Running Head: INDEPENDENT NURSE PRACTITONERS

A Descriptive Study of Independent Nurse Practitioners in Oregon

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Abstract

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The characteristics and practices of Independent Nurse Practitioners (INPs) were the foci of this study. Barriers to INP practice were particularly examined. Nurse practitioners are expected to know their scope of practice to consult with and refer to other healthcare providers. Criteria for independence were financial ownership of one's practice and/or autonomous decision-making power in practice concerns. In-depth focused interviews were conducted with ten INPs in Oregon. INPs are likely to be entrepreneurial and located in rural areas. Barriers to practice consist of reimbursement difficulties, local politics, and burnout due to time pressures. Competition was perceived as a minor barrier that INPs have overcome by gaining physician respect. For those considering INP practice, it is advisable to be prepared for these barriers, for long hours, and to begin only after obtaining significant clinical experience. Having a second provider in the practice results in less burnout. Having a collaborating physician was found to be helpful but not essential since the Oregon Nurse Practice Act allows nurse practitioners to function without physician supervision.

Table of Contents

List of Tables

Introduction and Statement of the Problem

This descriptive study of the nature of the practices of Independent Nurse Practitioners (INPs) in Oregon will examine the setting, population served, relationships with and utilization of other providers, barriers to practice and strategies for success. Data will be collected that describe INP practice in rural and urban communities throughout Oregon.

For the purpose of this study, independent NPs will be defined by either of two characteristics. The individual must either have financial ownership in the practice (total or partial), or must have autonomy for decision making issues concerning the practice. However, autonomy is never absolute or complete. Autonomy, and thus independence, can be viewed as on a continuum ranging from lesser to maximal amounts, that changes with varying situations (Dempster, 1994). The INP must meet one or both of these criteria to be considered independent for the purpose of this study.

Readiness for autonomy involves elements such as evolution, growth, development, opportunity, competence, mastery, and movement and/or progression from one level to another related to autonomy in practice (Dempster, 1994). Individuals choose to be independent for different reasons. While these INPs may identify themselves in varying ways, one characteristic that may be common to them all is possessing entrepreneurial style.

Vogel and Doleysh (1988), define an entrepreneur as an individual who assumes the total responsibility and risk for discovering or creating unique opportunities to use personal talents, skills, and energy, and who employs a strategic planning process to transform that opportunity into a marketable service or product. This definition takes into

account the innovation, drive, foresight, and management that entrepreneurship demands, as well as the creative fertility and continual hard work that are essential for success. It also supports the belief that entrepreneurs are not an elite group but an assortment of ordinary individuals whose common characteristic is their willingness to invest in and give of themselves to realize their goals (Vogel & Doleysh, 1988). The entrepreneurial spirit is associated with a particular way of approaching problems. It can be explained as "integrative" or "the willingness to move beyond received wisdom, to combine ideas from unconnected sources, to embrace change as an opportunity to test limits" (Baker & Pulcini, 1990).

As the face of healthcare changes in response to a rapidly changing environment, nursing, as a component changes in response to societal demands and needs. Nurses have been empowered by society to make a difference. Empowerment includes legitimacy, sanction, legal status, and having rights and privileges (Dempster, 1994). It can come from inside one's self or be granted by others legally. Legal empowerment has lagged behind the self-empowerment possessed by these nurse entrepreneurs. It is through this self-empowerment by the very nature of their role, that nurses have moved the boundaries of nursing further into a realm previously the sole domain of other professions (Baker & Pulcini, 1990). Nursing has made significant progress toward being recognized as a profession capable of and entitled to self-determination. Nursing's emphasis on the total person extends the boundaries of nursing practice beyond the limits of traditional medicine, and the outcomes of litigation support this expansion of boundaries (Vogel & Doleysh, 1988). As a result of these advances in nursing practice, nurses are in an

optimal position to develop their entrepreneurial skills and establish their own healthcare businesses.

Nurse practitioners have expanded the boundary of nursing practice. Historically, NPs have responded to new needs and demands impinging on nursing, as evidenced by their movement into the community in response to the inaccessibility of health care in rural and other underserved areas in the late 1960s. The NPs emphasis on comprehensive assessment and independent decision making about health and in particular about care needs of individuals and groups has changed the intraprofessional and interprofessional intersections of nurses and other health care providers from dependent to independent and interdependent (ANA Scope of Practice, 1985).

Review of Literature

Early Independence

The history of nursing is grounded in independence, dating back to the late 1800s with Florence Nightingale. During the Crimean War, through her independent actions, she demonstrated that the morbidity and mortality of soldiers could be lessened by simply offering better nutrition and sanitation. As a result of independent nursing care, soldiers had a better chance for survival. It was this independent decision-making and her careful documentation of outcomes that sparked a new trend in American nurses that led to new opportunities of independence and autonomy (Garey & Hott, 1992).

Nurses in America stumbled across independence fortuitously. As a result of Nightingale's efforts, hospitals recognized the importance nursing had on patient outcomes. Recognizing improved outcomes, hospitals began to utilize staff nurses to care for patients. However, in order to make it financially advantageous, they staffed wards with student nurses who provided free labor. Although advertised as an educational opportunity, the hospital training was often an exploitative system in which senior students supervised more junior ones (Connolly, 1998). This left experienced nurses out of work. These nurses began to look for opportunities to use their skills and knowledge elsewhere. Many became private duty nurses. They performed domestic services to families in their homes by contracting with their patients for pay. There was no physician on site, or even close by, to make decisions or dictate care. The care they provided soon became recognized as a critical need in the community for those individuals who could not afford care or for those who lived in areas that were not routinely visited by physicians.

In 1893, Lillian Wald and Mary Brewster opened the first Nurses' Settlement in New York City, leading to the advent of visiting nurses. The settlement grew and soon nurses were seeing thousands of patients independently. By 1910, the backbone of a rudimentary public health system was formed (Dock & Stewart, 1938).

In 1925, the Frontier Nursing Service was founded by Mary Breckinridge in the mountain regions of Kentucky. Her visiting midwives were mounted on horseback and visited homes caring for mothers and infants who needed healthcare. Despite primitive conditions, they were able to significantly reduce the maternal and infant mortality rate in the area (Dock & Stewart, 1938).

With the advent of public health nursing, nurses entered rural areas, offering care to those that had never had health care before. By the mid-1900s, public health nursing became publicly funded. It became clear that public health nurses were making a difference in the lives of the rural poor.

Professional and Economic Competition with Physicians

Unfortunately, as the nation grew more accepting of and relied on these independent nurses, physicians began to view them as a threat, professionally and financially. In 1929, the American Medical Association lobbied against public funding. They cited public health nursing as unproductive and as promoting communism. Because of their efforts, public health funding for the continued care provided by these nurses ceased. This may well have been the biggest factor that temporarily arrested the advancement of independent practice in nursing (Garey & Hott, 1992). As nursing became a hospital based service, there was an erosion of independent decision-making and financial independence. Nurses became employees of hospitals subjected to

physician's orders in a hierarchical system that stifled innovation and risk-taking and rewarded conformity. This new trend was the main catalyst that moved the hospital to the nucleus of healthcare delivery. Consequently, the practice of nursing became stereotyped as being physician controlled as opposed to independent or autonomous. A hierarchical relationship with physicians superior to nurses developed. Training and practice of nursing was controlled by physicians and hospitals which reduced formal power of nurses.

With the passage of time, this hierarchical relationship also became a legal relationship with the passage of laws defining the roles and scope of practice. Physicians were given authority and the power over nurses. Because of societal norms, the public came to view the physician and nurse in the same superior-dependent hierarchical relationship (Dempster, 1994). Thus, the evolution of independent practice among NPs was forced to occur outside the hospital setting as nurses ventured forth to meet unmet needs.

Today, with advancing technology, greater education of nurse practitioners, and social change, there is a growing acceptance of NPs among some physicians. Other physicians are less willing to give up their control of nurses. This opposing point of view was articulated by Schwartz (1993) when he said,

> "Doctors have a couple of thousand years of experience in what it takes to make clinical judgements. Nurses do not. It is inappropriate for nurses to practice independently as gatekeeper-- to do the things they want, which overlap extensively with primary care medicine. Patients know that the doctor is ultimately in charge, and would sooner have a doctor caring for

them than a non-physician." (p.8)

The American Nurses Association (ANA) and the American Medical Association (AMA) have established a mutually agreed upon definition of collaboration, despite many remaining points of contention between the group. Nurses believe the definition needs to focus more on "working interdependently" with "shared values and mutual acknowledgment and respect for each other's contribution." The AMA Council on Medical Services proposes that the term *integration* rather than *collaboration* be used and that integration focus on "mutually agreed-upon guidelines" that reflect each group's qualifications (Holladay, 1995).

Louise Kinlein was the first NP to set up a solo practice. As an INP in Maryland, emphatically states that a nurse practitioner's approach should be from the point of health and not from the point of disease, as many physicians are trained to do. She cautions nurses of the importance of not practicing medicine, while at the same time, using the same knowledge that the physician does. In her judgement, the nursing role in independent practice should be unique, and not that of a physician substitute (Young, 1992).

Social, Economic, and Political Forces

Societal trends, which include the demand for humanizing technical care, have influenced the public's expectations of the way health care is delivered. These trends have also influenced how roles are determined. Roles evolve continuously in response to societal demands, the competence demonstrated in new roles by health care providers, and the interaction among such groups as health care providers, consumers, and legislators.

