospitalists first when an acute patient situation occurred. They felt they were not recognized as advanced practice nurses who could resolve these situations.

Partnering with the patients was described as critical by the NPs interviewed. Since most of the complex psychosocial issues surrounding patients and families were delegated to the NPs, they needed to develop a solid rapport with both the patients and their families. Robust evidence exists that strong partnerships with patients and their families promote more empowered patients and better self-management post discharge from the hospital (Doss et al., 2011). This partnership allowed for better patient outcomes and improved compliance with post discharge instructions. Although initially, many patients did not understand the NP position, once it was explained they were responsive to the recommendations of the NPs. The NPs struggled with the lack of recognition of their position from both patients and physicians; however, they continued to educate both groups as necessary throughout their adjustment to their hospitalist position.

Becoming a Provider as a Hospitalist

Many of the participants who acknowledged they had been providers of care as a bedside RN remarked on the difference, they felt now being in the NP hospitalist position. For some of the participants this NP hospitalist position was their first advanced practice nursing position. Adjusting to the NP hospitalist position was compounded by a lack of a formalized orientation program. As an NP hospitalist, their responsibilities included ordering diagnostic testing and

prescribing medications and treatments. Many stated they often doubted their ability with these responsibilities and felt they were ill equipped to provide this level of treatment because of the limited guidance they were given. All participants reported that they relied on their previous bedside nursing experience to keep them grounded but had soon realized they needed to build their knowledge base quickly to meet the demands of the NP hospitalist position. This circumstance caused great concern and uncertainty and left them feeling overwhelmed. Even when paired with another hospitalist, it was with an MD hospitalist who was not familiar with the NP scope of practice and assumed that graduate school had prepared him or her for the hospitalist position. In fact, NP education does not include hospitalist medicine based education; however, some postgraduate fellowship programs include strategies to care for the adult or geriatric medical patients (Bryant, 2018). Additionally, regardless of the NP educational track, few tracks include clinical rotations in the hospital medicine specialty (Kaplan & Klein, 2021).

Rigor and Limitations

Throughout this study, strategies were employed to promote rigor and mitigate possible limitations. The researcher's memos addressed issues that arose related to the grand tour question. The original grand tour question was "Tell me about being an NP hospitalist," however, after the first four interviews, the researcher changed the grand tour question to "Tell me about *becoming* an NP hospitalist." This allowed the researcher to elicit key information from the participants regarding the processes the participants employed while adjusting to the hospitalist position.

Lincoln and Guba (1985) discussed that the worth of study is directly related to the trustworthiness of the study. Trustworthiness of this study reinforces credibility, transferability, dependability and confirmability. The researcher accurately transcribed and interpreted the

participants' interviews and assured the data and analysis were true representations of the participants' experiences, supporting credibility and confirmability. Since this study can be transferred to NPs in similar settings with similar experiences and the findings were consistent and can be repeated, transferability and dependability were also supported.

Limitations

Despite the researcher ensuring trustworthiness in the study, there remain limitations. Since the sample represented only hospitals in Long Island, NY and Queens, NY, these settings presented a limitation. These demographics revealed that 71% of the participants were White non-Hispanic and 76% of the participants were female. These demographic characteristics can also be considered a limitation of the study. Culture and gender can contribute to specific values related to interpersonal relationships with the MD hospitalists presenting another limitation of the study. Perspectives were gleaned from a convenience sample of NP hospitalists who were members of the New York State (NYS) NP Association. Admittedly, this use of convenience sampling may have led to selection bias. While every effort was made to recruit a sample that was diverse (i.e., various genders, ages, experience levels), all participants were recruited from one professional NP association. This sampling possibly limits the transferability of findings to other NP populations, care settings, and geographic locations. Additionally, the final seven interviews occurred after the acute phase of the COVID-19 pandemic, May 2020 through January 2021. The pandemic could have skewed experiences simply because the pandemic changed the landscape of so many factors in the acute care setting. Patients were more complex in their illnesses; numerous deaths were occurring daily, which is uncommon in the acute care setting, and stress levels were heightened for all health care providers. Furthermore, although the interview was focused on becoming an NP hospitalist, the remnants of the pandemic may have

influenced participants' recollection of their becoming an NP hospitalist purely because the pandemic was ever-present in their minds.

