Exploration of the Practices of Credentialing of Nurse Practitioners

in Acute Care Hospital Settings

by

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Abstract

The nursing shortage, physician shortage, advancing age of the population, and concerns about equalizing access to health care have supported the movement of the Nurse Practitioner (NP) role into the acute care hospital setting (ACHS). Expansion of the role has resulted in efforts by regulatory and accreditation bodies to require standardized processes to ensure that credentialing and privileging supports the role of the NP in the acute care hospital setting. Historically credentialing processes have been developed with the physician role as the template. However, it is not clear that those processes support the role of the NP in the acute care setting.

The purpose of the study is to understand and describe the processes by which Nurse Practitioners are credentialed and granted privileges to practice within the acute care hospital setting. A qualitative multi-sited case study approach was used to identify the rules and norms of the credentialing process of Nurse Practitioners. From three acute care hospitals, a purposeful sample of NPs (n=9) and other members of the credentialing bodies (n=3) were interviewed, a demographic survey completed, and documents defining structure collected. Analysis of the data included development of themes across the interviews and cross-case analysis for the three sites.

Three major areas were identified that gave rise to specific themes: a) required activities that Nurse Practitioners must complete to receive organizational approval to practice in the advanced role; b) nurse practitioner perceptions of the credentialing process; and c) enhancement of the credentialing process for the Nurse Practitioner. Themes within the area of required activities that Nurse Practitioners must complete to receive organizational approval to practice in the advanced role are: a) required information for acute care credentialing; b) importance of timeliness of completing the process; c) steps for adding and maintaining competencies; d) people involved in the process; and e) common barriers to the credentialing process. Nurse

practitioner perceptions of the credentialing process themes are: a) emotional responses of NPs to the credentialing process; b) fit of the credentialing process with the intended role of the NP; and c) involvement of the right people in the credentialing process. Themes within the area of enhancement of the credentialing process for the Nurse Practitioner are: a) reduction of barriers in the NP credentialing process; and b) external factors impacting the NP credentialing process.

Cross-case analysis revealed these differences among the sites. Employed NPs and those not employed by the ACHS enter the credentialing process at the same point at two of the study sites. The human resources department is the entry point for employed NPs at the third site, while NPs not employed by the ACHS enter through the medical staff office. The same two sites have implemented a nurse credentialing committee as the first review of the completed application. The third site did not have a nurse credentialing committee at the time of the interviews. The governing body at Site One and Two is the final decision making body for credentialing. Site Three uses the governing body for NPs not employed by the ACHS and the human resources department for approval of employed NPs. The required documents for proof of education, licensure, and competency and other credentialing structures are similar across all three sites.

Structure and content of the credentialing process for all three sites were similar. However, variation and barriers were identified by the participants. Findings from this study include opportunities to further standardize and enhance the credentialing process for NPs. Opportunities for standardization and enhancement include: a) communicate needed information about the credentialing process-during the NP educational experience; b) determine consistencies for core competencies and specialty competencies validation across disciplines; c) clearly define methods for obtaining and verifying new psychomotor competencies; d) advocate

that the right people, not just functional groups, are involved in the credentialing process within the acute care setting; e) include a contact person for NP credentialing; f) automate and streamline required paperwork, remove confusing language, focus privileging forms on the specialty education of the NP; and g) promote the value of a central verification organization (CVO) to include NP credentialing to the national organizations that represent advance practice nurses. Continued refinement of the credentialing process as well as the implementation of strategies listed above that will enhance the process and may assist in reducing some of the barriers and frustrations identified in this study.

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Exploration of the Practices of Credentialing of Nurse Practitioners in Acute Care Hospital Settings

The changing healthcare landscape of the previous five decades including the current nursing shortage, primary care physician shortage, decreased resident work hours, advancing age of the population, and concerns about equalizing access to health care have supported the movement of the Nurse Practitioner (NP) role into the acute hospital care setting (Ford, 1982; Sochalaski & Weiner (2011)). However, NPs have experienced barriers to achieving privileges in some practice settings due to variations in state practice acts that range from direct supervision to independent practice (Safriet, 2011).

As the role has been accepted and expanded, there is a need to understand the roles and functions surrounding credentialing and privileging. Expansion of the role has resulted in efforts by regulatory and accreditation bodies to require standardized processes to ensure that credentialing and privileging supports the role of the NP in the acute care hospital setting (The Joint Commission, 2011). Acute care hospital settings (ACHS) have mechanisms in place to facilitate a determination that licensed independent practitioners and other members of the medical staff will not cause harm. Historically credentialing processes have been developed with the physician role as the template. It is not clear how those processes support the role of the NP in the acute care setting.

Background and Significance

The Future of Nursing: Barriers to Role Advancement

The role of the NP has grown and largely been accepted since its beginnings in the mid-1960s. However the ability to use the full scope of their knowledge and competencies has been hindered by both flawed licensure processes and political and financial interests. Safriet (2011)

identified inconsistencies that have served to create confusion and barriers. These inconsistencies include issues that are specific to nursing as well as regulatory roadblocks.

Nursing specific concerns identified by Safriet are: the diversity of nursing practice; economic invisibility; and multiple routes of entry. The diversity of nursing practice has been perceived as a positive element of the profession allowing for nurses to find their unique niche for providing nursing care. However, Safriet believes this diversity has served to hide nursing and resulted in the exclusion of nursing from discussions around measurement development that will drive quality and reimbursement models in the future. Nursing costs remain embedded in most health care bills as part of room charges or other professional fees which hides the revenue potential of nursing. The ongoing debate of level of entry into the profession remains as a point of contention during discussions of the educational backgrounds of nurses entering advanced practice (Safriet, 2011).

According to Safriet (2011), two specific regulatory issues are: (a) limitations to the scope of practice for NPs and other advance practice roles by state licensure boards, and (b) payment and reimbursement policies that limit or exclude direct payment for services. The traditional view of the ownership of all elements of health care within the medical practice act significantly hampers the NP to work within their full scope of knowledge and competency.

In light of the escalating needs for health care in this country, both types of barriers must be removed to allow for all levels of quality, cost-effective care to be available. Early versions of the health care reform legislation included: (a) language that excludes discrimination against providers that includes NP; (b) recognition of the NPs as primary care providers; (c) NPs as leaders in public and home care medical home pilots and demonstrations, and funding for nurse managed clinics; (d) funding for graduate nurse education and post graduate experience

demonstrations; and (e) inclusion in primary care Medicare payment increases and in accountable care organizations (ACOs) (What's in health care reform, 2011).

In the legislation, provider neutral language is used that would support the practice of nurse practitioners in many settings and at the same time protects the member's choice of health care provider. Unfortunately this portion of the reform legislation did not survive.

Evolution of the Nurse Practitioner Role

Hamric, Spross, and Hanson (1996) defined advanced nursing practice as "the application of an expanded range of practical, theoretical, and research-based therapeutics to phenomena experienced by patients within a specialized clinical area…" (p. 47). This definition of advanced practice includes the roles of the Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Certified Nurse Midwife (CNM) and the Certified Registered Nurse Anesthetist (CRNA). The American Association of Nurse Practitioners (What is an NP, 2014) further defined the role of the nurse practitioner as one of "serving as a primary care or secondary care provider and as a consultant for individuals, families and communities in a variety of ambulatory and inpatient settings" (para 3).

The social and economic unrest of the 1960s provided fertile ground for the germination of the NP role. Changes in nursing education to a focus on clinical specialties and increased interest in doctoral preparation was occurring (Ford, 1982). Issues such as affordability of health insurance for the poor, a shortage of physicians, and growing complexity in healthcare, triggered a desire in some nurses to practice outside their traditional boundaries. These early nursing pioneers desired to "improve care, fill a need, and remain nurses" (Resnick et al, 2002, p. 484).

While the federal government continued in a model that viewed the physician as the source for all health care, Ford (1982) saw the social, economic, and educational trends of the

1960s as a testing ground for an expanded role for the nurse. Initially intended to provide needed health care services for well children in ambulatory care settings, the NP role rapidly evolved to include expanded roles in family, adult, school, geriatrics, perinatal and the acute care setting (Ford, 1982).

Early Nurse Practitioner programs were primarily certificate programs housed in the education departments of hospitals, medical schools and schools of nursing (Towers, 2005). The NP role met resistance from some nursing educators who saw the role as physician oriented and from colleagues in medicine who perceived the NP as competitors (Miller, Snyder, & Lindeke, 2005). Other barriers included inconsistency in state legislation and reimbursement practices that limited the scope of practice. Early successes in implementation of the role resulted in additional funding to educate NPs at the graduate level. Nursing leaders and educators began to see the role as an opportunity for increased nursing autonomy and a movement away from the medical model of healthcare (Ford, 1982).

In 2004, member schools affiliated with the American Association of Colleges of Nursing (AACN) voted to endorse the development of the Practice Doctorate in Nursing (DNP). **"**This decision called for moving the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate-level by the year 2015" (DNP Factsheet, 2013, para 1).

Hathaway, Jacob, Stegbauer, Thompson, and Graff (2006) provided a history of the development of practice-focused nursing doctorates and believed that the development of the DNP is part of the natural evolution of nursing resulting from the establishment of the NP role. Early development of doctoral programs for nursing during the 1920s and 1930s met with resistance. University leaders did not feel that nursing had established a substantive knowledge

base to support doctoral work on its own (Beckstead, 2010). Nursing schools worked within the university structure to develop curriculums that resulted in traditional research-oriented doctoral programs (Beckstead, 2010). In 1979 the first nursing practice-focused doctoral program rather than research-focused was opened, providing yet another alternative to advanced practice in nursing (Hathway et al., 2006).

"DNP curricula build on traditional master's programs by providing education in evidence-based practice, quality improvement, and systems leadership. The DNP provides an alternative to research-focused doctoral programs" (DNP Factsheet, 2013, para 2). DNP-prepared nurses are equipped to implement into their practice the science developed by nurse researchers prepared through research-focused nursing doctorates (Hathaway et al., 2006).

The NP role is intended to be independent and capable of providing care for individuals who require coordinated care across a variety of settings. AACN identified several factors that are contributing to the movement to change graduate nursing education (DNP Fact Sheet, 2013):

> …the rapid expansion of knowledge underlying practice; increased complexity of patient care; national concerns about the quality of care and patient safety; shortages of nursing personnel which demands a higher level of preparation for leaders who can design and assess care; shortages of doctorally-prepared nursing faculty; and increasing educational expectations for the preparation of other members of the healthcare team (para 3).

Inconsistencies in State Requirements for NPs

Organizational placement of the NP has varied by facility and state (Safiert, 2011). In some organizations NPs are employees of the facility and function within a specified job description. Other NPs may be in collaborative practice with a physician practice group, while others may practice independently in private practice. Previously, organizations credentialed NPs not employed by the ACHS through medical staff structures. Changes in accrediting standards require facilities to use the medical staff credentialing structures or an equivalent process for credentialing NPs whether they are employed by the organization, are part of a joint practice, or practice independently (The Joint Commission, 2011).

Pearson (2011) reported that in 2009 there were approximately 164,857 NPs in the United States, a 42% increase from 95,000 NPs in 2000. The number of NPs in the country continued to grow as identified by Phillips (2014) who reported approximately 183,748 NPs, a 10% increase, with 42 of the 50 states reporting. California, Kansas, and Indiana are the only remaining states that do not require national certification of NPs to practice (Hellier & Ramponi, 2013). NPs may write prescriptions in 19 states without physician involvement, nine require physician involvement only for prescriptions, 22 states require documentation of physician involvement through practice contracts and/or physician approved treatment protocols (Pearson, 2012, as cited in Improving Patient Access). NPs that have a doctorate are restricted in eight states from using the phrase “Doctor” in front of their name in the clinical setting (Pearson, 2011). Not unlike the debate of educational preparation for entry level nurses, state by state regulation variation has allowed the creation of multiple qualifications and restrictions to what by definition is the same NP role. This inconsistency is used by adversarial groups to support limiting the role (AMA Scope, 2009).