The evolution of nursing in our country has been grounded in the philosophies, social conditions, and beliefs from the late 19th through the 20th century. "Medicine" in its broadest sense includes many branches of the healing arts, one of which is nursing. Because nursing is so closely associated with the practice of medicine, it is sometimes claimed as a subordinate or secondary vocation to the physician. This statement is historically incorrect since nursing is as old, if not older, than medicine and has had an independent existence for hundreds of years. Despite similar roots, medicine and nursing seemed to respond differently, especially in the early years of their existence to different kinds of societal forces. Medicine flourished in periods when scientific inquiry and experimentation were active while nursing seemed to follow more closely the waves of religious awakening and of social and humanitarian effort (Dock & Stewart, 1938).

The early community and public health nurses of the Nightingale tradition were independent in their own right. The Nightingale concept of nursing was not that of a sub-caste of medicine or even as a handmaiden of medicine. Nurses were seen more as partners in a family or business enterprise where one worker in the team complemented and supplemented the other and where there was no subordination. There was instead interdependence and cooperation. This was a self-sustaining and self-respecting relationship that recognized differences in function and avoided duplication of effort. At the same time, responsibility was centered for each type of activity in the person who was best prepared in that particular field. Physicians and nurses worked together as a team to collaborate and manage patient care (Dock & Stewart, 1938).

Altruism

Nursing has the tradition of altruism, providing care to those who are in need, regardless of the setting or ability to pay. Because NPs are prepared to help meet the needs of those who have no healthcare, those who are underserved for healthcare, and all individuals who need healthcare regardless of their socioeconomic status or age, NPs can be major contributors as primary care providers in any reformed health care system (Dempster, 1994). NPs provide holistic services to their patients by directing care to all areas of an individual's life. Although NPs still emphasize health promotion and maintenance care, the role has evolved to include treatment of common acute and chronic illnesses. Treatment of disease is only one component on a continuum of care. The realization of this blending of life processes has provided a uniqueness to nursing care and has become a hallmark of advanced nursing practice.

Nursing's contract is with society. This contract holds nurses accountable for client health and cost outcomes. Society's demand for accountable, accessible, affordable, and quality health care and providers who appreciate the value of self-care and humanistic use of technology are forcing/promoting acceptance of NPs in advanced practice of nursing. The advent of NPs is fulfilling this demand of many segments of society (ANA Scope of Practice, 1985).

Risk-Taking

NPs are risk-taking innovators. The pillars on which successful innovations have rested include the commitment to change, the ability to risk, and the capacity to think creatively. NPs have reevaluated the status quo, adapted, and reconfigured it to establish new patterns of practice. Advanced nursing practice today entails new ways of

interacting with the healthcare system, the consumer, and professional colleagues. The driving forces that have encouraged these risk-taking changes include the desire for independence, control, and autonomy (Baker & Pulcini, 1990; Morain, 1992). INPs are drawn to the role because it offers opportunity for greater independence, control, and autonomy. Financial rewards may or may not exceed salaries earned by NPs who are not in independent practice.

Support for INP Practice

A report from the Physician Payment Review Commission (PPRC) meeting states that before the PPRC can make recommendations to Congress regarding NP reimbursement, there needs to be more documentation of exactly what NPs do and how they differ or complement care provided by a physician (Edmunds, 1991). By describing what INP practices and client populations are, their relationship with physicians, and current reimbursement practices and barriers specific to Oregon, this study may better inform legislators and NPs in Oregon and advance NP practice.

There are models for developing independent NP practices in the literature which draw on business, marketing, and legal advice (Buppert, 1996; Gallagher, 1996; Lambert & Lambert, 1996; Shay et al., 1996). These practical resources provide an overview of some of the financial and legal barriers the INP may experience and strategies to overcome them.

Quality and Cost of Healthcare

There is an abundance of literature to support the cost effectiveness and quality of NP practice, especially in comparison with care provided by a physician (Safriet, 1992; Pearson, 1994). A recent survey of NPs in Oregon provides information about NP

practice settings, job responsibilities, and salaries (Burns et al., 1997). There remains, however, a limited amount of literature actually describing INP practice, populations served, and current INP perspectives of barriers to practice, especially in Oregon.

NP Practice in Oregon

Historically, Oregon has been a state that has been successful in removing barriers to practice. Through revision of the Nurse Practice Act and legislation, with public support despite physician opposition, Oregon NPs obtained prescriptive authority, mandatory insurance, and fee-for-service reimbursement in the 1979 legislative session (Bifano, 1996). To date, NP privileges have been expanded further to include Medicaid and Oregon Health Plan (OHP) reimbursement, broadening of the prescriptive authority with adoption of formulary by exclusion, designation as a primary care provider (PCP), and rights to admitting privileges (Bifano, 1996).

In the state of Oregon, there is no legal requirement for NPs to work under the supervision of a physician. The 1996 Oregon State Board of Nursing Rules and Regulations provides for independent practice by stating that "The NP is independently responsible and accountable for continuous and comprehensive management of a broad range of health care. The NP is responsible for recognizing limits of knowledge and expertise, and for resolving situations beyond his/her NP expertise by consulting with or referring to other health care providers." (p. 6-7)

Currently in the state of Oregon, it is estimated that 28% of NPs work in an office with a physician (Burns et al., 1997). The remaining 72% of NPs work in a variety of settings, including offices without physicians, such as rural, community-based, school-based clinics, and other entrepreneurial settings where they have varying degrees of

physician collaboration.

Barriers to Independent Practice

Despite successes in reducing legislative barriers, INPs continue to report experiencing barriers to practice in the form of physician relations and acceptance, and reimbursement. There are also ongoing concerns about the inability of NPs to function to the full extent of their knowledge, qualifications, and scope of practice because of continuing resistance to the role (Dempster, 1994).

Direct reimbursement for NP services has been a continuing barrier to practice, despite advances made in the Oregon legislature. Until January 1, 1998, Medicare did not allow NPs to bill except in rural settings or using the "incident to" clause to bill through the physician's provider number for NP services which must be supervised (Hoffman, 1994). This significantly hindered practice for NPs who wished to practice independently serving Medicare populations. Indirect reimbursement for NP services has constrained the recognition of the full impact of nurse practitioners in healthcare because of the lack of adequate data regarding their usage (Timmons & Ridenour, 1994). Ironically, the lack of ability to obtain reimbursement rights limits the NP's ability to produce extensive data supporting their cost-effectiveness.

The high degree of managed care penetration in Oregon, estimated at 75-92% (Burns et al., 1997), also poses reimbursement difficulties for INPs. The documented cost effectiveness and quality of NP services, and NP's skill in prevention and counseling, may eventually enhance opportunities for NPs in managed care as more emphasis is placed on cost containment and outcomes (Havens, 1995). However, problems currently exist in that many INPs are unable to obtain contracts with various

Health Maintenance Organizations (HMOs). This may be because HMO panels consist mainly of physician organizations and groups such as Independent Practice Associations (IPAs). NPs have been excluded from IPAs by physicians, making contracting difficult. IPAs limit NP's ability to provide services while ensuring that physicians maintain control of market forces. In order to become a viable colleague, the INP must overcome these economic barriers. It is only then that he/she will be viewed as a partner and not as a subordinate.

Methods

Research Questions

The purpose of this descriptive study is to describe the nature of Independent Practice by NPs in Oregon. The research questions addressed in this study will provide the basis for the specific questions asked during the interview of key INP informants. The research questions are:

1) What are the characteristics of:
    a) NPs who practice independently in Oregon?
    b) The independent practices of NPs in Oregon?
2) What are the barriers to Independent Practice reported by NPs in Oregon?
3) What strategies have INPs used to overcome these barriers?
4) What are the personal and professional rewards of Independent Practice?
5) Are there changes in the current healthcare system of delivery or reimbursement that are affecting INP practice?

Sample

A local network of NPs that have served as experts to the researchers will be used to identify and obtain access to INPs in Oregon via personal referral. Oregon Health Sciences University School of Nursing faculty and preceptors throughout the state will be utilized as another method of obtaining personal referrals for subjects. The state professional organization, Nurse Practitioners of Oregon (NPO), will be used as a means for contacting additional INPs in the state.

From the information gathered from the local group of NPs, a purposive sample of ten INPs representative of urban and rural settings, and of the diverse practice sites in

Oregon will be selected as potential key informants. These key informants will be chosen based on their eligibility and expressed interest in participation in the study. Inclusion criteria in the selection of the key informants will be comprised of the following: NPs in independent practice as defined by 1) having either partial or total financial ownership of the practice or autonomy for decision making issues concerning the practice, 2) being in independent practice for at least one year, and 3) having current licensure in Oregon as an NP.

Procedures

The two researchers conducting this study are skilled interviewers and will be conducting the interviews with the key informants. Each interviewer will conduct five interviews with different key informants using the same guide. Prior to conducting interviews with the key informants, the interview schedule (Appendix B) will be piloted on a non-participating NP by both researchers at independent times to increase familiarity with the interview schedule, to practice probing when responses are brief, and to determine flow and length of interview. Following the piloting, the researchers will provide feedback to each other and debrief on potential obstacles in the interview process. At that time, adjustments to the interview schedule may be done to accommodate suggestions.