Throughout the entirety of the research process the researcher sought to be mindful of assumptions, expectations throughout data collection and analyses based on their own experiences as an experienced nurse educator and administrator, to ensure that identified themes, and trends were as unbiased as possible.

Recommendations for Future Research

As NPs continue to enter the specialty of hospital medicine, further research is recommended to look at retention rates of NPs in the hospitalist position. A study on physician burnout that surveyed outpatient internal medicine physicians and inpatient internal medicine physicians (i.e., hospitalists) reported that both groups suffer from higher rates of burnout and lower rates of satisfaction than most other specialties (Roberts et al., 2014). A similar study should focus on NP hospitalists. Additionally, although a deeper look at responses from participants based on gender or race showed no significant differences, further research is recommended with male participants and with participants that are not White non-Hispanic. Further research in a different homogeneous ethnicity may highlight perceptions and experiences that may be specific to that ethnicity.

Implications for Nursing

Most of the NP hospitalists interviewed voiced concern over a lack of a structured orientation. Generally, nursing places a strong emphasis with onboarding of new staff members. The study participants commented that they expected such when they became NP hospitalists. Unfortunately, a formalized, standardized orientation program was not in place for any of the study participants. A study of hospital medicine program directors across the US showed that

offering fellowships helps retention rates of non-physician hospitalists (Klimpl et al., 2019). The fellowships were created to train new non-physician hospitalists and improve retention rates of the non-physician hospitalists. Residency programs for new graduate NPs are in demand. Residency programs allow for a formalized, extended orientation program that includes specialty clinical rotations and in total promotes better preparation for the specialized NP position (Brown et al., 2015).

The NP hospitalist position is broad-based and for some of the NPs interviewed, was their first position in the advanced practice nursing position. Without a structured orientation process, many struggled during the adjustment period. Although the NP hospitalist position reports to the department of Medicine, closer focus should be made on nursing education strategies when onboarding NP hospitalists to provide a standardized, organized orientation process.

Conclusion

The 2020 State of Hospital Medicine report indicates that 83% of hospitalist groups employ non-physician hospitalists (Kaplan & Klein, 2021). As the physician shortage is expected to continue, NP hospitalists in the workforce are likely to increase. NP hospitalists have a unique opportunity to impact patient outcomes and patient satisfaction. A study by Sidani and Doran (2009) explored the relationship between processes and outcomes of NPs in acute care and reported that the level of care coordination and patient education provided by NPs in the hospital setting directly increased patient satisfaction. A recent study reported that just as higher level of baccalaureate prepared RNs improved patient outcomes such as mortality rates, fewer readmissions, and higher patient satisfaction, favorable outcomes were more likely in hospitals with more NPs/100 beds than in hospitals with fewer (Aiken et al. 2021). Additionally, the

hospitals with more NPs/100 beds also recognized decreased Medicare spending and staff recommendation of the facility was ranked higher.

As patients become more complex and healthcare resources increasingly need validation, there will be a critical need for high level of care regardless of who provides the care. There is strong evidence on the quality of care provided by NPs and NPs are positioned well to contribute greatly to improve patient outcomes. This study highlights the adjustment of NPs as they move into hospitalist positions and illuminates the measures necessary to ease their adjustment process.

Addendum

This addendum is written post a successful dissertation defense of the research study, "Nurse Practitioners' Adjustment to the Hospitalist Position: A Grounded Theory Study" at the request of the Executive Director of the City of New York (CUNY) Ph.D. program, Dr. Juan Battle who was a member of the dissertation defense committee.

New York State (NYS) was selected as the region for the study participant sample based on specific factors. These factors include, but are not limited to, the demographics of NYS both in the patient population and healthcare team member population. Additionally, there are over 210 healthcare facilities located in NYS. These include over 60 comprehensive medical centers, 10 academic medical centers, 8 Veteran administration facilities, and numerous community and rehabilitation hospitals. Selection of this region provided a rich pool of participants who lived through and could talk about their experience of becoming a nurse practitioner (NP) hospitalist for this qualitative study.

Organizational hierarchy and policies that guide the practice of NP hospitalists were not explored. Analysis of both hierarchy and hospital polices may have provided an understanding of role expectations and insight into the experiences of the NP hospitalists. It is recommended that this be considered for future research.