Role Confusion

Over the preceding 40 years the role of the nurse practitioner has been more clearly differentiated, yet confusion continues about the scope of the function. The National Council of State Boards of Nursing (NCSBN) began work in the early 1990s to develop administrative rules and competencies for the advance practice roles. Criteria for certification programs and accreditation agencies were developed during 2000s. The American Association of Colleges of Nursing (AACN) and National Organization of Nurse Practitioner Faculties (NONPF) were directed by the Alliance for Nursing Accreditation to develop a consensus document for the certification of advance practice nurses (Consensus, 2008). Thirty-two organizations came together at the 2004 meeting to provide feedback. Over the next three years work groups and conferences were held to complete the consensus document.

The target date for implementation is 2015. The model outlined the structure for licensure, accreditation, certification, and education of the Advanced Practice Registered Nurse (APRN) (Trossman, 2009). The model included the four roles currently identified as advanced practice: nurse practitioner, clinical nurse specialist, nurse-midwife, and nurse anesthetist. The APRN will select a specific population for one of the four specialty certifications. Populations include adult-gerontology (adult-gero), acute primary care family-individuals, women's health/gender related, neonatal, pediatrics or psychiatric-mental health (Trossman).

Core educational content outlined within the model included "advanced physiology-pathophysiology, advanced health assessment and advanced pharmacology" (Trossman, 2009, p 12). The American Nurses Credentialing Center (ANCC) and other credentialing organizations will be responsible for assessing the competence of the APRN in their specialty area(s). If implemented, APRN would become the legally protected title with additional titling based on role; such as Advanced Practice Registered Nurse-Certified Nurse Practitioner (APRN-CNP) for

the nurse practitioner role. The population specialty (e.g., adult-gero, pediatrics, etc.) would be noted as part of the license. (Trossman, 2009).

Nurse Practitioner Certification

National certification is required in 94% of the states. Two major organizations [the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners (ANNP)] provide national certification for Nurse Practitioners. The purpose of the certification process is to provide recognition of the practitioner's knowledge of the key domains of practice of the NP.

The ANCC (General Testing, 2013) administers certification exams for the Acute Care Nurse Practitioner, Adult Nurse Practitioner, Family Nurse Practitioner, Adult Gerontology Acute Care Nurse Practitioner, Adult Gerontology Primary Care Nurse Practitioner, Pediatric Primary Care Nurse Practitioner, Adult Psychiatric and Mental Health Nurse Practitioner, Family Psychiatric and, Mental Health Nurse Practitioner. Certifications are retired as practice areas change, for example the Adult Nurse Practitioner certification is being replaced by the Adult Gerontology Acute Care Nurse Practitioner.

To qualify to take the exam, NPs are required to hold an active, unrestricted professional nursing license in the United States, have a master's degree or higher in nursing, and have completed formal training in their specialty area through their graduate program in nursing. In addition, they must have graduated from an accredited program that includes graduate level academic credit for both didactic and clinical coursework including a minimum of 500 hours of supervised clinical practice in their area of specialty (General Testing, 2013).

The American Academy of Nurse Practitioners (AANP) offers certification for Adult Nurse Practitioner (ANP), Gerontology Nurse Practitioner (GNP) and Family Nurse Practitioner

(FNP). The exam is offered to NPs with masters, post-masters or doctoral degrees in adult, gerontology or family specialties from approved programs. AANP offers the option of petitioning the board to sit for the exam for those who do not meet the qualifying criteria (Certification, 2014).

Purpose of the Study

As previously described confusion and inconsistencies in the scope of the NP have created barriers to its full implementation. The influence of these on NP's practice in acute care hospital settings is not fully understood, and there is a lack of research into the institutional credentialing of the NP for practice in the acute care hospital setting. Using a case study approach and complexity science as a guiding framework, the purpose of the study is to understand and describe the processes by which Nurse Practitioners are credentialed and granted privileges to practice within the acute care hospital setting. Additionally the study is designed to: (a) describe the experience of Nurse Practitioners requesting privileges; (b) identify the categories of privileges requested by NPs; (c) describe the structural frameworks for requesting and granting privileges to non-physician providers; and (d) inventory the background and experience (APRN education and role preparation) of decision makers in the privileging process. The following research questions will be explored:

1) What is the experience of the Nurse Practitioner during credentialing relative to their vision of the role in acute care?
    a. What are the consistencies and inconsistencies of the experience?
    b. What enablers and barriers were experienced?
2) Are the privileges requested by NPs credentialed in the acute care setting in line with the educational content of their advanced practice programs?

a. What specific privileges are considered core to the NP in the acute care setting?
b. What privileges are being requested that are specific to the scope of practice of the NP?
c. What privileges are being requested that are not specific to the NPs scope of practice?
d. Are these privileges consistent with the educational background of the NP?

3) What implicit and explicit rules guide the credentialing body in acute-care hospital settings through the review of credentials and granting of privileges to nurse practitioners?
   a. What is the structure that supports the process?
   b. What organizational roles are involved in making privileging decisions?
   c. What is the knowledge level of the decision makers relative to the NP role, educational requirements and clinical competencies?

4) How has the experience of credentialing evolved for the NP?

For the purpose of this study, credentialing will refer to the institutional structures and processes required for gaining approval and privileges for the NP to practice in the acute care hospital setting (ACHS).

Complexity Sciences as a Framework

Complexity sciences have emerged from the work of multiple disciplines including quantum physics, thermo-dynamics, and biology (Holden, 2005). Newton's mechanistic understanding of physics influenced the reductionist world view of the 18th century. Predictability and understanding of the whole by understanding its parts guided the physical and

social sciences of the time. During the early 20th century, technology allowed scientists to delve below the surface to the subatomic level. Physicists exploration revealed that subatomic particles (protons, neutrons, electrons) did not, as previously believed, always act in predictable ways challenging the previous world view (Holden, 2005).

Lindberg, Nash and Lindberg (2008) stated that complexity science "examines systems comprised of multiple and diverse interacting agents and seeks to uncover the principles and dynamics that affect how such systems evolve and maintain order" (p. 32). Agents may be a person, molecule, element, or component that acts based on local knowledge and conditions. The individual moves of the agent are not controlled by a central body, neuron or Chief Executive Officer. Agents interact, learn and adapt new strategies. Complex systems are nonlinear and unpredictable. An action by an agent may produce a small change, a large change, or no change in the system. (Lindberg, et al., 2008).

All hospitals, including acute care, are complex adaptive systems (CAS) that are themselves embedded with other CASs (Zimmerman, Lindbergh, & Plsek, 2001). Healthcare organizations experience rapid change and are challenged to respond efficiently and innovatively while much of the time continuing to use traditional organizational values and structures (Peirce, 2000). Evolution of organizational roles such as the APRN requires the CAS to modify existing responses.

Traditional case study approaches have viewed the organization as a mechanism, a sum of its parts, rather than complex systems (Anderson, Crabtree, Steele, & McDaniel, 2005). Within the complexity framework organizations are seen as dynamic social systems that are continuously changing through self-organization and self-creation as a result of interaction with other components of the system.

Concepts important to the study design and analysis of data will include: the interactions and interdependencies among the organizational components; understanding of the dimensions of the relationships; identifying nonlinearities (example: small actions with large outcomes); looking for the unexpected; focusing on processes as well as events; and recognizing patterns across levels (such as the NPs and credentialing body) (Anderson, et al, 2005). Identification of patterns and relationships will be important for describing the credentialing process within and across the study settings (James, 2010).

Definitions

Key concepts in this proposal are nurse practitioner, credentialing, privileging and, certification:

Advance Practice Registered Nurse. The Advanced Practice Registered Nurse (APRN) is a broader classification group that includes Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Certified Registered Nurse Anesthetists (CRNA) and Clinical Nurse Specialists (CNS).

(a) A Nurse Practitioner (NP) is a registered professional nurse who completes advanced graduate education and clinical training. The NP provides a range of services in the acute, primary, and specialty settings. NPs work autonomously and/or in collaboration with other health care professionals to provide health care services. Services may include diagnosis and management of common, as well as complex, medical conditions to individuals of all ages (What is an NP?, 2014).

(b) The Certified Nurse-Midwife (CNM) is a registered nurse educated in the two disciplines of nursing and midwifery that provide health services to women of childbearing age including but not limited to prenatal, labor and delivery and post-delivery care. (What is a certified nurse midwife?, 2014).

(c) The Certified Registered Nurse Anesthetists (CRNAs) are master's prepared advanced practice nurses who provide anesthetics to individuals undergoing a variety of surgeries or procedures (CRNA Scope of Practice, 2014).

(d) The Clinical Nurse Specialists (CNS) are licensed registered nurses with graduate preparation, who provide direct patient care, improve patient outcomes through expert consultation, care coordination, monitoring quality indicators and communication between the health care team and family (APRN Factsheet, 2011).

For the purpose of the study, the subgroup of Nurse Practitioner (NP), specifically the NP in the acute care hospital setting, remains the focus.

Certification. Certification is a process that involves nongovernmental agencies that validate the qualifications and level of knowledge of a professional to practice within a defined area of specialty. Predetermined standards for the specialty area are the basis for the certification process, and vary based on discipline and the specialty within the discipline. Review of the certification(s) of the professional seeking to provide services in an ACS is an essential part of the credentialing process.

Credentialing. Credentialing is often used interchangeably with certification For the purposes of this study credentialing is defined as either national credentialing or patient care service (institutional) credentialing.

National Credentialing. National credentialing refers to healthcare professionals who had taken national exams offered by various national organizations to predict cognitive understanding of basic educational material by discipline National credentialing is generally focused on specialty practice areas such as oncology, critical care, emergency nursing and others.

Testing of basic knowledge in the specialty areas is done to achieve certification. Hospitals applying for "magnet" status encourage nursing staff to strive for national credentialing status. National certification is a required step for the NP to practice in many states.. National credentialing was identified in nine abstracts examining the "magnet hospital" experience (Barrella, et al., 2007; Taylor, 2004; Balogh & Cook, 2006). These abstracts focused on the magnet experience and value for health care organizations rather than the process of institutional credentialing activities.

Patient Care Service (Institutional) Credentialing. The definition provided will be used to represent institutional credentialing for this study. The Joint Commission (TJC) defined credentialing as the "process of obtaining, verifying and assessing the qualifications of a health care practitioner to provide patient care services…" (TJC, 2011, p. GL-9). Specifically, for this study, the credentialing process is relevant to the institutional credentialing activities within acute care hospitals.

Privileging. Hand in hand with credentialing is the concept of privileging. Privileging is "the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance" (TJC, 2011, p. GL-30). The credentialing body authorizes the practitioner to order or perform specific diagnostic or therapeutic services within the hospital setting (Hravnak, 2009, p.12). The practitioner may have the education and training to perform services but must be granted permission to perform them. The privileging process typically includes steps to verify the educational background and historical performance of the practitioner as they relate to privileges requested.

Scope of Practice. The scope of practice of nurse practitioners has been defined by the AANP (Scope of Practice, 2013) using four themes: the professional role; education level; accountability; and responsibilities of the NP. Services identified within the professional role of the NP may be provided in the ACHS and included in the credentialing process. The services identified within the AANP scope include but are not limited to: "ordering, conducting, supervising and interpreting diagnostic and laboratory tests; and prescription of pharmacologic agents and non-pharmacologic therapies" (para 1).

For clarification, this study was focused on the processes of institutional credentialing. The full scope of practice may not be reflected in that process. Further analysis of that relationship was beyond the boundaries of this study.

Summary

The NP role initially was intended to meet the need for more accessible, cost-effective, primary care providers in rural communities. However, gaps in healthcare accessibility, nursing and physician shortages, healthcare economics, and expansion of practice settings resulted in the development of additional specialty areas for NPs. Reimbursement of ~~the~~ NPs is influenced by their ability to become credentialed in the practice setting. Credentialing and privileging for practice in the acute care setting has been traditionally designed for physician roles. These traditional structures for credentialing may not support the NP role in its continually evolving form.