Potential key informants will be sent a recruitment flyer (Appendix A) to complete that describes the study and determines their eligibility and interest in participating in the study. A self-addressed stamped envelope will be included for respondents to return their completed flyers. If, after three weeks, there is no reply, a second flyer will be sent. If there continues to be no response, no further attempts at

contact will be made. When the completed flyers are returned, the researchers will meet to determine which respondents will be participants in the study. Criteria used to select ten from the total returned will include meeting the established definition of inclusion criteria for independence, distance from researchers, diversity in NP specialty, location of practice, and duration of practice. The key informants chosen to reflect different types of INPs will be contacted by phone. At that time, arrangements will be made with regards to time, date, location of interview, and an alternate telephone number to reach the INP if needed. The interview settings will be selected mutually to accommodate preferences of INPs and researchers while maintaining confidentiality. The day before the scheduled interview is to take place, the researcher responsible for the interview will make a confirmation call to the INP to confirm the meeting.

If an INP's practice site, or meeting location exceeds a 3 hour one-way driving time, the interview will be conducted over the phone. In the event of a phone interview, the interview schedule (Appendix B), demographics data (Appendix C), and consent (Appendix D) will either be mailed or faxed to the INP. The receipt of the materials will be confirmed one week after being mailed, and the next day if materials were faxed. For face to face interviews consent will be obtained immediately prior to interview and demographics questionnaire will be given at end of interview.

Mutual agreement and informed consent will be obtained between the researchers and key informants surrounding the following issues: 1) anticipated time and involvement required, 2) confidentiality, 3) anonymity or publication recognition, 4) potential benefits and risks, and 5) permission to tape interviews and destroy tapes at conclusion of research study. During each individual interview, there will only be one

researcher present.

Because the sample of INPs is small and unique, the participants are at risk for loss of anonymity. Each INP will be assigned an identification code and all data will be stored in locked file cabinets available only to the researchers. All data will be reported in aggregate form so that no responses can be linked to the identity of specific respondents.

In-depth focused interviews will be conducted using an interview schedule with the key informants. The interview settings will be private, quiet and free from distractions. Prior to the actual interview process, the INP will complete the consent form and at the conclusion of the interview, the demographics data form. Interview questions will be developed from knowledge gained from the literature review and designed as open-ended questions to uncover their perspective of current practice issues and barriers. The interviews will be tape recorded after permission is obtained from the INP. The recording device will be placed at a location equally distant from the INP and researcher. At the beginning of the interview, the tapes will be coded with the date, time, INP code, and researchers name and checked for reliable functioning before proceeding. If the interview is to take place over the phone, attempts at recording the interview will be made, and the recording method will be tested prior to phone interviews. If recording phone interviews is not possible, the researcher will make detailed notes as the interview is progressing. During the interviews, the researcher will have a copy of the interview schedule in her possession at the commencement of the interview to serve as a guide for the flow of questions. The format of the interview will be semi-structured in order to facilitate detailed descriptions of the INP's perspective of the practice. A minimum of 45 minutes to one hour will be allowed for each interview.

At the completion of each interview, the researcher will promptly make personal notes on blank paper away from the interview location that are relevant to the interview that may be useful in future interviews. Nonverbal language and overall interpretation and impression of the interview will be documented. The researchers will meet together after each completes her first interview to discuss the process and any unexpected problems in the process. As the interviewing process continues, the researchers will meet periodically thereafter as necessary.

Data Analysis

Upon completion of the interviews, the researchers will meet and review the taped interview data together with the intent of extracting global and geographical specific themes regarding practice characteristics, barriers, and strategies for success. Each researcher will record her perception of the information given by the INPs. The researchers will record their thoughts independently tallying frequencies of themes heard and noting pertinent narratives. When each taped interview is reviewed, the researchers will discuss their findings with each other. Discrepancies will be discussed and resolved by consensus and input from a third reviewer if needed. Practice characteristics, barriers, and success strategies reported will be described and their frequencies utilizing summaries and narratives from the in-depth interviews.

A final step in the analytical phase is directed toward assuring that the identified concepts and themes are the best interpretation of the data, and that all important data segments have been included in the interpretation. As these concepts and themes are identified, they will be checked against specific research questions to determine their inclusiveness.

Through focused interviews with INPs regarding the characteristics of their practices, frustrations and motivations, and how they feel they are meeting the needs of their community, commonalties and differences will emerge with respect to the characteristics of both the individuals themselves and the practices they operate. These data will provide a clear and current picture of INP roles and barriers to practice in Oregon. While independent practice may not be an option for every nurse practitioner (NP) in Oregon, the results of this study may aide the NP who is desirous of becoming an entrepreneur and starting his or her own practice. The results may also be instructive for others contemplating independent practice elsewhere as many of these attributes are not unique to Oregon.

Table 1.

Description of Independent Nurse Practitioner Sample on Selection Criteria (N=10)

Characteristic	Frequency	%
Financial independence/accountability [a]		
Full ownership of agency	3	30
Partial ownership of agency	3	30
Member of governing board	3	30
NP contracts for own services	6	60
Clinical independence/accountability [a]		
NP developed practice standards	5	50
NP developed policy/procedure	4	40
Solo Practitioner	6	60
Employs MD	4	40

[a] Totals may exceed 100% as respondents were able to choose more than one category.

Table 2. (Table Continues)

Characteristics of a Sample of Independent Nurse Practitioners in Oregon (N=10)

Characteristic	Frequency	%
NP Specialty		
Adult	1	10
Family	5	50
Pediatric	1	10
Geriatric	1	10
Psych / Mental Health	1	10
Other [a]	1	10
Highest Nursing Degree		
AND	1	10
MS /MN	8	80
PhD	1	10
Type of NP Education [a]		
Certificate	1	10
MS / MN	8	80
Post Masters Certificate	2	20
Gender		
Female	9	90
Male	1	10

Table 2. (Continued)

Characteristics of a Sample of Independent Nurse Practitioners in Oregon (N=10)

Characteristic	Frequency	%
Ethnicity [b]		
Caucasian	9	90
African American	1	10
Native American	1	10

Characteristic	Range	Mean	SD
Yrs. Experience in nursing	9-28	22.5	7.7
Yrs. Experience as NP	4-23	11.9	6.0
Yrs. in practice at this location	1-21	11.4	5.8

[a] One respondent was certified in Women's Health and then practiced in a specialty field.

[b] Totals may exceed 100% as respondents were able to choose more than one category.

Table 3. (Table Continues)

Employment Characteristics of Sample of Independent Nurse Practitioners in Oregon (N=10)

Characteristic	Frequency	%
Average Hrs. worked per week		
30-39 hrs	4	40
40-49 hrs	3	30
50-59 hrs	2	20
> 60 hrs	1	10
Average annual salary		
$35,000 - 44,999	3	30
$45,000 - 54,999	2	20
$55,000 - 64,999	1	10
$65,000 - 74,999	3	30
> $75,000	1	10
Salary Method [a]		
Hourly	2	20
Salary	4	40
Incentives / Bonuses	1	10
Other:	5	50
Production	2	20
Production less overhead	1	10

Table 3. (Continued)

Employment Characteristics of Sample of Independent Nurse Practitioners in Oregon (N=10)

Characteristic	Frequency	%
Profit Sharing	1	10
Contract	1	10
Second job held:		
No	6	60
Yes: type	4	40
Independent NP[c]	1	10
NP	2	20
NP Faculty	1	1
Avg. hrs. worked per week-both locations[b]		
40-49 hrs	1	10
50-59 hrs	2	20
> 70 hrs	1	10
Avg. annual salary-locations combined[b]		
$55,000 - 64,999	2	20
$75,000 - 84,999	1	10
$85,000 - 94,999	1	10

[a] Totals may exceed 100% as respondents were able to choose more than one category.

[b] Totals reflect only those respondents with applicable data.

[c] One INP practices in two separate organizations.

Table 4. (Table Continues)

Characteristics of Sample of Independent Nurse Practitioner Practice Settings in Oregon (N=10)

Characteristic	Frequency	%
Population of community served		
< 25,000	6	60
50,000 - 74,999	1	10
> 100,000	3	30
Distance to nearest hospital (in minutes)		
< 15	7	70
15 – 29	1	10
30 – 44	1	10
45 - 59	1	10
Practice type		
Solo provider (without MD)	6	60
Group practice (at least one MD)	4	40
Primary Care Provider Insurance Status		
Yes	7	70
No	3	30
Out of Clinic Practice Sites		
Nursing Home	4	40
Foster Home	3	30

Table 4. (Continued)

Characteristics of Sample of Independent Nurse Practitioner Practice Settings in Oregon (N=10)

Characteristic	Frequency	%
Residential Care Facility	1	10
Patient's Home	4	40
Hospital	3	30
On Site services provided		
Lab	8	80
EKG	4	40
Radiology	4	40
Extended office hours available		
Yes	5	50
No	5	50
Call time		
NP only	6	60
Shared Call	4	40
Hospital Privileges		
Desired and Obtained	3	30
Not Desired or Obtained	7	70

Table 5.

Fiscal Characteristics of Sample of Independent Nurse Practitioner Offices in Oregon (N=10)[a]

Characteristic	Range	Mean	SD
Number of patients seen per day [b]	12.5 - 35	22.8	8.4
Characteristic	**Frequency**	**%**	
Estimated % of managed care patients			
< 25%	4	40	
25-50%	4	40	
51-75%	1	10	
>75%	1	10	
Billing methods utilized for NP [c]			
Medicare	7	**70**	
Using NP ID#	3	30	
Using MD ID#	1	10	
Using Clinic ID#	4	40	
Medicaid	**9**	**90**	
Using NP ID#	6	60	
Using MD ID#	1	10	
Using Clinic ID#	2	20	

Table 5. (Continued)

Fiscal Characteristics of Sample of Independent Nurse Practitioner Offices in Oregon (N=10)[a]

Characteristic	Frequency	%
Oregon Health Plan	**8**	**80**
Using NP ID#	7	70
Using MD ID#	1	10
Using Clinic ID#	1	10
HMO	**8**	**80**
Using NP ID#	7	70
Using MD ID#	1	10
Private Pay	**8**	**80**
Indigent Care	**8**	**80**
Types of HMO contracts held		
Partial Capitation	6	60
Full Capitation	4	40
Withhold	4	40
Fee For Service	6	60

[a] Data collected in 1997, prior to Medicare changes in 1998.