In addition, the researcher acknowledges that future research should consider if other health professions are undergoing similar expansions into new roles, which could be compared with what is going on with NPs in the United States and globally. As described in nursing transition theory, adjustment encompasses creating a new "self-perspective". This concept of developing a new self can be applied to numerous professions and disciplines. This broader

perspective of adjusting to a new self encompasses many modifications and could help to identify other professional growth opportunities across numerous occupations.

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Exemption Granted

06/13/2019

Donna Tanzi,
The Graduate School & University Center

RE: IRB File #2019-0544
Nurse Practitioners' Adjustment to the Hospitalist Position:A Grounded Theory Study

Dear Donna Tanzi,

Your Exemption Request was reviewed on 06/13/2019, and it was determined that your research protocol meets the criteria for exemption, in accordance with CUNY HRPP Procedures: Human Subject Research Exempt from IRB Review, (2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects? responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects? financial standing, employability, educational advancement, or reputation You may now begin your research.

Please note the following information about your approved research protocol:

Documents / Materials:

Type	Description	Version #	Date
Interview Question(s)	Interview Questions.docx	1	05/30/2019
Advertisement	Recruitment Flyer.docx	1	05/30/2019
Other Data Collection Tools	Demographic Tool	1	05/30/2019
Informed Consent/Permission Document	Informed Consent	1	05/30/2019

Although this research is exempt, you have responsibilities for the ethical conduct of the research and must comply with the following:

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http://www.cuny.edu/research/compliance.html

Amendments: You are responsible for reporting any amendments or changes to your research protocol that may affect the determination of exemption and/or the specific category to the HRPP. The amendment(s) or change(s) may result in your research no longer being eligible for the exemption that has been granted.

Final Report: You are responsible for submitting a final report to the HRPP at the end of the study.

Please remember to:

- Use **the HRPP file number** 2019-0544 on all documents or correspondence with the HRPP concerning your research protocol.

- Review and comply with CUNY Human Research Protection Program policies and procedures.

If you have any questions, please contact:
Susan Brown
718-982-3867
Susan.Brown@csi.cuny.edu

Appendix A
Demographic Tool

Date _____/_____/_____ **Participant Number**: _____

Gender: Female ☐ Male ☐ Prefer Not to Answer ☐

Age: _____

Current position title: _____

Organization Type: Tertiary Hospital ☐ Community Hospital ☐

Total years as an NP_____

Total years as a Hospitalist _____

Is this your first Hospitalist position? YES ☐ NO ☐

Is this your first NP position? YES ☐ NO ☐ If you answered NO:

Previous NP experience prior to becoming an NP Hospitalist? Please specify years and practice specialty_____

NP Education Track:
ACUTE CARE NP ☐
FAMILY NP ☐
ADULT- GERO NP ☐
OTHER ☐

Certification: Please list specialty_____

Length of time as an RN prior to becoming an NP (years): _____

Appendix B
Recruitment Flyer

Nurse Practitioner Hospitalists Needed for a Nursing Study

Description of Project: I am a PhD candidate conducting research on NP Hospitalists. The aim of this study is to explore how NPs adjust to the hospitalist position in the acute care setting. You are invited to participate in a private interview about this topic at a time and location that is convenient for you. Your interview will take approximately one hour.

To participate, you must:

- Currently work as an NP hospitalist in an acute care setting.
- Have at least 1-year experience and no more than 7 years' experience as an NP hospitalist.

You will receive a $25 gift card for your participation.

To learn more, contact PhD Candidate:
Donna Tanzi PhD (c), MPS, BSN, RN-BC, NE-BC
Dtanzi@gradcenter.cuny.edu

Please share this opportunity with your NP Hospitalist colleagues

Appendix C

Interview Guide

"Grand Tour" Question:

- Tell me about becoming an NP hospitalist?

Additional questions will be developed from participants' statements, which occur during the interview, and they may be adapted during ongoing data analysis to fully explore and develop the emerging theory.

Verbal Probes:

- "Go on…"
- "Tell me more about…"
- "Then what…"
- "Give me an example of…"

Nonverbal Probes:

- Periods of silence
- Gestures

Appendix D

Informed Consent

THE CITY UNIVERSITY OF NEW YORK

City University of New York Graduate Center

Department of Nursing

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: Nurse Practitioners' Adjustment to the Hospitalist Position: A Grounded Theory Study

Principal Investigator: Donna Tanzi, MPS, BSN, RN-BC, NE-BC
PhD Student

Faculty Advisor: Barbara DiCicco-Bloom, PhD, RN
Associate Professor
College of Staten Island
Department of Nursing

You are being asked to participate in a research study because your experience working as an NP Hospitalist could provide insight into how nurse practitioners adjust to the hospitalist position.