Chapter Two

Review of the Research Literature

The focus of this review is to identify research associated with the process of credentialing of NPs in the acute care setting. An overview of the scope of the current literature will be presented. Research related to credentialing in other health care disciplines will be discussed. The availability and content of research publications describing the process of credentialing for NPs will be explored.

The keywords credentialing and nurse practitioner were used using CINAHL. Parameters of the search included English language publications, from peer reviewed, research-oriented, full text publications for the years 2000-2010. Boolean and SmartText modes were used in the search and resulted in 30 abstracts. A secondary search was performed with the same parameters using the keyword credentialing only resulting in 92 publications for review. Duplications were identified resulting in 110 unique publications for review.

Disciplines identified in the search are Physical Therapy (PT), Respiratory Therapy (RT), Paramedics, Dieticians, Physician Assistants (PA), substance abuse professionals, massage therapists, laboratory personnel, environmental health professionals in Public Health, Complementary Alternative Medicine (CAM), nursing, college health services, state based health centers, and physicians. Examples of the meaning of "credentialing" for major groups will be provided.

Rationale for Credentialing

The function of credentialing is to protect patients from incompetent practitioners. Negative outcomes established hospital's corporate liability for the quality of the medical staff in the 1960s and 1970s (MacLean, 2001). The Illinois Supreme Court accepted the Joint

Commission requirements for monitoring quality as the legal standard in the case of Darling v. Charleston Community Memorial Hospital. Delay in treating compression from a cast that was too tight resulted in amputation of a young man's leg (MacLean, 2001). The family sued both the surgeon and the hospital. In Gonzalez v. Nork (MacLean, 2001) the hospital was held responsible for knowing that a surgeon on their staff was performing unnecessary procedures, in this case, laminectomy. The hospital board ultimately is held responsible for appropriateness of physician privileges. These and other cases resulted in the formalization of credentialing and privileging processes. Hospitals must ensure the robustness of their credentialing and privileging processes and monitor for quality of the services provided (MacLean, 2001). A health care organization's thoughtful and meticulous credentialing and privileging process is not only required by state and federal regulations but also is essential for building a quality professional staff (Lumb & Oskvig, 1998).

Physical Therapy, Respiratory Therapy, and Clinical Science Laboratory Professionals

Credentialing was explored in 13 publications related to Physical Therapy (PT). Credentialing is a process associated with a national certification program that exists for clinical instructors (Housel & Gandy, 2008; Housel, Gandy, & Edmondson, 2010). Evaluation found that students with a credentialed clinical instructor showed greater improvement over time than those whose instructors were not credentialed. Other publications found that characteristics such as the age of the program, number of clinical credits, and whether the programs were in public or private institutions were associated with successful completion of the National Physical Therapy Examination (NPTE) (Maring & Costello, 2009).

Respiratory Therapy (RT) and the laboratory population had one publication each that were not research-oriented. The RT focus was on the process for identifying new competencies

that will be needed in the health care environment of 2015 and forward. The American Association for Respiratory Care established several task forces that are exploring what new activities and skills may become the responsibility of RT as a result of recent reforms in health care (Barnes, Gale, Kacmarek, & Kageler, 2010). Seven competency areas were identified that include diagnostics, disease management, evidence-based medicine and respiratory care protocols, patient assessment, leadership, emergency and critical care, and therapeutics. Specific competencies in each area are under development (Barnes, et.al, 2010).

The American Society for Clinical Laboratory Science (ASCLS) Board of Directors commissioned a task force to address issues concerning the preparation of students for the current clinical laboratory environment (Beck, Epner & Briden, 2007). Laboratory managers believe a discrepancy exists between the skills possessed by graduates of laboratory educational programs and the needs in the workplace. Results of the study included recommendations to redesign training and education, redefine roles of the laboratory professional, and modify the certification exams to better measure levels of practice and accreditation standards.

Physician Assistants and Physicians

Physician assistants have a national certification exam requirement similar to other disciplines. Blankenship and Boissonneault (2006) looked for correlations between performance during their education and the students results on the Physician Assistant National Certification Exam (PANCE). The group found that the grade point average at the end of the didactic phase of study was highly correlated to performance on the PANCE. The role of student clinical encounters and their performance on the PANCE was evaluated by Min, Comstock and Dickey (2009). They suggested that the quality of the encounter rather than the number of clinical encounters have more impact on student's PANCE outcomes.

The search resulted in only one article directly focusing on the process for credentialing physicians (Wilson & Iacovella, 2000). Unlike the previous cited publications, Wilson and Iacovella focused on the traditional physician credentialing process seen in health care organizations and serves as the template for credentialing other disciplines. The use of primary source verification to substantiate original education, eligibility for Medicare/Medicaid reimbursement, reports to the National Practitioner Data Bank (NPDB), board and national certifications, hospital affiliations, current liability insurance, and claims history are required before membership can be considered. The use of credential verification organizations (CVO) is presented as an efficiency tool for the health care organization. There is no discussion of who participates in the actual credentialing process itself or parameters that surround the credentialing function.

Complementary Alternative Medicine

Looking at credentialing for other health care disciplines, Cohen, Hrbek, Davis, Schachter, and Eisenberg (2005) and Nedrow (2006) performed similar, related studies with a focus on the credentialing process of healthcare facilities for complementary and alternative medicine (CAM) therapies and their providers. Examples included in the CAM scope were chiropractic, acupuncture, massage therapy, nutritionist, and naturopathic providers of care. The studies included facilities that integrate CAM into traditional medical settings. Results indicated inconsistency in the approach used to credential and privilege these providers across settings though similarities existed in the types of information required for the process.

Nursing

Review of the publications focused on nursing revealed similar content identified in the general literature search. Credentialing as part of the Magnet experience (Middleton, Griffiths,

Fernandez & Smith, 2008; Ma, Hwang, & Alexander, 2010) and various specialty certifications for nurses were included (Finnell, Garbin, & Scarborough, 2004; McShane & Fagerlund, 2004).

"The magnet journey" is a common phrase within the nursing domain (Broom & Tilbury, 2007). Magnet status as defined by the American Nurses Credentialing Center (ANCC) stands as the highest measure for excellence in nursing (Ellis & Gates, 2005). Organizations are evaluated for magnet characteristics through written documentation and site visits.

Magnet organizations exhibit the ability to not only react but to be innovative in response to the rapidly changing health care environment. Organizations recognized at the magnet level display characteristics that include provision of higher quality patient care (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009). Magnet encourages nursing specialty certification and promotes advanced education of nursing staff.

Refusal of credentialing for NPs was discussed in two publications. Hansen-Turton et al. (2006) and Buppert,(2010) focused on the issue of Managed Care Organizations (MCO) who refused to credential Nurse Practitioners. The Balanced Budget Act of 1997 included the Primary Care Health Practitioner Incentive Act that removed restrictions and approved direct Medicare reimbursement to the APRN (Frakes & Evans, 2006). Despite the legislation the barriers remained. Hansen-Turton and colleagues (2006) surveyed MCOs regarding their practice related to credentialing of NPs for coverage of services. Of the 112 surveys returned, respondents reported that 33% of MCOs had policies for credentialing NPs as primary care providers (PCP). From the one-third of MCOs that had policies for credentialing, 40% of them provide managed-Medicaid programs that also credentialed NPs as PCPs. They also reported that in states where the NP had higher levels of prescriptive authority and independent practice the more likely they were to be credentialed by the MCO. In the presence of state laws that provide for recognition of

the role of PCP, 60% of MCOs reported that they did not credential NPs (p. 219). Hansen-Turton, et al (2006) expressed concerns about future impact of the refusal of MCOs to credential NPs in independent practice settings such as nurse-managed health centers. Buppert (2010) suggested that change has been noted in the practices of some insurers; however, each company has their own rules that guide the reimbursement structure for NPs. NPs are advised to look carefully at each organization's policies to avoid issues with improper billing.

NP Credentialing Literature

There was a dearth of research in the literature review that focused on the processes of credentialing and privileging of NPs. For the purposes of this review, the search was based on the previously presented definition for credentialing and privileging as the "process of obtaining, verifying and assessing the qualifications of a health care practitioner to provide patient care services…" (TJC, 2011, p. GL-9). Similarly no studies were found that addressed inequalities of credentialing and privileging when compared to other health care disciplines that might exist for NPs in acute care settings.

Credentialing process. General existing literature focused on describing common credentialing processes and the rationale for credentialing and privileging of health care practitioners (Hravnak, 2009; Hittle, 2010; McLaughlin, 2007; Swan, 2000). Their focus was on the importance of setting up processes to collect and evaluate required materials for credentialing including: primary source verification of education, licensure, National Practitioner Data Bank (NPDB) inquiry, claims history, and eligibility for Medicare/Medicaid reimbursement. They outlined similar processes discussed by Wilson and Iacovella, (2000) for physicians. Swan (2000) detailed the process focusing on establishing relationships with third-party payers. However, as

with Wilson and Iacovella, there was no discussion of who the recommended participants might be in the credentialing and privileging committees.

Regulatory and accrediting bodies, including the Centers for Medicare and Medicaid Services (CMS) and TJC have defined standards for hospital credentialing structures. The hospital Conditions of Participation (COP) (CMS, 2009, p. 149) grant the governing board authority to grant privileges to non-physician practitioners. Within the Joint Commission Medical Staff and Human Resources chapters specific standards provide the guidance in framing credentialing requirements. Human Resource standards (HR.01.02.05) require organizations to do primary verification of licensure for all positions that require licensure. Additionally the same standard under Element of Performance (EP) number 10 and 11 requires PAs and NPs that practice within the hospital to be credentialed, privileged, and re-privileged through the medical staff process or an equivalent process (TJC, 2011, p HR-5). The process must be approved by the governing body of the hospital. The process must include evaluation of the NPs credentials, current competence, peer recommendations, and input from individuals and committees, including the medical staff executive committee (MEC) (TJC, 2011). "Input" and specific types of committees other than the MEC are not defined. Certified Nurse Midwives and Certified Registered Nurse Anesthetists traditionally were credentialed and privileged through the medical staff structure prior to changes in the standards.

Klein (2003) and Magdic, Hravnak, and McCartney (2005) presented the typical process of credentialing and the information required. The application process requires submission of proof of education, licensure, experience, current malpractice insurance and, mental and physical health status. Primary sources provide proof of the authenticity of education and licensure. The National Practitioner Data Bank (NPDB) is accessed with initial applications and each

reapplication to provide information relative to adverse actions against the practitioner. Credentialing bodies evaluate the history of previous malpractice suits and settlements, criminal background checks and, eligibility to participate in Medicare programs. These elements fit into the four categories of information that TJC (2011) requires: current licensure, relevant training or experience, current competence, and the ability to perform the privileges requested.

During the credentialing process applicants request specific privileges they wish to perform in the hospital. The facility defines privileges based on the applicant's specialty and existing specialty standards. Privileges outside the traditional specialty role may require additional educational training and experience. The verified information is sent to the credentialing body for review and approval.

At this point the process becomes less well defined. Regulatory and accreditation bodies require that the medical staff and governing boards have a process in place for credentialing. The medical staff and governing boards define the process for each facility rather than through the use of a standardized national template. The composition of the credentialing body is not mandated by any organizations. Regulations and standards merely require that members of the medical staff, as defined by the medical staff, participate in the credentialing function (TJC, 2011).

Barriers to credentialing. With the exception of the study by Hansen-Turton et al. (2006) discussion of barriers to credentialing and privileging in acute care hospital settings of NPs is noticeably missing. Plager and Conger (2007) performed a secondary analysis using data from an outcome study involving NPs and CNSs practicing in the southwest United States. The sample included nurses from five states practicing in five settings including 13% who were associated with an acute care setting. The analysis identified barriers to role fulfillment. Themes

identified included the conflict between actual and desired role, nursing versus the medical model, role recognition, independent practice, and hospital privileges (Plager & Conger, 2007). The theme, nursing versus the medical model, highlighted the role that nursing values the role of patient-centered and holistic care and their importance to the advanced practice role. The medical model was described in the study by Plager and Conger (2007) as limiting the time the NP was able to practice the values in the setting. Payment codes are focused on the medical model and become a disadvantage in the NP model.