[b] Data shown do not include the PMHNP. With these included, Range=4-35, Mean=20.9, SD=9.9.

[c] Totals may exceed 100% as respondents were able to choose more than one category.

Table 6. (Table Continues)

Personal Attributes of Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Attraction to Independent Practice	Desired independence
	Desired rural setting
	Lack of local employment options
	Community need
	Desired ownership
	Planned decision
Preparation for Independent Practice	Risk taking
	Willingness to make personal sacrifice
	Clinical expertise
	Previous independent clinical experience as RN (ER, ICU, Home Health)
	Communication skills
	Responsibility
	Knowledge of own limitations
	Ability to self monitor
	Self confidence
	Perseverance
	Altruism

Table 6. (Continued)

Personal Attributes of Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Preparation for Independent Practice	Previous business experience
	Leadership skills
	Networking skills

[a] Responses are listed in descending order of frequency.

Table 7. (Table Continues)

Clinical issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Acceptance of Independent Nurse Practitioners	Very well accepted
	Well accepted
	They are "big fans"
	"Occasionally a family will object to NP care"
	"We have to work 5 times as hard as MDs to gain community acceptance"
Strategies to improve patient/ community acceptance	Community service
	Health fairs / screenings
	Flu shot clinics
	Word of mouth
	Public speaking
	School programs
	Local advertisement
	Personal marketing to MDs
	Flexible hours / Walk in hours

Table 7. (Continued)

Clinical issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Problematic issues when referring Patients	Paperwork / Referrals
	Lack of recognition of NP as PCP
	Local politics
	Hospital Admissions
	Respect of physicians
	Physician resistance to collaborate with NP
	Payment of services
	NPs can't sign Home Health orders
	Finding indigent services for patients
Strategies to overcome referral issues	Education about NP role
	Networking
	Pay MD to consult / teach procedures
	Don't be adversarial, introduce self to MDs
	Build a 2 way referral system with MDs
	Negotiate for PCP Status

Table 7. (Continued)

Clinical issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Are risks different in independent practice versus another setting?	No –8 Yes – 2, You are more accountable for our decisions and results
Risks and benefits of independent clinical decision making	**Risks:** More autonomy Less bureaucracy Less purchasing power More accountability **Benefits:** More job satisfaction More learning "you are forced to" More broad scope of practice Must be knowledgeable and realistic about your limitations to minimize risks Indigent care, when to test / refer

Table 7. (Continued)

Clinical issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Modifying practice policies/standards of Care	Per patient needs
	Per literature / conferences
	Per insurance regulations
	Per regulatory agency (CLIA, OSHA)
	Per consultation with specialists
	Per audit results, Medicare, insurance, IPA
	Annual Policy review
	Modifications on as needed basis
Measurement of quality of care in Independent NP practice	No formal process
	Informally via patient outcomes
	Patient satisfaction surveys
	Chart reviews (Medicare, insurance, professional organization, IPA)
	Regulatory agency audits (CLIA, OSHA)
	Informal peer review

[a] Responses are listed in descending order of frequency.

Table 8. (Table Continues)

Administrative / Business Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Business skills needed	Bookkeeping
	Accounting
	Staffing
	Raising Capital
	Acquiring technology
	Legal advice
Business resources	Friends / Relatives
	Hired administrator
	Hired accountant / bookkeeper
	Hired attorney
	Business consultants
	On the job training
	Area Health Education Centers
	Office of Rural Health
	Small Business Administration
	Reading
	Business classes
	IPA

Table 8. (Continued)

Administrative / Business Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Business resources	Professional organizations
Problematic business/administrative Issues	Raising capital
	Acquiring technology
	Acquiring / training staff
	Marketing
	Accounting / accounts receivable
	Prescriptive privileges questioned out of state
Business/administrative strategies	Computers
	Networking
	Business partners
	Negotiate for used equipment at a discount
	Donations and grant funding
	Assertive collections
Impact of managed care	**Positive:**
	Financial bonus return at year end
	Better payment with Oregon Health Plan

Table 8. (Continued)

Administrative / Business Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Impact of managed care	**Positive:** More people insured More preventive care More phone triage Better management of budget No change in time spent with patient Same number of patients seen per day
Impact of managed care	**Negative:** More paperwork time spent on referrals Greater administrative costs Greater dictation of practice by insurance More local competition and politics Lost patients because NP not on provider panels

Table 8. (Continued)

Administrative / Business Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Impact of managed care	**Negative:**
	Less continuity of care / less patient choice
	Less time for health maintenance
	Pressure to compromise quality for quantity
	More time needed and less time available for patient education

[a] Responses are listed in descending order of frequency.

Table 9. (Table Continues)

Job Satisfaction Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Impact on personal life	Lack of time to take care of yourself
	Less opportunity for vacation time, family time, personal time, educational time
	Call time infringes on personal life
	Lack of coverage when away
	Time management stress
	Finances dependent on your success
	Pressures decreased with call sharing / vacation coverage
	Scrutiny by rural community, must be role model
Impact on job satisfaction	All INPs were satisfied with current job
	Greater personal benefits / rewards
	Greater accountability / autonomy
	Bonding with community / patients
	"See the results of your labors"
	Greater emotional/financial job investment

Table 9. (Continued)

Job Satisfaction Issues for Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
Have you ever thought of leaving this setting? Why or why not? What makes you stay?	6 INPs have thought of leaving 4 INPs have not thought of leaving **Reasons for leaving:** Burnout Fear of competition Bad days Lack of time **Reasons for staying:** Commitment to community Long term goals Financially motivated Desires independence / autonomy Challenged Because we make a difference
Would you go into independent practice today, given the economic climate of health care?	Yes – 9 No – 1

[a] Responses are listed in descending order of frequency.

Table 10. (Table Continues)

Advice from Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
What do you think it takes to be successful as an independent nurse practitioner today?	Hardworking Dedicated Better to have collaborating MD, but not necessary Confidence Personal accountability and responsibility Financial reserves Business sense or partners Good interpersonal skills Contracts or IPA involvement
What advice or pearls of wisdom would you give to a NP considering independent practice?	"Have good front office staff / secretary" "Office staff can make or break you" "Get experience first" "Get a reputation first" "Be an FNP" (rather than specialist) "Don't start alone, much easier in a group or with business partners"

Table 10. (Continued)

Advice from Sampled Independent Nurse Practitioners in Oregon

Interview question	Responses / themes [a]
What advice or pearls of wisdom would you give to a NP considering independent practice?	"Know your patients, make them laugh" "You've got to love it, or don't do it" "Get a loan, go to Small Business Administration" "Be frugal…don't grow until you outgrow your current situation" "Don't have a chip on your shoulders about doctors, be a team" "Build a good consult base" "Train your patients well so you don't have much call" "Don't live near your clinic, get unlisted phone number / address and caller ID block" "Be willing to wait for the payoff" "Independence is a process of evolution"

[a] Responses are listed in descending order of frequency.

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Appendix A

Independent or Entrepreneurial NP Study

Hello,

We would like to invite you to participate in our research study. Our names are Kim Montagne and Lori McMillian. We are MS / NP students at OHSU conducting a descriptive study on NPs who are Independent or NP Entrepreneurs. Your name has been selected as an NP who may qualify as a potential informant. We will be interviewing approximately 10 NPs and we hope to be representative of the many different fields and specialties.

Our study will consist of **a one-hour interview and demographical questionnaire**. The interviews will be conducted at a time and place of mutual agreement. All information will be confidential and will be reported so respondents are not identifiable. It is our hope that this information will provide a clearer picture of what independent NP practice in Oregon consists of, including the rewards and drawbacks, and strategies for success.

We hope that you will choose to participate in this study, and we are certain that your viewpoints and expertise in this field will provide insightful information to NPs who are considering independent or entrepreneurial practice in the future. **Please respond as soon as possible by completing the information below and returning it in the enclosed self addressed stamped envelope.** We will contact you by phone upon receiving your reply to schedule an interview.

Thank you very much for your time. Please feel free to call us for any questions.
Kim Montagne RN, BSN 541-752-6135 Lori McMillian RN, BSN 541-484-7267
Supervising research advisor: Katherine Crabtree, DNSc, ANP, OHSU School of Nursing

Name: _____
☐ YES, I would like to participate in this study. (Please complete information below & return)
☐NO, do not include me in the study. (Please reply with your name and we will remove you from the list.)