Purpose:

The purpose of this qualitative research study is to explore how NPs adjust to the hospitalist position and to identify the processes they employ during their adjustment.

Disclosure of Financial Interests: N/A

Procedures:

If you volunteer to participate in this research study, we will ask you to do the following:

- Participate in one in-depth interview. The interview is expected to last approximately 60 minutes. The interview will take place at a mutually agreed upon location (researcher and participant) that will provide sufficient privacy to ensure your comfort and allow for thoughtful discussion.

Audio Recording:

- To ensure accuracy, all interviews will be digitally recorded for transcription and later review.

Time Commitment:

Your participation in this research study is expected to last for approximately one hour.

Potential Risks or Discomforts:

Your participation in this study does not involve any risk to you.

Potential Benefits:

- You will not directly benefit from participation in this research study. However, understanding how Nurse Practitioners adjust to the hospitalist position could contribute to future NPs successful transition.

Alternatives to Participation: N/A

Costs: There is no financial cost for participating in this study.

Incentive for Participation:

You will receive a $25 gift card for participating in this research study.

Research Related Injury

N/A

New Information:

You will be notified about any new information regarding this study that may affect your willingness to participate in a timely manner.

Confidentiality:

Every effort will be made to maintain confidentiality of any information that is collected during this research study. We will disclose information only with your permission or as required by law.

We will protect your confidentiality by de-identifying the recorded data and by ensuring all data is stored and available only to the researcher. All digital audio recordings will be destroyed once the data has been transcribed. The transcribed interviews will be kept for five years and destroyed after that time. The collected data will only be accessible to:

- Principal Investigator, Donna Tanzi
- Dr. Barbara DiCicco-Bloom, Dissertation Committee Chair
- Members of the CUNY IRB committee

The principal investigator, dissertation chair and authorized CUNY IRB staff may have access to the research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

Participants' Rights:

- Your participation in this research study is entirely **voluntary**. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

- Your participation or non-participation in this study will in no way affect your employment.

- You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

Questions, Comments or Concerns:

If you have any questions, comments or concerns about the research, please speak to the Principal Investigator, Donna Tanzi, (631) 553-1341. If you have questions about your rights as a research participant, or you have comments or concerns that you would like to

discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918 or email HRPP@cuny.edu. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

Signature of Participant:

I agree to be audio recorded_____

If you agree to participate in this research study, please sign and date below. You will be given a copy of this consent form to keep.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

Signature of Individual Obtaining Consent

_____
Printed Name of Individual Obtaining Consent

_____ _____
Signature of Individual Obtaining Consent Date

Appendix E

Participant Demographics (Pseudonyms)

Participant	Gender Ethnicity	Community vs. Tertiary	Degree	Years as NP	Years as Hospitalist	Previous NP Experience	Years as RN before NP
1- Andrew	M Caucasian	Community	FNP	16	10	LTC	10
2- Beverly	F Caucasian	Community	FNP	10	5	House Staff Primary care	7
3- Carol	F Asian	Community	ACNP	7	4	Cardiology	16
4-Dawn	F Black	Community	AGNP	13	2	Geri-Cardiology	10
5-Ellen	F Caucasian	Tertiary	AGNP	3	3	NO	6
6- Fran	F Caucasian	Tertiary	FNP	5	5	NO	5
7-Gloria	F Caucasian	Tertiary	ANP	10	8	Adult Geri	5
8-Helen	F Caucasian	Tertiary	FNP	10	4	Cardiology	17
9- Irene	F Caucasian	Community	FNP	9	5	Cardiology	5
10-Jane	F Caucasian	Community	AGNP	1.5	1.5	NO	5
11-Kevin	M Caucasian	Community	ACNP	2	2	NO	20
12-Laura	F Asian	Community	AGNP	13	7	Primary Care	35
13- Mallory	F Caucasian	Community	ACNP	1	1	NO	4
14- Nancy	F Caucasian	Community	FNP	2	1	Primary Care	6
15- Olivia	F Caucasian	Tertiary	FNP	1	1	NO	6.5
16- Paul	M Hispanic	Tertiary	ACNP	1	1	NO	5
17-Quinn	M Black	Tertiary	PA	3	3	NO	N/A

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