Independent practice is limited by varying state regulations and cumbersome public policy as previously identified in Pearson's (2011) most recent report. While state variations on prescriptive privileges are important, NPs themselves have been reluctant to accept the prescriptive role even when permitted by their state (Plager & Conger, 2007). Additionally the ability to practice autonomously and independently creates conflict between the desired role of the NP and the more limited scope when physician collaboration is required.

The theme of hospital privileges was not fully developed and no specific obstacles were described. It is acknowledged within the study that the ability for NPs to obtain hospital privileges has improved. However, it was not clear whether it was easier for NPs practicing predominately in an ACS were being credential more easily or any NP who was applying for privileges. The discussion of barriers focuses on individual practice and appears to be more relevant to NPs practicing outside the acute care hospital setting.

MacLean (2001), Klein (2003) and Magdic, Hravnak, & McCartney (2005) described the processes and expected content of the credentialing information with no reference to potential obstacles. Richmond and Becker (2005) touch briefly on a potential barrier, the medical staff, generated by fears of competition from advance practice nurses in general. A full exploration of

potential barriers for the NP during the credentialing and privileging experience was beyond the scope of the study.

Summary

Gaps exist in the current research literature involving the credentialing practices for the NP in the acute care setting and any research that has been conducted in this area. Reviews of credentialing and certification as related processes are common but are in reference to professional certification testing for nursing and related disciplines. The value of the magnet certification processes that includes the promotion of the importance of certification of nursing staff was prominent in the review.

Information was identified that outlined basic information and structure of credentialing systems within health care organizations. TJC standards provided similar details of what is required by regulatory agencies related to credentialing of medical staff and advance practice nurses. Barriers to obtaining reimbursement privileges from some payers were identified. What is not well described are the qualifications of the persons or committees involved in the actual credentialing process and whether a global understanding of the scope of the NP role is present.

Chapter Three

Methods

To better understand and describe the processes by which Nurse Practitioners are credentialed and granted privileges to practice within the acute care hospital setting, the following research questions using a case study approach were explored:

1. What is the experience of the Nurse Practitioner during credentialing relative to their vision of the role in acute care?
    a. What are the consistencies and inconsistencies of the experience?
    b. What enablers and barriers were experienced?
2. Are the privileges requested by NPs credentialed in the acute care setting in line with the educational content of their advanced practice programs?
    a. What specific privileges are considered core to the NP in the acute care setting?
    b. What privileges are being requested that are specific to the scope of practice of the NP?
    c. What privileges are being requested that are not specific to the NPs scope of practice?
    d. Are these privileges consistent with the educational background of the NP?
3. What implicit and explicit rules guide the credentialing body in acute-care hospital settings through the review of credentials and granting of privileges to nurse practitioners?
    a. What is the structure that supports the process?
    b. What organizational roles are involved in making privileging decisions?
    c. What is the knowledge level of the decision makers relative to the NP role,

educational requirements and clinical competencies?

4) How has the experience of credentialing evolved for the NP?

The present chapter includes the research design, description of the sample and setting, data collection procedures, the description of the interview guide with probes, a description of the case study approach, and the ethical considerations.

Research design and rationale

A multisite event-based case study method was used. Creswell (1998) defined a case study as "exploration of a 'bounded system' or case over time through detailed, in-depth data collection involving multiple sources of information rich in context" (p 61). Bounded refers to a defined time and place whether the case is a program, event, or specific population (Creswell, 1998). The event-based case will focus on the NP credentialing processes at three hospital sites: an academic medical center, a free-standing full service pediatric hospital, and a non-academic community-based full service hospital. Structured, purposeful interviews were conducted with NPs who have experienced the credentialing process and with members of the credentialing body to discover variations across settings and deviations from formalized rules and norms. Artifacts and documents were used to determine formalized rules.

Definition of the Study Case

Credentialing is a periodic event required for Nurse Practitioners to practice within the acute health care setting. For the purposes of this study the case is defined as the event of credentialing within the acute care hospital setting as it applies to NPs who currently have or are renewing privileges. The credentialing event includes the activities and documentation required prior to, during, and after the credentials are granted. For the purposes of this study, the cases consist of the credentialing process at each of the three hospitals. In this study, the three cases are

understood by describing the experiences that NPs had going through the process as well as the people responsible for credentialing. Analysis also compared and contrasted the experiences of the NPs within each case as well as compared and contrasted the experience across cases.

Setting

The selected cases were three hospitals in the Midwest where Nurse Practitioners provide services in the acute care area. The sites were selected for their diversity of services and patient's served. The three sites were in the same metropolitan area that crosses state boundaries. Therefore, two sites were in one state and the other site was located in another state but within three to twelve miles of each other. Population for the combined metropolitan area is approximately 2.3 million.

Setting One--Freestanding pediatric hospital. The pediatric hospital was established in 1897 as a single bed hospital that has grown to a 314 bed state-of-the-art facility. The medical staff includes approximately 700 pediatric specialists representing 40 specialties, 2,200 Registered Nurses (RNs) and 290 nurse practitioners (NPs). The hospital was re-designated as a magnet hospital in 2012. Nursing students from 16 local schools participate in clinical training at the hospital. The hospital is affiliated with a local medical school and provides residency affiliations nationwide.

Setting Two - Teaching hospital. The teaching hospital was established in 1906 and is closely associated with a university-based school of medicine, nursing and health professions. The hospital was re-designated as a magnet hospital in 2011. The full service hospital has approximately 606 staffed beds, 4,763 employees, 505 physicians, 341 residents, and 2,100 RNs including 280 NPs. The hospital is a major referral center for the state and provides services covering all age groups and specialty medical programs.

Setting Three – Community-based full service hospital. The community-based hospital has provided service in the same location for over 45 years. The hospital has approximately 700 physicians on staff, 1,145 RNs, and 18 employed NPs. The 504-bed hospital has a staff of over 2,800 and serves 20,000 inpatients and 180,000 outpatients annually. The hospital is used as a clinical site by local health care career programs.

Participants

Selection of participants was performed using purposive maximum variation sampling. To demonstrate the evolution of the credentialing process in similar yet distinct settings purposeful sampling methods are indicated. Maximum variation sampling allowed for capturing a range of credentialing experiences that describe unique or diverse variations that emerged as credentialing processes evolved (Patton, 2002, p. 243). Following Human Subjects Committee approval, a member of the departments or committees responsible for the structure and process of credentialing were interviewed (n=3). The members actively were involved in the granting of credentials for the NP within the facility. Support~~ive~~ personal that retrieve and maintain required elements of the credentialing process were included to obtain artifacts and documents. Informants were interviewed until a full picture of the complete process map of the credentialing process was obtained and verified in each case.

Names of Nurse Practitioners, (n=12), who had experienced the credentialing process at least twice within an acute care setting were obtained from the credentialing body member. Of the twelve who were invited to participate from each of the three settings, nine were interviewed.

Entry and Recruitment

Entry was made through connections within each setting. Contact was made with the credentialing body for NPs within the setting of the teaching hospital. The members expressed

support for participation in the study. The children's hospital contact is the chief nursing officer who is part of the credentialing body and her response was positive for participation. The chief nursing officer of the community-based setting was contacted for permission and entry.

Recruitment initially was done through emails; however, there was no response to the initial or second request. (See Appendix E). The email outlined the study, information collection plan and contact information for interested NPs and credentialing body members. A second distribution by the contact person was done because the initial response was slow or less than the minimum informants had responded. Names of potential participants were provided by the organization contact person and emails sent by the researcher directly. After the initial recruitment through the organizational contact person all further contact between the researcher and informants was done directly by the researcher to maintain confidentiality.

Information collection tools and procedures.

Interviews were audio-recorded, and documents and artifacts that frame the credentialing process were collected. Field notes were used to capture information about settings, events, and researcher impressions not contained within the interviews.

Semi-structured interviews generated insights and expand understanding of the phenomena of interest. Interviews were done with a member of the credentialing body for each organization to confirm facility demographics and enrich the understanding of the process followed by interviews with the NPs. Interviews were tape recorded, transcribed verbatim by a professional transcriptionist and reviewed. Information in the transcripts were coded and studied for themes and patterns by the researcher and co-investigators.

One-on-one interviews with the NPs included demographic data collection (Appendix A): educational background; state of licensure; specialty certification; employment status; year of

first credentialing; and years of practice as a NP. Topics contained within the guided interview process for the NP (Appendix B) included: description of the experience during the credentialing process; perception of its relevance to the vision of the NP for the role in the acute care setting; perceived consistencies and inconsistencies of the experience relative to the role and over time; description of the enablers and barriers experienced during the process; and perception of how the process has evolved.

Documents including policies, procedures, bylaws, credentialing process forms and pre-structured credentialing communication forms were collected that outline the credentialing process, requirements for credentialing, and membership of the credentialing body. An investigator-developed tool was used to collect organizational demographic information (Appendix C) including: organizational structure such as profit or non-profit, teaching or non-teaching, Magnet status, and composition of the medical and allied health staff. Information that is publically available was obtained by the researcher and confirmed with organizational contacts for accuracy.

An interview of a member of the credentialing body was conducted within each setting. Interview questions included: identification of implicit and explicit rules that guide the credentialing body as it relates to the NP; evaluation of the knowledge level of decision makers relative to the NP role; educational requirements and clinical competence; and perception of how the credentialing process has evolved (Appendix D).

Procedures. Identification of participants was facilitated by institutional contacts through electronic distribution of a structured email announcement outlining the study. NPs who met study criteria self-selected to be interviewed. Participating NPs at Site 1 and 2 accounted for 1 percent of the NPs at those sites with 17% of NPs represented at Site 3. Informed consent was

obtained prior to initiating the interview. Flexibility of scheduling of interviews supported the work obligations of the participants. Interviews generally were approximately an hour in length. Interviews for NPs occurred during work hours away from the direct work site. CBMs were interviewed in their work areas during work hours. Additional interview time was scheduled as needed to obtain further details necessary to understanding the credentialing experience.

The interviews were audio taped and transcripts of each interview were reviewed by the researcher for accuracy and initial analysis prior to subsequent interviews. No additional questions were added to the interview tool to expand on relevant topics based on previous interviews. Audio recordings and transcripts of the interviews were kept in a locked cabinet in the researcher's office when not in use for analysis. Transcripts and audio recordings will be destroyed following the Human Subjects Committee protocol for keeping research data. Pseudonyms were used to protect the identity of informants.

Data Analysis

A within-case and across-case approach for data analysis was used. Qualitative content analysis included: organization of the data; review and coding of the text; description of the case and its context; identification of patterns; similarities; and themes; with comparison of current literature and "lessons learned" (Creswell, 1998, p. 63). Analysis of the data included both the manifest (content) and latent (relationship) content (Graneheim & Lundman, 2004). Content analysis was done for each individual setting first (within-case), followed by analysis across the settings (across-case). Information relevant to all participants and information exclusive to specific informants was identified (Ayres, Kavanaugh, & Knafl, 2003). The unit of analysis was each case.

Organization of the data. Data were organized within each setting first (within case). Content areas were identified. Meaning units of related words or sentences established codes for the analysis. Categories and subcategories were generated from the coded data. A list of categories was maintained. New categories were added throughout the analysis until saturation was reached. Categories were mutually exclusive. Non-instances were included. Recurring meaning within the meaning units, codes or categories gave rise to content themes in the analysis (Graneheim & Lundman, 2004). Organization of the data was done for each setting case (within-case) followed by the across-case analysis.

Emerging patterns and themes. Patterns and themes within each case were identified and defined. Similarities and variations within and across settings were evaluated with consideration of current credentialing literature and application beyond the study settings (Ayres, Kavanaugh, & Knafl, 2003).