Place of employment: _____
Mailing Address: _____
_____
Phone: (_____)_____Best time to call_____

Type of NP Specialty:
☐ANP ☐FNP ☐PNP ☐GNP ☐WHCNP ☐PMHNP ☐Other_____

Your practice is best described as: (may choose more than one)
☐ Rural ☐ Urban ☐ Solo practice ☐ Group practice

Aspect of independence: (must check at least one in either category to qualify for study)
Financial independence and accountability experienced by:
☐ Full Ownership of Agency / Practice
☐ Partial Ownership of Agency / Practice

☐ Member of Governing Board for Agency – Specify Position _____
☐ NP Contracts with outside agencies for own services

Clinical independence and accountability experienced by:
☐ NP developed Practice Standards (☐ NP only or ☐ Committee)
☐ NP developed Policy and Procedures (☐ NP only or ☐ Committee)
☐ Solo Practitioner
☐ Employs MD

Appendix B

Interview Schedule

Hello, My name is (Kim/Lori). I am currently a Masters student in Nursing in the NP student at OHSU. My partner and I are conducting a descriptive research study exploring characteristics of INP practices. We will be interviewing approximately 10 INPs throughout the state to gather information about what it is like to be an INP, and what different types of INP practices exist. We will also be exploring what types of barriers INPs have experienced in Oregon and what strategies you have been used to overcome them.

Before we begin I would like you to read and sign this consent form, which includes permission to tape the interview for later review by myself and my research partner. Tapes will be destroyed when data analysis is completed. I expect that the interview will take 45 minutes to 1 hour. At the conclusion I will ask you to complete a 1½ page questionnaire with demographic information.

I would like to thank you in advance for participating in this study. It is our hope that our results will provide information for others who are considering independent practice and will assist in advancing INP practice throughout the state.

Sign Consent form - Start Tape - Check voice recorded - new batteries?
Review and confirm inclusion Criteria:

Financial independence and accountability experienced by:
☐ Full Ownership of Agency
☐ Partial Ownership of Agency
☐ Member of Governing Board for Agency – Specify Position _____
☐ NP Contracts with outside agencies for own services

Clinical independence and accountability experienced by:
☐ NP developed Practice Standards (☐ NP only or ☐ Committee)
☐ NP developed Policy and Procedures (☐ NP only or ☐ Committee)
☐ Solo Practitioner
☐ Employs MD

Type of NP Specialty in which you now practice:
☐ANP ☐FNP ☐PNP ☐GNP ☐WHCNP ☐PMHNP ☐Other_____
INTERVIEW START TIME: _____ STOP TIME: _____

1. Please give me a brief description of your a) role here, b) population served, and c)services provided.
   (Probes: a)Solo, group, collaborative, administrator, mentorship, b age ranges, clinic, nursing home, acute care, indigent, c)Emergency services, After hours services, Call time)

2. What drew you to this practice setting initially?
   (Probes: Independence, Altruistic, Pay, Ownership, Community, sudden or gradual decision)

3. What experiences or personal characteristics / traits best prepared you for practice as an INP?
   (Probes: business skills, tenacity, clinical skills, sacrifice, risk taking, altruistic, need of community, desired rural setting)

4. How have your patients and community responded to services provided by an INP? Have you utilized any strategies to improve patient or community acceptance or satisfaction?
   (Probes: acceptance, marketing strategies, patient satisfaction, expanding services or hours, access, location of business, educating patients about NPs, community service)

5. When you see a patient that requires services you cannot provide, or a patient whom requires consulting another provider, how do you obtain assistance?
   (Probes: Emergency Care, Local emergency services available, Referrals, Back-up MD- paid by NP or insurance, Consults – phone or in house, EKG or Xray interpretations, hospital privileges.)

6. When referring to other providers or agencies what issues have been problematic for you and how have you overcome them?
   (Probes: competition, politics, referrals, acceptance, PCP status, turf, respect)

7. What do you feel are the risks and benefits in making independent clinical practice decisions? Do you feel that the risks are different in independent practice versus in any clinical setting? How?
   (Probes: autonomy, patient care / outcomes, lack of resources, involvement of other providers / disciplines, creativity, opportunities, bureaucracy)

8. How and how often do you decide to modify your practice policies or standards of care?
   (Probes: in conjunction with patient need / demand, literature, business advisors, feedback from agency/ payors/ patients)

9. The literature often sites small business skills as being essential for success. What small business management skills have you used or needed? Where did you turn for resources?
   (Probes: Strategies for raising capital, legal, malpractice, marketing, overhead, acquisition of technology, acquisition or training of staff, local competition, community acceptance, dispensing/prescribing, professional organizations, NPO, small business administration, government, universities, AHEC, Office of Rural Health, colleagues, friends, consultants)

10. Were there any business or administrative issues that were problematic? What strategies did you use to overcome them?
(Probes: Strategies for raising capital, legal, malpractice, marketing, overhead, acquisition of technology, acquisition or training of staff, local competition, community acceptance, dispensing/prescribing, innovative, creative)

11. What types of reimbursement do you currently receive for NP services?
(Probes: Private, Third Party, HMOs, OHP, Medicare, Medicaid, contracts w/agencies)

12. What strategies have been a) successful in maximizing reimbursement? And b) unsuccessful in maximizing reimbursement?
(Probes: Partial reimbursement, billing through NP or MD, PCP status, contracts, IPA involvement, billing strategies)

13. Are there changes in the current system of healthcare delivery or reimbursement that have affected your practice?
(Probes: Positively, negatively, time, reimbursement, referrals, paperwork, # of pts)

14. How do you measure quality of care in your practice? Do you utilize a system for peer review of the outcomes of your care decisions? How frequently do you measure quality of care issues?
(Probes: Peer review, Morbidity/Mortality conferences, JCAHO, accreditation, NCQA, format of peer review committees, hired consultants, random review, case or diagnosis specific review, QI dept, chart audits)

15. How has your independent practice affected your personal life? Job satisfaction?
(Probes: autonomy, lack of time / vacation, family time, call time, back-up, continuing education, satisfaction, benefits, rewards)

16. Have you ever thought of leaving this setting? Why or Why not? What makes you stay? How long do you think you will remain in independent practice?
(Probes: satisfaction, money, being own boss, commitment to community, contracts, patients, risks, uncertainty)

17. If you were deciding today, would you enter into independent practice given the current economical climate in health care? What do you think it takes to be successful as an INP today?
(Probes: long hours, dedication, little pay, affiliation w/MD or agency, contracts, business skills)

18. What advice or "Pearls of Wisdom" would you give to an NP considering independent practice today?
(Probes: personal characteristics, capital, time, satisfaction, tips...)

Appendix C

NP Demographics

Please complete the following questionnaire and return it to interviewer. All data will be kept strictly confidential.

1. Type of NP Specialty in which you now practice:
☐ANP ☐FNP ☐PNP ☐GNP ☐WHCNP ☐PMHNP ☐Other_____

2. Years of experience as NP: _____ Total years of experience in Nursing: _____

3. Highest degree in nursing:
☐Diploma ☐ADN ☐BS ☐MS / MN ☐Ph.D.

4. Type of NP education: ☐Certificate ☐On the Job Training
☐BS ☐MS / MN ☐Post Masters Certificate ☐Doctoral

5. Years of practice at this site / location: _____

6. Average hours worked per week at this location:
☐<20hr ☐20-29hr ☐30-39hr ☐40-49hr ☐50-59hr ☐>60hr

7. This independent practice location is in a community with the population of:
☐<25,000 ☐25,000-49,999 ☐50,000-74,999
☐75,000-99,999 ☐ >100,000

8. Number of providers (including yourself) at this location:
____NPs ____PAs ____Physicians ____ RNs ____LPNs ____ Medical Assistants

9. Distance to nearest hospital:
☐<15 min. ☐15-29 min. ☐30-44 min. ☐45-59 min. ☐ >60 min.

10. Number of patients seen on average per day: _____

11. Estimated percent of managed care patients in your practice:
☐ < 25% ☐ 25-50% ☐ 51-75% ☐ >75%

12. Billing methods used for NP services: (check all that apply)

Payer Type	/ Billed through: NP ID #	/ MD ID #	/ Clinic/Practice ID#
☐ Medicare	☐	☐	☐
☐ Medicaid	☐	☐	☐
☐ OHP	☐	☐	☐
☐ Private	☐	☐	☐
☐ HMOs	☐	☐	☐

For HMOs – type of contractual arrangements:
☐ Partial Capitation ☐ Full Capitation ☐ Withhold ☐ Fee for Service

13. Your average annual salary at this location:
☐ < $14, 999 ☐ $15,000 – 24,999 ☐ $25,000 – 34,999 ☐ $35,000 – 44,999
☐ $45,000 – 54,999 ☐ $55,000 – 64,999 ☐ $65,000 – 74,999 ☐ > $75,000

14. NP wages paid by what method: (may choose more than one)
☐ Hourly ☐ Salary ☐ Incentives / Bonuses ☐ Other_____

15. Do you have a second place of employment? ☐ No ☐ Yes
(if Yes, How many hours do you work on average per week at all locations combined?) ☐ <20hr ☐ 20-29hr ☐ 30-39hr
☐ 40-49hr ☐ 50-59hr ☐ 60-69hr ☐ >70hr
Please describe your second employment position:
☐ Independent NP ☐ NP ☐ RN ☐ Other _____

16. Your average annual salary of all employment combined:
☐ < $14, 999 ☐ $15,000 - 24,999 ☐ $25,000 - 34,999 ☐ $35,000 - 44,999
☐ $45,000 - 54,999 ☐ $55,000 - 64,999 ☐ $65,000 - 74,999
☐ $75,000 - 84,999 ☐ $85,000 - 94,999 ☐ >$95,000

17. Gender: ☐ Female ☐ Male

18. (OPTIONAL) Ethnicity: ☐ Caucasian ☐ Asian American ☐ African American
☐ Hispanic American ☐ Native American ☐ Other_____

Thank you for your time!