Emerging assumptions were tested by searching for alternative explanations. Peer debriefing was used to confirm assumptions. A doctorally-prepared Registered Nurse (RN) who worked as the Director of Quality in an acute care setting was selected as a peer debriefer for this study because she was familiar with the NP role and qualitative research methods. Additional documents or interviews were requested to clarify or expand understanding. Reflective journal entries, and analytical memos were studied and integrated into the analysis for greater understanding of the case.

Audit trail. The audit trail was composed of the raw data, analysis and findings of the study (Wolf, 2003). Raw data were comprised of the audio recordings, the transcripts of interviews, and documents (policies, bylaws, credentialing documents). Analysis included codes, themes, analytical memos, process memos, reflective entries of researcher and peer debriefing

memos. Findings included interpretations, analytic descriptions, definitions, tables and figures. A separate audit trail was established for each case setting and for the across-setting analysis.

Writing the report. A description of the case and its context was provided. Identified issues with presentation of confirming and disconfirming evidence, assertions and conclusions were included. The cross-case analysis then was reported. Descriptive statistics with supporting graphs and tables were used for analysis of demographic responses, categories and themes. In qualitative studies, analysis continues through the writing process as the researcher further articulates the findings in a form that best portrays the findings of the study.

Credibility of the Study

Triangulation of data sources. Triangulation of data sources included: a) comparing perspectives of the NPs with the perspectives of the members of the credentialing body; b) comparison of interview data with data obtained from documents and artifacts; and c) checking for consistency of perspectives within the same interview (Patton, 2002). Data sources included elements of the audit trail: interview transcripts, analytic and process memos and notes from peer debriefings.

Assessment of rival conclusions. Identified patterns were evaluated for alternative explanations. Patterns from interviews and document and artifacts were tested for alternative meanings that provided the "best fit" based on the evidence (Patton, 2002, p. 553). Peer debriefing was used to identify meaning, to confirm accuracy of findings and interpretations, and to explore research bias to maintain honesty and trustworthiness of the study (Spall, 1998). An impartial, doctorally-prepared peer met with the researcher regularly throughout the study as needed by the researcher to address various issues related to interpretation of the study findings. This particularly was important during the analysis phase to ensure that the researcher was aware

of her own possible biases and assumptions. Debriefing included, but was not limited to; reviews of interview transcripts; evaluation of the coding process; provision of perception of influence of researcher bias on analysis; and testing of alternative conclusions. The researcher maintained reflective journal entries for the study audit trail.

Member-checking. A select group of NPs and members of the credentialing body were asked to provide reflective feedback based on the transcription and identification of patterns from their interviews. Information was provided and responses were communicated by email. Patterns identified from documents and artifacts were verified using the same mechanism. Member responses and researcher reflection based on the responses were added to the audit trail and the data analysis.

Expert audit review. Some members of the doctoral committee reviewed the data and analysis for quality and rigor. Samples of raw data, coded data and thematic analysis were kept in the audit trail report.

Researcher as instrument. The researcher is an integral part of the research process and acts as one of the instruments in qualitative studies. The personal experience of the researcher both facilitates and influences the understanding of the information collected. Prior to beginning the study, the researcher wrote out what she believed were her assumptions about the research topic and her concerns about doing this study. This was included in the final report.

Ethical considerations

The Human Subjects Committee (HSC) of the academic medical center approval was obtained prior to the start of the study. Informed consent was obtained from study participants (Appendix F). Organizational and individual identities were masked. Pseudonyms were assigned and maintained in separate secure files. Publications will contain de-identified data. Audio tapes

will be destroyed following completion of the study. Study material including transcripts of the interviews are maintained for the required time as established by the academic medical center (HSC).

Summary

A multisite event-based case study method was used to describe the credentialing experience of Nurse Practitioners in the acute care setting. NPs and members of the credentialing body were interviewed and artifacts and documents studied to establish categories and themes. Similarities and variation within and across settings described the rules and norms of the credentialing process.

Chapter Four

Results

The purpose of the study was to understand and describe the processes by which Nurse Practitioners (NPs) are credentialed and granted privileges to practice within the acute care hospital setting. A summary of the study participants are presented along with the story of the process in each institution. Themes within three identified areas are presented along with the results of the cross case analysis reporting a comparison of similarities and differences among the three sites.

Study Participants

Study participants included one credentialing body member (CBM) from each of the three sites and nine nurse practitioners (NPs), three from each site. The CBM interviews occurred prior to interviews with NPs. The CBM interviews provided details of the formalized structures for credentialing and privileging at each site. Discussion of the evolution and barriers of the process were included as the processes were reviewed. Two CBM members also were advanced practice staff who participated in the credentialing process themselves. The third CBM was responsible for coordination of the process and is a certified credentialing specialist. The CBM years of experience in the credentialing process role ranged from three months to 20 years.

A total of nine nurse practitioners (NPs) were interviewed. The number of years in practice as an NP ranged from two years to 20 years (See Table 1). Six of the nine NPs report their current role was their initial NP experience, and all had been through the re-credentialing process at least once. All participants were credentialed for both core and specialty-oriented privileges. All nine practitioners interviewed had received master's level education and two reported being enrolled currently in a Doctorate of Nursing Practice (DNP) program.

Table 1.

Nurse Practitioners by Years of Practice

	Years of Practice				
Role	PPCNP	FNP	AGPCNP	NNP	ACNP
Site # 1	6	3.5			20
Site # 2			9	6	3
Site # 3		12	9		2

Key: PPCNP = Pediatric Primary Care Nurse Practitioner; FNP = Family Nurse Practitioner; AGPCNP = Adult Gerontology Nurse Practitioner; NNP = Neonatal Nurse Practitioner; ACNP = Acute Care Nurse Practitioner.

A total of 12 interviews were completed, recorded, and transcribed. The transcribed interviews were placed into the NVivo10 program for coding. The CBM and NP interviews were coded separately.

The sites are geographically located in the same metropolitan area but in two neighboring states. The practice acts for NPs in both states are similar and require a collaborative relationship with a physician. NPs at all three sites were required to have a collaborative physician on staff and to establish a collaborative practice agreement prior to beginning the formal credentialing process.

Credentialing Process Maps

In order to understand the credentialing process at each site, a map of the process was developed following the interview with the credentialing body member (CBM). Process maps were reviewed and approved by the CBM following their development to ensure accurate

depiction of the credentialing process within their organization. A brief description of the credentialing process is presented for each site. Committees are given generic names reflecting their role rather than the specific name of the committee within each site. The credentialing process maps for each site can be found in Appendices G-I.

Site One

Site One is a freestanding pediatric hospital. Nurse practitioners employed by the organization or employed through a physician practice enter the credentialing process through the medical staff office (MSO). The MSO provides the credentialing packet and performs primary source verification of required information. Review by the MSO is performed to verify that all required documentation has been provided before the packet is forwarded to the credentialing committees.

The completed packet is directed first to the nurse credentialing body for review and recommendations. Scope of practice and requested privileges are examined for appropriateness to the role, the educational background, and the necessary competencies for each NP. The nurse credentialing body collects additional information as needed in order to reach agreement on credentialing status. Recommendations for applicants that are approved are forwarded to the medical staff credentialing body. The senior nurse leader or his/her designee participates in the nurse, medical staff and the organizational governance body credentialing committee meetings. They provide continuity of information across the three committees.

The nurse credentialing body makes recommendations to the next level, the credentialing body of the medical executive committee, who reviews the credentialing packet. Additional information may be requested if the group does not agree with the recommendations.

Recommendations for applicants that are approved are forwarded to the organizational governing body.

The organizational governing body is responsible for making the final determination of the credentialing status of the NP. A subcommittee of the governing body has been delegated to conduct the credentialing function. Additional discussion or information may be requested by the group. The governing body then provides final approval for the credentialing of the NP. A similar process occurs every two years for recredentialing or when new privileges or revised privileges are requested.

Site Two

Site Two is a teaching hospital. Nurse practitioners employed by the organization, the affiliated academic center, or through a physician practice enter the credentialing process through the MSO. The MSO provides the credentialing packet and performs primary source verification of the required information. Review by the MSO is performed to verify that all required documentation has been provided before being sent to the credentialing committees.

The completed packet is directed first to the nurse credentialing body for review and recommendations. Scope of practice and requested privileges are examined for appropriateness to the role, educational background, and competencies of the NP. The nurse credentialing body collects additional information as needed to reach agreement on credentialing status.

Recommendations for applicants that are approved are forwarded to the medical staff credentialing body. The senior nurse leader or his/her designee participates in the nurse, medical staff, and the organizational governance body credentialing meetings. They provide continuity of information across the three committees.

The nurse credentialing body makes recommendations that are forwarded to the credentialing body of the medical executive committee who reviews the credentialing packet. Additional information may be requested if the group does not agree with the recommendations. Recommendations for applicants that are approved are forwarded to the organizational governing body.

The organizational governing body is responsible for making the final determination of the credentialing status of the NP. A subcommittee of the governing body has been delegated the credentialing function. Additional discussion or information may be requested by the group. The governing body then provides final approval of the credentialing of the NP. A similar process occurs every two years for re-credentialing or when new or revised privileges are requested.

Site Three

Site Three is a community-based hospital. Nurse practitioners employed by the organization enter the credentialing process through the human resources (HR) office. The credentialing packet including the credentialing application and checklist of required documents is provided upon employment. The primary source verification of required information is completed by the HR staff. When sources have been verified the packet is provided to the medical staff office (MSO). All other steps in the credentialing process are followed by NPs whether they are employed by the organization or a separate practice group.

NPs employed through a physician practice enter the credentialing process through the MSO and not through HR. The MSO provides the credentialing packet and performs primary source verification of required information. Review by the MSO is performed for all NP applicants to verify that all required documentation has been provided.

At the time of the study there was no formal nurse credentialing committee in place. The senior nurse leader or their designee participates in the medical staff and governance body credentialing meetings. They provide support for the NP applicants throughout the process. An initial review of the completed packet and privileges request was performed by the chief of the medical department. Following this review the credentialing packet is sent to the medical staff department chair for review.

Following the review, the application is forwarded and reviewed by the medical staff credentialing committee where additional information may be requested and reviewed and an applicant interview may be requested. Once the application is reviewed, a recommendation is made to the human resources department for hospital-employed NPs.

The organizational governing body is responsible for making the final determination of the credentialing status of the NPs not employed by the organization. A subcommittee of the governing body has been delegated the credentialing function. Additional discussion or information may be requested by the group. The governing body then provides final approval of the credentialing of the non-employed NP. A similar process occurs every two years for re-credentialing or when new or revised privileges are requested.

Understanding the Credentialing Process

The results of this section are organized in such a way as to tell the story of how nurse practitioners are expected to successfully complete the organizational credentialing process. The placement of themes is purposive to facilitate presentation of the expected sequence of the journey for the NP.

To understand the credentialing process for Nurse Practitioners as designed in each site, three major areas were explored and themes were developed within each area. The three areas

were: (a) required activities that Nurse Practitioners must complete to receive organizational approval to practice in the advanced role, (b) Nurse Practitioner perceptions of the credentialing process, and (c) enhancement the credentialing process for the Nurse Practitioner. Table 2 presents the themes that will be described within each area.

Table 2

Major Areas with Themes for Understanding the Credentialing Process

Major Area	Themes
Required activities that Nurse Practitioners must complete to receive organizational approval to practice in the advanced role	1. Required information for acute care credentialing, 2. Importance of timeliness of completing the process, 3. Steps for adding and maintaining competencies, 4. People involved in the process, 5. Common barriers to the credentialing process
Nurse Practitioner perceptions of the credentialing process	1. Emotional responses of Nurse Practitioners to the credentialing process 2. Fit of the credentialing process with the intended role of the NP 3. Involvement of the right people in the credentialing process.
Enhancement of the credentialing process for the Nurse Practitioner	1. Reduction of barriers in the NP credentialing process 2. External factors impacting the NP credentialing process.