Appendix D

Oregon Health Sciences University

Consent for Participation

TITLE: A Descriptive Study of Independent Nurse Practitioners in Oregon

PRINCIPAL INVESTIGATORS:

Lori McMillian, RN, BSN (Phone: 541-484-7267)

Kim Montagne, RN, BSN (Phone: 541-752-6135)

Please feel free to contact us at anytime during the study.

Supervising research advisor: Katherine Crabtree, DNSc, ANP, OHSU School of Nursing

(Phone: 503-494-3828)

PURPOSE: You have been invited to participate in this research study because you are an independent or entrepreneurial Nurse Practitioner. The purpose of this descriptive study is to obtain information about Independent Nurse Practitioner(INP) practices in Oregon. Specifically, to describe the INPs and their practice settings using demographic data, and to explore the personal rewards and risks involved in independent practice. Barriers to practice will be explored as well as strategies to overcome them, and advice for NPs considering independent practice. Participation will entail scheduling and completing one 60 minute interview.

PROCEDURES: You will be interviewed about the characteristics of your practice, barriers that you have experienced and strategies you have used to overcome them. You will be asked to describe your personal experiences and relay advice you would give to

NPs about entering independent practice. One interview of approximately 45-60 minutes will be conducted at the time and place of your choosing. Following the interview, you will be asked to complete a 1½ page questionnaire containing demographic information.

Interviews will be taped for review, and the tapes will be destroyed when project is complete. Informants and all materials will be coded to protect anonymity. You may be contacted for clarification of data if necessary during review of interview tapes.

RISKS AND DISCOMFORTS: The interview may present an inconvenience as it may be scheduled during your off hours. Interviews will be scheduled at a quiet and confidential time and location that is mutually convenient and agreed upon. Scheduling interviews may require that we contact you briefly at work, which may interrupt your schedule. Please consider this in your consent to participate.

BENEFITS: The potential benefits are:

1) You may derive personal and professional satisfaction in collaborating in a nursing research study, and from sharing your reflections and experiences with others.
2) By serving as a participant, you may contribute information which will benefit NPs in the future.
3) If you choose, you may be listed on a roster of "Independent NPs" designed to establish a network for communicating with other INPs.
4) You will receive a summary of the completed study at your request.

CONFIDENTIALITY: Demographic information will be collected from each informant. Identities will be coded for purposes of the study and will be kept strictly confidential. Taped interviews will be destroyed upon completion of project. Tapes and files will be kept in a locked file drawer. Neither your name nor your identity will be used for publication or publicity purposes.

According to Oregon law, suspected child or elder abuse must be reported to appropriate authorities.

COSTS: There are no costs for participation in the study. Interviews will be conducted at time and location that is mutually convenient and agreed upon.

LIABILITY: This study is not sponsored or funded by any agency or institution. Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the university, its officers or employees. If you have further questions please contact: Medical Services Director at (503) 494-8014.

PARTICIPATION: Participation in this study is voluntary. Lori McMillian (541) 484-7267 and /or Kim Montagne (541) 752-6135 have offered to answer any questions you may have about this study. If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review

Board at (503) 494-7887. You may refuse to answer any questions or withdraw from the study at any time without affecting your relationship with Oregon Health Sciences University.

You will receive a copy of this consent form after signing it.

Your signature below indicates that you have read and understood the foregoing and agree to participate in this study.

Signature of Participant _____ Date _____

Place of Employment_____

Mailing Address_____

_____

Phone Contact ( )_____ Best time to call_____

Witness_____

☐ Please send me a summary of the results of this study to the above address.

☐ I do not need a summary of the results of this study.

Appendix E

Institutional Review Board Approval

OREGON HEALTH SCIENCES UNIVERSITY
Research Support Office (RSO), L106 (503) 494-7887

MEMO

Date: July 15, 1997

To: Kimberly Montagne RN, BSN 2501 NW Garfield, Corvallis OR 97330

From: Robert D. Koler, MD, Chair Institutional Review Board, L106
Leslie Bevan, PhD, Director Research Support Office, L106

Subject: ***4540 EX*** R D Koler MD
A Descriptive Study of Independent Nurse Practitioners in Oregon

Special Communication

☐ The RSO has not received a response to the request made on _____ for revisions of the above protocol/consent form. These were due in the RSO on _____.

☐ The attached advertisement has been approved as presented. Any changes to this advertisement must be submitted to the RSO for IRB approval.

☐ The IRB reviewed the attached advertisement on _____ . The following changes will need to be made before approval is given. [1]

☐ The above study involves only discarded tissues/samples that do not include *identifiable private data/information obtained in a form associable with an individual*. Therefore, the study does not require IRB review.

☐ The above study meets the criteria for waiver of consent.

✖ This study is exempt based on criteria category #2 .

[1] see appended copy for suggested editing

Appendix F

Article for Publication

Abstract

The characteristics and practices of Independent Nurse Practitioners (INPs) were the foci of this study. Criteria for independence were financial ownership of one's practice and/or autonomous decision-making power in practice concerns. Nurse practitioners are expected to know their scope of practice to consult with and refer to other healthcare providers. In-depth focused interviews were conducted with ten INPs in Oregon. INPs are likely to be entrepreneurial and located in rural areas. Barriers to practice consist of reimbursement difficulties, local politics, and burnout due to time pressures. Having a second provider in the practice results in less burnout. Competition was perceived as a minor barrier that INPs have overcome by gaining physician respect. Having a collaborating physician was found to be helpful but not essential since the Oregon Nurse Practice Act allows nurse practitioners to function without physician supervision. For those considering INP practice, it is advisable to be prepared for these barriers, for long hours, and to begin only after obtaining significant clinical experience.

Purpose

This descriptive study of the nature of the practices of Independent Nurse Practitioners (INPs) in Oregon examined settings, populations served, relationships with and utilization of other providers, barriers to practice and strategies for success. INPs were defined by either of two characteristics. The individual must either have financial ownership in the practice (total or partial), or must have autonomy in decision-making in issues concerning the practice. The nurse practitioner must meet one or both of these criteria to be considered independent for the purpose of the study.

While these INPs identify themselves in varying ways, one characteristic that may be common to them all is possessing entrepreneurial style. Vogel and Doleysh (1988), define an entrepreneur as an individual who assumes the total responsibility and risk for discovering or creating unique opportunities to use personal talents, skills, and energy, and who employs a strategic planning process to transform that opportunity into a marketable service or product. This definition takes into account the innovation, drive, foresight, and management that entrepreneurship demands, as well as the creative productivity and continual hard work that are essential for success.

Nurse practitioners (NPs) have responded to societal demands and needs, changing the face of health care. With society's support, NPs have expanded the boundaries of nursing further into a realm of practice previously the sole domain of other professions (Baker & Pulcini, 1990). As a result of these advances in nursing practice, NPs are in an optimal position to develop their entrepreneurial skills and establish their own healthcare businesses. The NPs' emphasis on comprehensive assessment and independent decision-making about healthcare has changed the intersections of nurses

with other health care providers from dependent to interdependent (ANA Scope of Practice, 1985).

The roots of independent practice in nursing can be traced back as far as Nightingale. Her astute observations and study of the causes of morbidity and mortality among soldiers during the Crimean War led to initiation of sanitary and nutritional reform. Her careful documentation of outcomes led to an appreciation of nursing and opportunities for nurses to be trained to care for the ill. Lillian Wald and Mary Brewster, who opened the first Nurses' Settlement in New York City, provided independent care to thousands of patients. Through their efforts, a rudimentary public health system was formed. Mary Breckenridge, founder of the Frontier Nursing Service, sent midwives on horseback to homes of the poor in Appalachia and significantly reduced infant and maternal mortality.

Unfortunately, as the nation grew more accepting of these independent nurses, physicians began to view them as a threat, professionally and financially. In 1929, the American Medical Association lobbied against public funding that these nurses were receiving. They cited public health nurses as unproductive and as promoting communism. Because of their efforts, public health funding for the continued care provided by these nurses ceased, temporarily arresting the advancement of independent practice in nursing (Garey & Hott, 1992). As a result, nursing became a hospital based service which eroded both the independent decision-making and financial independence of nurses. Nurses became employees of hospitals subject to physicians' orders in a hierarchical system that stifled innovation and risk-taking, and rewarded conformity.

Because nurses still valued independence and recognized the importance it had on the community, they continued to strive for it inside and outside hospital boundaries. The advent of the NP role in 1964 was an opportunity for advanced practice nurses to become more independent in the decision-making role and to become entrepreneurs.

Louise Kinlein was the first NP to set up a solo practice. As an INP in Maryland, she emphatically stated that a nurse practitioner's approach should be from the point of health and not from the point of disease, as many physicians are trained to do. She cautioned nurses not to practice medicine, while at the same time, using the same knowledge that the physician does, just differently (Young, 1992). The NP role has continued to evolve, with greater shift toward managing more complex patients. This overlap with medicine necessitates skill and knowledge of when and how to collaborate with physicians for optimal patient outcomes.

Another tradition of nursing is altruism, providing care to those who are in need, regardless of the setting or ability to pay. Because NPs are prepared to help care for persons regardless of their socioeconomic status or age, they can be major contributors as primary care providers. In the tradition of holistic health, NPs provide services to their patients by directing care to all areas of an individual's life. Although NPs still emphasize health promotion and maintenance care, the role has evolved to include treatment of common acute and chronic illnesses. Treatment of disease is only one component on a continuum of care.

With advancing technology, social change, and greater education of nurse practitioners, there became a growing acceptance of NPs among consumers and some physicians. However, other physicians have been less willing to give up their control of

nurses. The American Nurses Association (ANA) and the American Medical Association (AMA) have attempted to establish a mutually agreed upon definition of collaboration, despite many remaining points of contention between the groups. Nurses believe the definition needs to focus more on working interdependently with shared values and mutual acknowledgment and respect for each other's contribution. The AMA Council on Medical Services proposes that the term *integration* rather than *collaboration* be used, and that integration focus on mutually agreed-upon guidelines that reflect each group's qualifications (Holladay, 1995).

Economic competition under managed care has also increased physician resistance to the independent functioning of NPs. This resistance has been increasing despite the abundance of literature to support the cost effectiveness and quality of NP practice compared with physician care (Safriet, 1992; Pearson, 1994). There remains a limited amount of literature actually describing INP practice, populations served, and current INP perspectives of barriers to practice, especially in Oregon.

Historically, Oregon has been a state that has been successful in removing barriers to practice. With public support, Oregon NPs lobbied for revision of the Nurse Practice Act in the 1979 legislative session. They obtained prescriptive authority, mandatory insurance reimbursement, and fee-for-service reimbursement, despite physician opposition (Bifano, 1996).

In the state of Oregon, there is no legal requirement for NPs to work under the supervision of a physician. The 1996 Oregon State Board of Nursing Rules and Regulations provides for independent practice by stating that "The NP is independently responsible and accountable for continuous and comprehensive management of a broad

range of healthcare. The NP is responsible for recognizing limits of knowledge and expertise, and for resolving situations beyond his/her expertise by consulting with or referring to other healthcare providers" (p.6-7).

Despite successes in reducing legislative barriers, INPs continue to report experiencing barriers to practice in the form of physician relations and acceptance and reimbursement. There are also ongoing concerns about the inability of NPs to function to the full extent of their knowledge, qualifications, and scope of practice (Dempster, 1994).

The high degree of managed care penetration in Oregon, estimated at 75-92% (Burns et al., 1997), also poses reimbursement difficulties for INPs. The documented cost effectiveness and quality of NP services and the NPs' skill in prevention and counseling may eventually enhance opportunities for NPs in managed care as more emphasis is placed on cost containment and outcomes (Havens, 1995). However, the striving for equity of reimbursement of NP services at the same rate as physician services may make NPs less attractive as employees to HMO managers seeking low cost care.

Methods

For this descriptive study, a purposive sample of ten INPs was interviewed. They were asked to complete a brief demographic questionnaire. In 1996, it was estimated that there were 1000 NPs in Oregon, 8% of which practiced without a physician in the office, and 3% were identified as rural (Burns, et al., 1996). The INPs in this study were located utilizing personal referrals from a local NP network and the Nurse Practitioners of Oregon (NPO) registry. A total of 30 candidates were contacted via mail to invite participation in the study if inclusion criteria for independence were met. Although it is

difficult to specify the exact number of INPs in Oregon, it may be assumed that thirty represents approximately one-third of their number.

Independence was defined by 1) having either partial or total financial ownership of the practice or autonomy for decision-making issues concerning the practice, 2) being in independent practice for at least one year, and 3) having current licensure in Oregon as an NP. Of the thirty candidates, 21 (70%) responded. All were qualified. Ten were chosen for the study, to represent the different specialties, and to include INPs who were new, experienced, and potentially leaving INP practice. To further diversify, INPs were chosen from both rural and urban settings. These key informants were then contacted by phone to arrange an interview time. Phone interviews were conducted with those who lived greater than 3 hours driving distance from the researchers.

An interview schedule was developed after a review of literature to include historical perspectives on independent practice, entrepreneurial traits, and barriers to practice such as competition, politics, legislation and business or administrative issues. Each investigator piloted the interview schedule independently and then debriefed and clarified questions to be pursued with subjects. Each investigator interviewed 5 key informants after obtaining informed consent. All ten interviews were taped for later review. Interviews ranged from 50-75 minutes with a mean of 59.8 minutes and a standard deviation of 8.0 minutes. Following interviews, researchers made notes regarding overall impression and new themes. All interview data were coded and securely stored to protect confidentiality. Contact was made between the researchers after each interview to discuss any complications or new themes that were encountered.

Following completion of all interviews, the researchers met to review taped data and compile demographic information. Data were reviewed with each investigator recording her perception of information given and identifying concepts, frequency of themes, and pertinent narratives.

Results

The data collected addressed the following research questions posed in the study.

1. What are the characteristics of Oregon INPs and their practices?

The sample was predominately female and Caucasian, reflective of the NP population in Oregon. The NP specialties included were Adult (ANP), Family (FNP), Geriatric (GNP), Pediatric (PNP), Women's Health (WHCNP), and Psych-Mental Health (PMHNP). Half of the sample were FNPs, possibly because FNPs are more likely to be rural providers and thus solo or independent. Nearly all of the INPs had obtained Masters level education. The sample had a significant amount of nursing experience, with the group mean being 22.5 years, and 11.0 years experience as an NP.

The INPs interviewed had variable incomes and hours worked. (Insert Table 1.) A majority of the group worked greater than 40 hours per week at their primary jobsite and four of them had second jobs which increased their weekly hours. The INP practices surveyed were amazingly diverse, ranging from solo practitioners in rural settings to independent solo practitioners in specialty settings, to INPs functioning independently within group clinics. (Insert Table 2.) Several INP entrepreneurs owned their own businesses or contracted independently for their services. A majority of INPs were solo providers, some employing physicians for consulting services.

The practice locations and services provided were also diverse, with 60% in rural

or communities less than 25,000, and 40% urban with 70% of that number being within 15 minutes of a hospital. The number of patients seen per day ranged from 12-35 with a mean of 22.8 patients per day. Seventy percent of the INPs were functioning as primary care providers (PCPs) for managed care organizations. The few that were not PCPs were functioning as specialists in the offices of a physician. Many of the INPs also conducted visits in areas other than their primary clinic setting such as skilled care facilities or the patient's home. Three INPs had hospital admitting privileges. Half of the clinic sites had extended office hours. Laboratory services were available at 80% of the sites while EKG and radiology were only available at 40% of the sites. All of the INPs were responsible for covering patient calls after clinics closed, 60% alone, and 40% shared call time.

The INPs utilized a variety of billing methods depending on their population. Also, billing practices varied as to whether or not INPs billed utilizing their own billing identification numbers or those of the physician or clinic. (Insert Table 3.) Obtaining PCP status is important for reimbursement. INPs reported it was obtained by negotiating with insurers, by virtue of being the only rural provider in an area or by joining an Independent Practice Association (IPA) that has NPs as members. There is literature available to guide the NP in insurance negotiation, but IPA membership can be difficult to obtain if the governing body of physicians refuses to admit NPs. Litigation is a last resort, although NPs have been successful in restraint of trade suits in other states.

Those NPs who were not designated as PCPs were more likely to bill private insurers through collaborating physicians or pre-established contracts. Eight of the ten respondents reported 50% or less of their practice were managed care patients. Eight of ten respondents provided indigent care to clients, illustrating nursing's tradition of

altruism. When reviewing billing data, it is essential to note that these data were collected prior to Medicare regulation changes that broadened the ability of the NP to bill Medicare independently.

When asked about their decision to enter independent practice, the majority of NPs sought out an independent setting, some desired a rural setting, and two became independent when there was a lack of other local employment options in their community. Many INPs stated that they were filling a community need. For most, it was a planned decision, and for many, resulted in ownership of a business.

Clearly the NPs drawn to independent practice possessed some personality traits in common. These traits included risk taking, willingness to make personal sacrifices, commitment to hard work and responsibility. These characteristics fit the profile of an entrepreneur defined earlier (Vogel & Doleysh, 1988). All of the INPs were experienced clinicians and had practiced advanced nursing, many in settings such as Emergency Care and Intensive Care where critical decision making is required, and in Home Health where nurses are fairly autonomous. Other traits the INPs felt were essential in preparing them for independence included the ability to self-monitor and know one's limitations, self confidence, perseverance, altruism, leadership, networking, and business skills.

2. What are the barriers to Independent Practice reported by NPs in Oregon and what strategies have INPs used to overcome them?

The INPs were asked to describe barriers to practice, including clinical and administrative issues that are often cited in the NP literature. All of the INPs reported they had gained community acceptance. Some stated that their clients were "big fans," some driving substantial distances just to continue care with the NP. More than one INP

voiced a concern that NPs have to work five times as hard as physicians to gain community acceptance. A number of strategies were implemented to gain and develop community support, and most INPs continue these activities today. Strategies used can be characterized as predominantly community service in the form of organizing health fairs and screenings, and flu shot clinics. NPs volunteered as public speakers, and taught in local schools. Strategies to market NP services included local advertising, personal marketing to physicians, and flexible hours or schedules that allowed for walk-in patients. All INPs stated their best marketing tool was favorable word of mouth from patients and colleagues.

Hospital admitting privileges are an issue for NPs in Oregon. Hospitals may decide on an individual basis whether or not to allow NPs to admit. In the study, only three INPs had hospital privileges. The remaining seven did not, and stated that they were not currently seeking them. Interestingly, five of the seven had attempted to obtain privileges in the past and had been unsuccessful. In one case, the NP had hospital privileges for a number of years when employed by a physician group. When she entered independent practice, her admitted privileges were revoked. Granting hospital privileges to NPs remains an area of controversy in Oregon.