Required Activities Nurse Practitioners Must Complete to Receive Organizational Approval to Practice in the Advanced Role

Five themes emerged from the data that describe the required activities that nurse practitioners must complete to receive organizational approval to practice in the advanced role: (a) required information for acute care credentialing, (b) importance of timeliness of completing the process, (c) steps for adding and maintaining competencies, and (d) people involved in the process, and (e) common barriers to the credentialing process. Each theme will be described using participant quotes to illustrate the meaning.

Required Information for Acute Care Credentialing.

Participants at each site described similar content that is required from nurse practitioners prior to approval to practice (See Table 6). The information is aligned with information required of physician members of the medical staff and identified in the literature review (Klein, 2003; Magdic, Hravnak, & McCartney, 2005). The importance of the information contained in the credentialing packet was identified by a participant, " …it's incumbent upon the hospitals to protect patients and you absolutely have to ensure that the providers that you're employing, and that you allow in the door as a provider are safe and educated and have clean backgrounds …". Another participant describes the basic content " …so with the initial credentialing we get a packet that we fill out the credentialing application … that's along with references, copies of your licenses, degrees, resume, all that..". A third participant provided additional details:

> Um, they did a background check… All my classes. I had to show them all the classes, as well as what was in the transcripts. But everything had to be written. There were references I had to put in there...Insurance and RN licensor and, you know, copies of all that.

Credentialing packets also include documents for requesting privileges relative to the scope of practice as described by this participant:

> Part of that packet is the request for scope of practice, that they have that conversation with their collaborating physician and say, you know, what is going to be the scope of my practice? And there's a scope of practice document for the nurse practitioners that aligns generic scope of services, things like admissions, discharges, ability to read tests and treatments, write orders, and then there are some additional specialty based credentialing that they may be requested by their sponsoring physician to have as well.

The information is collected for each credentialing candidate. Specific information is required to be verified through its primary source. A participant identified primary source information: "So, now I know that the reason it takes so long is that we have to have primary source verification for licenses and education and previous work experience and malpractice insurance."

Recredentialing is required every 2 years and is a streamlined process. The focus of recredentialing is on quality of care and maintenance of required licensure, certifications and competencies for the 2 year time frame. It is not required to verify original education and certifications with each recredentialing so the process is less labor intensive. Information required at recredentialing includes current licensure, review of information on the National Provider Data Bank (NPDB), malpractice claims, and meeting continuing education requirements. Sponsoring physician feedback and peer feedback address quality of care provided. A participant describes the process:

> …so every time they come up for recredentialing they have to turn in one of those lists so the physician will have to sign off that it is still okay for them to do these things on the list and then they sign the evaluation form – like have they had any disciplinary action in

the last 2 years? Do you know of any malpractice suits? Do you know of any drug and alcohol problems? That kind of stuff – so those things go through with the checklist, then proof that they have done enough to maintain competency.

Importance of Timeliness of Completing the Credentialing Process.

When describing the experience both nurse practitioners and members of the credentialing body identified the importance of timeliness of completing the process. NPs are not allowed to function in the advanced role within the acute care setting without receiving approval of the oversight committees. A CBM participant related occurrences: "I've had people who've had to delay their moving and stuff like that based on the credentialing not being complete at other hospitals." Another CBM related that "a lot of the docs don't even want to hire the nurse practitioners until the credentialing process is through, because that way they don't have to pay a salary on a non-productive person." Once collected and verified the credentialing information proceeds through a variety of groups. Delays may result from packets that are incomplete and cannot be sent forward to the credentialing committees.

The process at two sites includes the use of three separate committees that review the credentialing information and make recommendations to the next committee. One site uses a single individual for the initial review then forwards their recommendations to the two remaining committees (See Appendix G - I process maps for committee names). The committees meet on a monthly basis and delays in review by one committee will result in the candidate being delayed in moving forward to the next committee. Credentialing body members' at all three sites reported they have projected timeframes, i.e. 60 to 90 days, for the completion of the credentialing process. One participant responded: "I don't know how long it takes other places to get through credentialing, but 60 to 90 days. … for the most part I can get everybody through in 60, but 60's

still too long. It's a long time." Another participant explained the ideal timeframe but acknowledged it might not be met for a variety of reasons:

> I would say the average is probably 3 months. …. we have to take it through 3 committees or pass it through 3 committees and each committee only meets once a month. The packet has to be complete and there are several steps to get it prepared before we present it to the first committee and they have to be presented in order. Best case scenario – very few people are ready to turn them in…. I have had it take up to as long as 6 months before. But that was more a case of the employee not getting all the pieces of paperwork back.

Another CBM participant stated that there is a deadline within this time frame, after which the process must start over: "Well we would never let it go beyond six months. After six months it expires. That's rare I think there's just been a couple, few that that's happened to."

CBM members reported discussions with NPs who are applying for privileges to educate them about the process and possible barriers. One participant stated: "Whenever I'm interviewing a nurse practitioner, I am painstakingly detailed about this process and what the bumps are and I spend a lot of time at it." Another participant reported being included in the orientation program for the employed NPs: "I go through credentialing very carefully now that I have been part of the orientation program…"

Steps for Adding/Maintaining Competencies.

Core competencies (See Table 3) for the nurse practitioners for the three sites were based on their basic educational curriculums. The core competencies are included in the collaborative agreements with the sponsoring physician and organizational policies.

Table 3.

*Nurse Practitioner Core Competencies**

Core Competencies
Evaluate the physical and psychosocial health status of the patient through a comprehensive health history and physical examination
Assess normal and abnormal findings using history, physical examination and laboratory reports
Plan, implement and evaluate care based on findings of the assessment and diagnostic findings.
Consult with the patient, significant others and members of the health care team. Plan for the acute and ongoing health care needs or referral of the patient.
Manage the medical plan of care. The plan is based on protocols or guidelines adopted jointly by the nurse practitioner and the sponsoring physician in the collaborative agreement
Initiate and maintain accurate records.
Develop individualized teaching plans with the patient and significant others based on health needs
Counsel individuals, families and groups about health and illness and promote health maintenance
Assess need for and develop and implement professional and community educational programs
Participate in periodic evaluation of services rendered
Participate, in the review and revision of adopted protocols or guidelines

*Based on interviews and review of policies provided.
Additionally, there are independent practice competencies that have been identified by NONPF (2012, p. 4) (See Table 4).

Table 4.

National Organization of Nurse Practitioner Faculties (NONPF), Nurse Practitioner Core Competencies, Independent Practice Competencies.

Competency
1 Functions as a licensed independent practitioner.
2 Demonstrates the highest level of accountability for professional practice.
3 Practices independently managing previously diagnosed and undiagnosed patients. a) Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end of life care. b) Uses advanced health assessment skills to differentiate between normal, variations of normal and abnormal findings. c) Employs screening and diagnostic strategies in the development of diagnoses. d) Prescribes medications within scope of practice. e) Manages the health/illness status of patients and families over time.
4 Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision making. a) Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration. b) Creates a climate of patient-centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect. c) Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care. d) Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care.

*National Organization of Nurse Practitioner Faculties (NONPF), (2013), Nurse practitioner core competencies, Independent practice competencies, p 4.

Core competencies are awarded at the initial credentialing while specialty competencies unique to the area of specialty are typically granted at a later time and were different at each site

(See Table 5). Specialty competencies require additional information to support the NPs knowledge and skill set to perform the role.

Table 5.

Nurse Practitioner Specialty Privileges by Site

Role	**Specialty Oriented Privileges**
	Site # 1
FNP	Writing blood transfusion orders, writing chemotherapy orders, chemotherapy administration
PPCNP	Removing PICC lines
ACNP	Gastrostomy tube placement, suturing, lumbar puncture, fracture management, incision and drainage
	Site # 2
ACNP	Central line placement, arterial lines, chest tubes, Bronchoscopy, PEG placement, Vasoactive drugs, ventilator management, PA catheters, tissue debridement, ACLS, RNFA
NNP	PICC & Midline catheter insertions, verification of central line placement by radiological methods, endotracheal intubation, umbilical line insertions, thoracentesis, chest tube placement, ventricular reservoir tap, circumcision on neonatal males, frenotomy on neonates with ankyloglossia,
AGPCNP	Vasoactive drips (outpatient)
	Site # 3
ACNP	Electrophysiology, Non-invasive EP studies, pacemaker checks, ICD checks, re-synchronization checks, echo-guided resynchronizations
FNP	None
AGPCNP	Stress Testing (exercise treadmill)

Key: PNP = Pediatric Primary Care Nurse Practitioner; FNP = Family Nurse Practitioner; AGPCNP = Adult/Gero Nurse Practitioner; NNP = Neonatal Nurse Practitioner; ACNP = Acute Care Nurse Practitioner; RNFA=Registered Nurse First Assistant; ACLS=Advanced Cardiac Life Support; Site # 1 = Freestanding Pediatric Hospital; Site # 2 = Teaching Hospital; Site # 3 = Community Hospital

A credentialing body member (CBM) described expectations for specialty privileges:

> …unless they have documented evidence of competency in a procedure, they have to go through a proctoring example. So you could be a 14-year nurse practitioner doing colposcopies, if you don't have documented evidence of competency through logs… you're going to start back at square one for that whole process.

Specialty competencies are frequently based on procedural activities but may be associated with an expanded core competency unique to the practice setting as described by this participant: "I had to do biotherapy and chemotherapy course. I had to do some online learning for ordering blood and transfusion reactions and those things associated with it. So that was different."

Requests for specialty competencies during initial credentialing generate discussions in the committees to assure that they are appropriate to the education and role of the NP. A participant provided an example:

> I had an acute care nurse practitioner … that had requested, with the sponsoring physician, intubation; to be able to intubate patients. And, um, because the role was new here, fairly new here, there was a lot of objection to that in that committee.

Another participant described the occurrence of discussions about special privileges for nurse practitioners that may interfere with medical students having sufficient access for achieving competency for the skill as well:

> …We have residents, we have medical students, we have all these people that need intubation experience and why should we be letting a nurse practitioner do it? And so there was a lot of, no, we're not going to let that go forward. And that's relaxed a lot since five years ago.

Maintenance or continued evaluation of competencies granted includes monitoring the volume of events, as well as feedback from peers and sponsoring physicians. A participant shared: "…we have to do certain things to keep the competency, so we have to keep proving we are doing 5 sutures a year to maintain that competency". Another participant described the use of simulation models to support competency evaluation:

> We go from the very beginning …you know, person presents acutely, you develop your history, physical, plan of care, medication, you know, and how you collaborate, what your, you know, how you would take that person right down the path and you get checked out.

Types of specialty competencies evolve as the role grows and as practice changes. NPs who were credentialed by their organizations in the early years of this evolving process report being closely involved in the development of their job roles and in establishing competency criteria:

> …they didn't have any hospital practitioners, I had to help come up with my own collaborative agreements and, you know, I find other practices and try to rewrite and sort of put together all of our agreements and kind of teach them what nurse practitioners and mid-levels do.

Another participant recalls being asked to determine what types of nurse practitioners would be needed in their practice setting:

> He did not even know what he really wanted me to do, okay. He's like…I mean we have seven different…eight different teams in our department and I was one. He's like …I want you to kind of assess our department's needs and tell if we…kind of like a consultant type thing, where do you think nurse practitioners would fit in here.

Evidence-based materials including national organizational standards are being used when available to establish minimum competency expectations as described by a participant "…in the literature there are several procedures like that that, there are white papers or that have established criterion for how many it takes to do and then there are others that don't."

Obtaining approval for a new competency includes the use of learning opportunities to provide the knowledge base, a period of observation of the skill by a credentialed provider and a specific number of successful demonstrations by the NP. A participant related how a new competency was being acquired in their setting:

> We just are in the process of becoming credentialed to do telemedicine. And, of course, we did attend a class, we took a test and we will have to demonstrate our ability to do three different interactions with patients using a telemedicine model and to me that makes sense.

Another participant related taking additional steps to meet their personal expectations of their ability to perform a specialty privilege, "So I ended up going to a formal stress test class on my own and then after doing about 500 of them now, I think I can do them safely and good now."

People Involved in Credentialing Process.