Obtaining assistance for patients who need services not provided by the INP can be problematic, especially if the INP is a solo provider, is not a primary care provider for insurance purposes, or does not have hospital privileges. Most NPs reported good working relationships with physicians. Consulting services were obtained either by phone, by utilizing colleagues on premises, by utilizing the back up physician, or the Oregon Health Sciences University Hospital Consult Line. X-rays were generally

interpreted by an outside radiologist. Regulatory issues, such as NPs being unable to sign Home Health orders or filling out-of-state prescriptions, were frequently cited as problems. The INPs referred patients to medical specialists as indicated by history and exam, and hospital admissions were accomplished by referral to the appropriate specialist. Referral issues could be troublesome in many ways, with the amount of paperwork being at the top of everyone's list. The primary strategy for minimizing referral issues was networking with physicians and other providers to build relationships and a referral network. Other strategies included employing physicians to consult or teach procedures, and negotiating with insurers for PCP status.

The INPs felt that overall, their relationship with local physicians was one of mutual respect, and not adversarial. Nearly all of those interviewed relayed instances where they had encountered physician resistance or refusal to work with an NP. Most of the situations were remedied with education about the NP role, and developing respect for another provider after working together on a few cases. Some physicians, however, remained adversarial and the INPs have chalked it up to personality differences and have continued to deliver care.

Time management and professional burnout are possibly two of the biggest factors limiting INP practice. Our respondents all mentioned that the time and energy required to be a successful INP was very extensive, leaving them with little time for themselves and their families. This should be a consideration for anyone contemplating independent practice. Many had found that sharing call and having partners to cover for vacations significantly eased this burden. For many solo providers in rural areas this was not always possible. Educating patients well greatly reduced the number of calls

received. There is also a service provided by the Oregon Health Sciences University Hospital used by one INP so that all calls are first screened there and handled by a nurse, significantly minimizing the amount of calls the INP received.

Independent clinical decision making was explored in interviews, and 8 of 10 INPs felt that decision making was no different than if they were in another practice setting. Those who felt there were differences stated the difference was that the INP was soley accountable for clinical decisions and results. The INPs stated the risks of clinical independence as being more accountable, having less purchase power, having to know your limitations, and when and how to test and refer indigent patients. The benefits of being an INP were greater autonomy, less bureaucracy, job satisfaction, and broadened scope of practice. Some INPs felt they were forced to learn more to be successful in independent practice.

Ongoing evaluation of quality of care was lacking in many practices. Most practices had no formal process for this, but relied on chart audits done by outside agencies such as Medicare, insurance companies, professional organizations, Independent Practice Associations (IPAs), CLIA, or OSHA. Two INPsconducted routine patient satisfaction surveys, and several stated they monitored quality on an ongoing basis by informally using client feedback and outcomes. Practice modifications of policies or standards of care were done on an as needed basis when indicated by insurance or regulatory agencies, audit results, or annual policy review. Clinical practice was modified in response to information INPs gained through literature review, conferences, or consultation with specialists.

Business skills were deemed essential by many of the INPs, especially the solo

providers and owners. A majority of the INPs recommended obtaining business skills such as bookkeeping, accounting, staffing, raising capital, acquiring technology, and marketing and legal knowledge advice. Alternatively, the INP could contract for these services. Some had partners who served as the clinic administrator or attorney. Others hired accountants, bookkeepers, attorneys, administrators, and business consultants. Some providers found assistance through agencies such as the Small Business Administration, Area Health Education Centers, Office of Rural Health, IPAs and professional organizations. Many found colleagues a valuable resource as well as attending business classes, reading, and on the job training. Strategies to overcome business and administrative barriers include utilizing computers, networking, obtaining business partners, negotiating for used equipment at a discount, and having assertive collections by staff members. Other INPs had sought donations and grant funding. An additional unanimous strategy for success was to develop good front office staff. INPs believed the office staff could make or deter the INP's success.

3. What are the personal and professional rewards of Independent Practice?

All of the INPs surveyed were very satisfied with their jobs. Nine of ten respondents stated they would enter independent practice again if given the choice today. The reasons given for job satisfaction were greater personal benefits and rewards, greater accountability and autonomy, bonding with the patients and community, greater emotional and financial investment in the job, and "seeing the results of your labors." Despite these benefits, there are many drawbacks due to the toll that independent practice takes on one's personal life. The stressors mentioned frequently and by all respondents were lack of time to take care of oneself, less time for family, less professional education,

and lack of vacations. Those who took call felt that it infringed on their personal life at times. Other drawbacks included time management stress, stress from finances being directly dependent on your success, and scrutiny in rural communities with pressure to be a role model. With these pressures being very evident, the researchers questioned the INPs as to whether or not they had considered leaving this setting. Six of ten had considered leaving at some point, stating their reasons as burnout, fear of competition, having a bad day, and lack of time. The reasons the INPs gave for staying in independent practice were often commendable, such as "because we make a difference," commitment to the community, challenging job, long term goals, desire for independence and, in a few cases, financial rewards.

As Table 2 indicates, four of the INPs held second jobs. Each of these individuals stated that the second jobs were for professional advancement and satisfaction, not necessarily for additional income. Some of the sample reported that when they first began their independent practice, they did need to hold other jobs to meet their financial needs.

4. How has managed care affected INP practice?

Managed care penetration in the state of Oregon is relatively high. The INPs were asked to estimate the percentage of managed care patients in their practice. Four had less than 25%, four had 25-50%, one 51-75% and one greater than 75%. As previously stated, seven providers had PCP status with the remainder being specialty focused or working with a physician. Rural providers are more likely to function as PCPs. The INPs described the positive effects of managed care as receiving a financial bonus return at year end, better reimbursement for care since the inception of the Oregon Health Plan, more people insured, more preventive care, more phone triage, and better ability to

manage their budget. A few providers felt that there was no change in the time spent with their patients or the number of patients seen per day. The negative effects of managed care were unanimously stated as increased paperwork and referral hassles. Additional negative effects were greater administrative costs, greater dictation of practice by insurers, increased local competition and politics, less continuity of care, less patient choice, losing patients as a result of not being on provider panels (lack of PCP status), less time for health maintenance, more time needed for patient education with less time available, and pressure to compromise quality for quantity.

Conclusion

Currently the exact number of INPs in Oregon is unknown, but is estimated to be between 80-100 individuals. Nurse practitioners have many degrees of independence ranging from clinical independence in creating policies and standards of care, to being a solo provider responsible for all clinical and administrative aspects of the business. Being an INP in Oregon may be easier than in other states due to a broad scope of practice which allows NPs to diagnose, treat, and prescribe independently. However, the introduction of managed care into Oregon has forced providers of all types, physicians and NPs included, to join groups to obtain greater contracting and purchasing power. This phenomenon has resulted in fewer solo providers of any type. Only in recent months have there been anecdotal reports of providers buying out of their practice groups to become independent, hinting that the pendulum may be beginning to swing in the opposite direction.

Oregon INPs perceived the barriers to independent practice as reimbursement, lack of hospital privileges, economic competition with physicians to some extent, and the

investment of significant time and energy required to be successful. INPs have confronted reimbursement issues in a variety of ways. For those INPs lacking hospital privileges, all of our respondents felt that they had established a large referral network and could easily refer patients to the appropriate specialist for admission.

Competition with physicians was something nearly all respondents had experienced, but none felt that it was currently an issue. The consensus was that if the INP provided physicians with education about the NP role, and demonstrated clinical expertise, that a mutual respect eventually developed. Networking with physicians, not taking an adversarial role, and building a two-way referral system were recurring themes and highly recommended strategies for success. Many of the INPs felt that having a collaborating physician could be beneficial in some ways, but was not essential to their success.

Local politics seemed to represent more of a barrier, especially with the increasing numbers of physicians/providers forming groups, alliances with hospitals, and IPAs. Many of the smaller towns in Oregon became "one group towns." If the NP was not a member of that physician group or IPA, they had little chance at obtaining a contract. One NP who had just sold the business and was preparing to join a group, summed it up nicely "I was tired of paddling upstream, so I finally decided to just get on the boat!"

For the others, success could be defined as financial security, loyalty of satisfied patients, and the long term stability of these providers. Their self satisfaction comes both from being an Independent Nurse Practitioner and providing exceptional healthcare for the members of their community.

The INPs interviewed all gave thoughtful tips for those who are considering this type of entrepreneurial practice. (Insert table 3.). It is advisable to first have a solid clinical background and expertise. Planning is essential to the success of operating a solo practice. Investment of much time and energy is needed to reap the benefits.

Additional research would be necessary to document the actual numbers of INPs in Oregon, and enable the establishment of a network for these providers which could be beneficial. Further investigation of reimbursement and political barriers is warranted as these significantly hinder the advancement of NP practice. The study also reveals that there is a need for formal monitoring of quality of care in independent practice. Recommendations include the establishment of a network of INPs for peer review. Possibly linking with area NP education programs would provide NP students with INP patient and outcome data for quality improvement research, the results of which would benefit the INP practice.

Independent nursing practice today has evolved from a rich heritage of visionary nurse leaders who were innovative risk-takers. They not only recognized the potential contribution of nursing to the improvement of health outcomes for society but acted upon their beliefs. Their legacy is important to INPs today because they remind us that altruistic motives serving the indigent wins public support but may not be sufficient in the light of resistance from organized medicine who see NPs as competing providers. Today, INPs need more than vision and altruistic motives, they need business skills and political savvy to form alliances with consumers, insurers, and supportive healthcare providers so that the quality of services they provide are recognized as meeting society's needs.