No specific criteria exist for who should or must be involved in traditional organizational credentialing processes. Certain people who function in a specific capacity are expected to participate including organizational administration, medical staff leaders, and governance leaders. Medical staff office (MSO) personnel serve in the role of facilitation of the credentialing process for the medical staff and have prominent roles in the NP credentialing that was collected across the three sites.

Medical Staff Office Personnel. The MSO performs a gatekeeper role by providing the credentialing packets, facilitating or performing primary source verification, and maintaining records of the candidates. A credentialing body member defines their role:

> I help process initial applications and probably the key person, you know, for entering the information and looking at the application, determining if anything is missing. I'll pass it on to another team member, they'll get the verifications and we look it over real good, determine if there's any additional documentation, if there's any red flags remaining.

Communication becomes an important function to keep the collection of required material on track and move credentialing candidates smoothly through the process. The MSO serves as the source experts on the requirements and process of credentialing.

Administrative Leaders. Administrative leaders from each of the three sites participate. At each site the senior nurse leader is identified as being involved in all steps of the process (See Appendix G-I for process maps). For two sites the nurse leader is a member of the nurse credentialing body where the initial evaluation of the candidate's credentials is done and for NPs where the in-depth review occurs. The nurse leader or their designee provides consistency and information when the candidate's application is taken to the medical staff committee and to the organizational board committee for final approval. For each step of the process a participant describes: "… so one of us (CNO/director or assistant director of professional practice) will go, with our schedules it depends but one of us will go." Their role is to provide the NP's information to the other members of the credentialing bodies. Questions that are generated are addressed by the nurse leader based on the in-depth work of the nurse credentialing body.

In addition to the senior nurse leader or their designee the nurse credentialing committee includes currently credentialed NPs representing a variety of specialties. The NPs bring expert

knowledge of the scope of practice and competencies. The nurse credentialing body performs a review of the candidates credentialing materials. The information is reviewed for completeness, consistency of the requests with the scope of practice, and evidence of competency for the privileges requested. A participant describes the process followed in their committee:

> ….then those documents are reviewed by two of the nurse credentialing committee members for applicability according to what our guidelines are for credentialing and then that is taken to the nurse credentialing committee meeting where that is debated… as to what degree and what level of credentials we're going to give.

When there are gaps in the information provided, further requests are sent to the applicant. When all questions have been answered and all required material has been reviewed the committee makes a recommendation for the application to proceed to the next committee. For the site that does not have the nurse credentialing committee, the medical staff chair for the specialty does the initial review.

Medical Staff Leaders. Medical staff credentialing body reviews the NP applications after the initial review has been completed. This group typically is comprised of medical leaders for specialty departments such as: surgery, emergency medicine, cardiology, internal medicine, and so on. Applications are reviewed by physician members with input from the senior nursing leader. The participants report that over time they perceive there are fewer questions coming from the medical staff committee compared to when they first began credentialing NPs at their organizations. If questions about requests for privileges develop, the committee may request additional information be provided by the applicant. Questions about specialty privileges may necessitate the appearance of the candidate and their collaborating physician as describe by a participant:

> I don't even know at what point it was, they're like okay, we understand the vent thing, we understand the drip thing, we understand some of these procedures, but the medical board now has questions. So I said, fine, I'll go talk to them. So the next medical board committee I went before them, I brought one of my sponsoring physicians who's well known here.

When all questions are answered the committee makes a recommendation to forward the application to the medical staff executive committee who will than send the recommendation to the final credentialing body, generally the governance board of the organization. At one site the recommendations for the NPs who are hired by the organization are forwarded to the human resource department for final action.

Governance Body. The governance board of the organization has responsibility for the final approval of the request for privileges. The board may have a subcommittee that has been designated to function as the approval group. Members of the committee include administration, including the senior nursing leader, physician leaders, and lay members. The candidates are presented and the board may choose to further evaluate them or rely on the recommendations from the previous review groups. A participant describes the credentialing role of the board:

> The same process where we present and go through the candidates and some of the people that attend are physicians and they will occasionally come up with a question, but usually by the time we get to that point there aren't any further questions.

The question of whether the right people were involved in the credentialing process was asked of all participants. While overall there was agreement that these were appropriate people, there were concerns expressed by the NPs about the role of the medical staff. These comments centered on the desire for recognition by the state nursing boards as autonomous practitioners.

Common Barriers to the Credentialing Process.

Delays to completing credentialing influence the NPs ability to practice fully in their role. NPs and members of the credentialing body identified barriers that contributed to delays. One of the major barriers identified by credentialing body members included difficulty in obtaining primary source verification for original education when the NP had been in practice for many years, were from another country, or had not taken their national certification exams prior to employment. A NP participant with many years in nursing reported this delay as well:

> Well I think because I've been a nurse for a long length of time, that to obtain some of the information that they wanted, I really had to dig and make some phone calls to get copies of it. Such as my undergraduate information, it was on microfilm. It was long…it was quite a few years ago so to get that, because I didn't have a current diploma, I didn't know where it was, so I had to call them again.

Another participant had observed that "… some people start and haven't taken boards yet. So we can't even start the process until they are licensed." This varies depending on state practice regulations and organizational policies. Geographic diversity of candidates may create delays as identified by this participant: "It just depends, you know. I've got one (NP) now "who's" ….from India, have been very difficult…it was very difficult to get credentials. The international barriers just present a whole other level of difficulty to it."

Other delays identified by CBMs related to slow responses for requests for peer references and when candidates requested privileges that were outside the expected scope.

> And they pick people that never answer their emails, never answer their mails, you know, they're just not responsive to it. So I always tell the nurse pracs, make sure those three

> people you pick answer their mail and answer those things, because that alone will slow you down more than anything else.

Additionally, NPs reported delays related to communication issues between the MSO and the NPs when information was missing or peer reference responses were delayed. One participant expressed concern about what appeared to be duplication of efforts:

> …I still think it's just amazing, you know, to be hired you have to submit a lot of documentation of your education experience and it just absolutely astounded me that the credentialing process started over from the beginning that there was all the documentation submitted before I got the job, that I frankly assumed had been verified. … I was here nearly six months before I was credentialed.

Another participant recalled delays in being notified when privileges had been approved and commented:

> …like my other officemate here, she started in August, she was never…she never even received anything saying that here are your approved privileges, here's what you're approved to do, here's the board's approval…she kept asking, did I get approved, did I get approved and then somebody finally said, why yes, you were approved for core only. But she never received any documentation.

Nurse Practitioner Perceptions of the Credentialing Process

There are three themes that nurse practitioners perceive about the credentialing process and include the following: (a) emotional responses of Nurse Practitioners to the credentialing process (b) fit of the credentialing process with the intended role of the NP and (c) involvement of the right people in the credentialing process. Each theme will be described using participant quotes to illustrate the meaning.

Emotional Responses of Nurse Practitioners to the Credentialing Process.

Interviews with NP participants revealed several emotional responses to the credentialing process. Confusion, frustration and dissatisfaction were expressed in some form at all three sites. There also was acknowledgement that the process was evolving and sources of these frustrations were being modified. Common to all sites was confusion about the entire process of credentialing, its purpose and value and who was involved in the decision-making step. Frustration centered on the time it took for credentialing to be completed, steps involved, and inconsistencies in the process. Dissatisfaction included disagreement with the role of the medical staff in NP credentialing process but this will be presented in the discussion of the third theme, involvement of the right people in the credentialing process.

Confusion. Confusion about credentialing was noted early in interviews when the NP was asked about when they had their first credentialing experience. Several NPs assumed we were discussing their specialty certifications not the credentialing they completed to gain practice privileges at their organization "Oh, I'm sorry. Yeah, my certification is what I was thinking…" and "Oh, it should be 2007. I'm sorry, I was thinking certification".

Confusion on what credentialing is and its purpose was expressed by some participants:

> What does credentialing mean? No one really knows that. Like what really is credentialing, what does that do for you, what does it do…is it a legal thing? I just don't…there's a poor understanding and I'm not sure I even know.

A participant related they had been practicing in their role for some time before being required to go through credentialing at the organization, "so we got out of school and we just started working and then someone was like, well you have to have this credentialing and so, you know,

we get this packet of credentialing stuff …". Another participant expressed that they came to a better understanding after becoming part of the credentialing process:

> And now I know that it really is about that we have safe practitioners and that I guess before I came to this role I assumed that everyone who graduated was pretty okay to practice. But I've learned we need to watch it.

Other sources of confusion involved the process. A participant expressed their confusion as an NP and manager when a new employee was going through credentialing:

> ... it's very unclear what you're supposed to be doing during those two to three months, so if I hire somebody, are they not supposed to work during those two to three months, are they supposed to be supervised during that time?

Credentialing body members expressed another area of confusion about when specialty privileges are approved. The confusion is due to the credentialing process itself and lack of experience of the NP in requesting privileges.

> …so you know you know they have this privilege list with all these things they check off and then they turn it in and it goes to the credentialing committee and so that first time it goes to the committee they haven't completed any of those competencies but they often think they are granted those privileges just because – and that stuff is actually just to say we approve them to work on those competencies – so they are not actually granted the competency until they turn their paperwork back in showing they met the requirements.

Another CBM related similar steps that are not always understood by the NP requesting privileges:

> So those core privileges that they ask for, those are very standard, but then the specialty ones…everybody always has a specialty that they want in there and so they have

> to…they have to submit proctoring plans and if it's a brand new skill set that they haven't gotten in school, then they have to not only submit a proctoring plan, they have to submit a plan for how they're going to achieve initial education on what they're going to do and then their proctoring plan with it.

Another site CBM also reported the need for additional work when privileges outside of the core are requested:

> If they want to do something beyond what is on our standard privilege form then they would have to request that additional privilege, we would have to develop…probably develop credentialing criteria across the board for every specialty that wants to do that and then take that through all the medical staff committees for approval.

Several participants expressed a sense that there was still confusion regarding the NP role and what should be a standard part of their competencies. A participant described their response to the scope of practice "…what I said to the med staff offices, this scope of practice does not capture the essence of the work I do every day. …it feels like this scope needs to reflect the work that you do."

> `One participant described the content of a competency packet for the acute care role:
>
> ... Like you had to be an acute care nurse practitioner or take these tests…these ICU tests. I'm like so you're comparing a critical care nurse practitioner…an acute care nurse practitioner training to critical care nurse classes? I was like I've been an ICU nurse for five years. What a nurse does and what a nurse practitioner is not…they don't even correlate. It was like that's a slap in the face to sit there and say they're parallel…

Another participant related a similar experience:

> There are also things that wind up in the scope of practice that are not things that need to be credentialed, they're sort of nursing functions that have somehow found their way onto these scopes. And I'm like it doesn't make any sense that I could do that as a nurse without being credentialed for it, but now all of a sudden I need to have credentialing. So we've tried to peel those away.

Another participant described a skill considered to be part of the basic nursing role:

> Which didn't even occur to me that I should need to be granted a privilege to remove a PICC line because I'd done it quite a lot as a nurse, as an RN. And it did turn out that I had to get checked off by an RN to be able to remove a PICC line and to include that on my privileges, my allowed privileges.

A similar situation was described for a common nursing task, "It is actually an RN competency, but the nurse practitioners have to do it as well. It enables us to be able to give MDI (metered dose inhaler) and nebulizer treatments. "

Frustration. During the interviews frustration was identified by a CBM with the reported inconsistencies of how NPs are granted initial and ongoing competencies. From this CBM perspective, medical staff and residents also must be approved to perform non-core privileges; thus, NPs are not being asked to do anything different from the physicians and residents requesting privileges. One credentialing board member stated:

> And physicians have to prove it too. So if the physician presents here that's been doing whatever for 14 years…and this just happened…and now they come here and they want to do the same thing, we require them to present a log the same way…

However, experiences of the NP participants reported that they perceived differences in the expectation of how those competencies have been attained and credited to the practitioner. A

participant described the information she obtained when investigating how competency was documented and determined in a discussion about how medical residents were measured:

> So when I was trying to determine what was considered competent, I went to the residency director of our department. I said well what do the students have to do? He's like they just do it. I'm like, so they don't have to be checked off or anything? They're like, well you know they have a simulation themselves, but they have no documentation, so I've done it this many times and here's my proof of this. So I thought that was very interesting.

Another NP described the expectation that an NP will continue to maintain competencies that are not expected in the same way for the medical practitioner:

> I've had some discussions with my collaborating physician, you know, why do you have these…why do you have these competencies listed in our system that we list them and, you know, what did you do to get those competencies. He's like well I just went to school. And I was like, okay. And it's unusual, because here, like my collaborative physician has removal of foreign body from the ear canal listed as one of his (core) competencies. He probably doesn't do that very often, I do it almost daily when I work, but I don't have a (core) competency that says I can do that.

Another NP at a different site expressed a similar concern:

> I don't know. I feel like in general… advance practice nurses are held to a higher standard than physicians. So the physician that sponsors me, does he have to show that he can intubate, no. He doesn't have to provide any documentation of any of the skills that I have to provide documentation for, so I don't…that doesn't make sense to me. I don't

> have problems showing that, but I feel like my sponsor and physician should have the equal responsibility.

A sense of frustration was expressed for the lack of preparation the NP receives during their educational experience on credentialing and gaining privileges in their future practice settings:

> Anyway, I've worked a lot with credentialing, actually found it to be one of the most frustrating things about becoming a new nurse practitioner. There was no preparation for what that would be, you know, they certainly didn't really talk about it at all in school. And then you graduate and you're handed, you know, this packet from med staff.

Fit of the Credentialing Process with the Intended Role of the NP.

Accreditation organizations have standards that require the nurse practitioner to be privileged either through the medical staff process or an equivalent procedure. Credentialing board members have described the process at their sites as equivalent: " I consider it to be equivalent. We think it's important to have separate credentialing because NPs have completely different rules and regulations that physicians don't always understand". Another participant described it as parallel, "It's very similar. In fact, I think they're parallel processes. I don't see any difference between what we're doing with the nurse prac(titioner)s than we are with our physicians." The remaining site believes it is an "equivalent process."

There was not a clear understanding of the credentialing process by the NPs and two of the CBM participants interviewed. However, they were asked if the state nurse practice acts were changed to support a more independent NP role, what change in the process would they suggest? A NP replied that, "In the hospital I don't know that it would change a lot, because our credentialing will go through the same channels as a physician." Another NP agreed, "I don't

think much would change here, because we're in the hospital. We are governed by hospital rules; I don't think that would change our practice much." Finally a CBM participant agreed with other participants:

> ... if they change it to say we don't have to have collaborative practice anymore? The only thing that will change is that the collaborative agreements would go away – because I think collaboration is important to making sure the person is doing their job.

The scope of practice for NP specialties was identified. Education and skills of the family nurse practitioner (FNP) and acute care nurse practitioner (ACNP) were specifically explored. Concern was expressed by two CBMs and one NP centered on the FNPs who later express a desire to perform more like an ACNP. One CBM participant described discussions with potential physician sponsors about the differences in the roles:

> You know, in my world the critical care physicians are…have been notorious for hiring FNPs into the role and they aren't prepared to do, acute care nurse practitioner stuff and I have hired probably no fewer than a dozen FNPs into an acute care nurse practitioner role and to have them fail because they didn't have the clinical expertise to be able to do that. They don't get that in school, that's not the focus of an FNP program. And you can take a critical care nurse that's gone to an FNP program and kind of do that, but they don't get the procedural stuff that they want them to do, that's not the focus of an FNP program, you know, it just isn't. And so I have to kind of sit down with them and go, what is it that you want them to do and let's figure out what's the best approach. If they're going to work in your clinics, FNP's a great person to have in there. But if you want them putting in swan ganz catheters and triple lumen catheters, you're either going to train them entirely from scratch or you're going to look for an acute care nurse practitioner…But

> there's a big difference in the teaching and learning between an acute care and an FNP program.

Another CBM participant at a different site described similar variations in the NPs basic education and requested privileges:

> I would say the majority are primary care trained. Occasionally we will get lucky enough that one has some specialty training but I would say the vast majority are new or recent graduates with primary care training…each competency is a little different, but we would have and I don't have that competency on my list, but for more technical competencies like LPs we have a packet of reading they have to do first, and then they have to go through and verbalize the process and the indications, and have someone sign off that they did that. And then they have to watch three procedures being done by someone else and have that signed off. And then they can start doing the procedure. They have to do three procedures successfully and have signatures that they did that and when they have all that done they submit that packet and we take that to the credentialing committee to have it added to their privilege list. So often they don't have any of those sort of privileges the first time they go through – they kind of add it.

A NP participant expressed frustration when approached by an NP to broaden their scope of practice

> And if I hear one more FNP come to me wanting a more in-patient focus, some of them really want to do critical care and I say why did you pick FNP, (they respond) cause I'm more marketable. That's BS and I'm tired of hearing it.

Involvement of the Right People in the Credentialing Process.

Participants expressed concerns about the appropriate people (including other health care disciplines) are involved in the credentialing process. These concerns included communication issues due to lack of understanding by credentialing body members and the medical staff. One participant described concerns about the structure and ability of all groups involved to provide approval:

> Uh, no, it's a little weird too. The nurse credentialing committee, what's interesting is probably what would be the lowest level of approval is the nurse credentialing committee, but they're the ones in the most (best) position to make the determination…after it leaves the nurse credentialing committee, no one after that is really in a position to make a determination based on the skill set of the person.

Communication issues are reported during the process when the medical staff office personnel involved don't understand the terminology for competencies being requested:

> … the other challenge with Medical Staff office and they're very helpful people, but they're not really medical people. And so for instance, I've hired nurse practitioners, like PRN that work at other institutions. So they'll bring their procedure log so they can get reappointment and if the wording on their procedure log for… log doesn't match exactly the wording on our scope, they'll deny them a privilege.

Lack of complete understanding and knowledge of the NP role by physicians continue to present challenges. As one participant indicated:

> No. Uh, not completely, I should say, not now. It's, again, been a learning thing… they just kind of let you go free willy and you have to have, as a nurse practitioner, the mindset to say, no I can't do that, that's not in my scope.

The view of the NP in a lesser role by physicians also was identified by one participant, "And one of the physician's I work with in particular would like to see his practitioner as scribes. I really [resist] that designation."

The role of the physician in the credentialing of NPs was not positively received: As one participant stated:

> I felt like at the time I came here it was something like a secretary gathering all my evidence for my being credentialed and submitting it to a committee, which I think were primarily physicians…I'm not convinced that we should ask permission of physicians to be nurse practitioners.

Another participant didn't perceive that the credentialing process would likely change to eliminate medical staff involvement. This was reinforced by the statement: "I doubt it will change, the physicians like to keep control. Luckily it hasn't been a barrier for us at least."

Enhancement of the Credentialing Process for the Nurse Practitioner

Two themes emerged from the data: (a) Reduce barriers in the NP credentialing process and (b) Improve external factors that influence the NP credentialing process. The themes will be described using participant quotes to illustrate the meaning.

Reduce Barriers in the NP Credentialing Process.

Participants identified common barriers that have been experienced by NPs during their initial credentialing experience. They also made suggestions for how to reduce the barriers. These suggestions included: (a) provide a contact person to facilitate the process, (b) improve communication, and (c) modify content/forms to reduce confusion.

Provide a contact person to facilitate process. In response to complaints about the process, sites have established specific contact staff to guide the NP through the completion of

the application. One site established a specific role responsible for all the credentialing documents and that person also is a member of the nursing credentialing committee. As one participant reported, "…she maintains all of the documents for credentialing. She is the one that gives the credentialing packet." Another participant reported that their practice setting has a resource person who helps maintain information needed for credentialing and provides it to the Medical Staff Office when requested, "So like our credentialing specialist keeps a copy of ours updated every year, we send it to her, so if the medical staff office requests that I think she provides that." An NP at another site also described the role, "And … takes care of most of that for us. So she shepherds our privileges through."

Improve Communication. Improving communication of the status of the credentialing application was suggested. One participant stated:

> … I think giving updated status reports to them, where is it at, because you can be waiting and you don't know and then all of a sudden oh we need this and it's like, I didn't know I needed that. So, we've received it, you know, it's scheduled to be presented at the board at this time.

Modify content/forms to reduce confusion. Nurse practitioners suggested that confusion about the process and the required competencies could be corrected by modifying the process and information provided to NPs upon initiating the credentialing application process. A participant provided strategies to decrease confusion:

> We would have competencies that make more sense, less like checklists, and we would have various ways for people to maintain competencies besides coming up with arbitrary numbers of repeated demonstrations, on the form I don't think it is necessary to request the privilege to work on getting a competency, but if that is the case it needs to be much

> more clear on the form that they are requesting the ability to start working on it or that they are granted that competency because people don't understand that, and have everybody be more educated about the process.

External Factors Impacting the NP Credentialing Process.

Participants in this study identified two external factors that potentially could impact the nurse practitioner credentialing process. Recommendations were made by three of the CBMs and seven of the NPs of what they thought would improve the process for nurse practitioners as well as enhance the credentialing process within the acute care setting. These two recommendations included: (a) centralization of information and automation of processes and (b) inclusion of organizational credentialing in educational curriculum.

Centralization of information and automation of processes. One NP and one CBM, from the same state but different sites, reported that the use of a national site similar to one used by physicians would help to consolidate practitioner information and allow credentialing staff quicker access. There is a central repository that the physicians use and they are recommending a similar site for nurse practitioners. As one CBM participant stated:

> They've got a central database …that everything goes into there. It's your letters of recommendations, it's your competency, it's your grades, it's your, you know, everything that you do gets fed into this very secure database that is then accessed by the people who want to take you, you know, and do… And that should be like a national database around that you can access as a person wanting to hire them and pull all that stuff off, rather than this everybody does their own thing over and over again.

Another NP participant related similar information, "… institutions can log on …and find your

> licensure information, find your malpractice claims, find if you've been sued before,

> what the outcomes of those cases were and the background check. It's kind of a clearinghouse".

Inclusion of organizational credentialing in educational curriculum. Lack of knowledge about credentialing and inexperience with the process was identified as a barrier. Five of nine NP participants reported that no discussion of credentialing for privileges was provided in their initial education. Two reported minimal content about credentialing in their curriculum. The remaining two NPs did not remember as a significant period of time has passed since their initial education. Suggestions of ways that schools could facilitate NPs in their initial credentialing were identified. One nurse practitioner exemplified this when she stated:

> I think in school it would have helped if they would have said anything you do here you can be used to probably be credentialed, because then … said that. She was like if you put in lines in school and have proof of that, then you can use that for this. I was like well I did a couple A-lines and one central line, but I had no documentation. Like I didn't have somebody say this is the date, this is the time, I watched you, you did it, sign and date. I mean that's all they want…in anything that's all they want, proof that somebody watched you do it. And so I do wish probably in school they would have brought that out more.

However, another participant did report that their school had provided a checklist that was helpful during their credentialing experience.

Cross Case Analysis

Case Similarities and Differences

State requirements. The sites are geographically located in two neighboring Midwestern states. The practice acts for the NP in both states are similar and both states include the requirement of a collaborative relationship with a physician. NPs at all three sites were required

to have a collaborative/sponsoring physician on the medical staff and to establish a collaborative practice agreement prior to beginning the formal credentialing process.

One of the states requires national certification of the NP for practice, and the other state does not. However, one organization for which national certification is not required by the state has established national certification as a requirement within one year of graduation for the NPs.

Organizational credentialing processes. For the most part, the credentialing process is similar in structure within and across the sites. The structure in most ways is a replication of the process in place for credentialing physicians and other members of the medical staff. Required information, primary source verification of critical information, supporting competencies, and peer reviews are parallel to the traditional medicine-based structure. Both the NP process and medical staff process include review by groups with similar roles and competencies culminating in recommendations for final approval by an institutional governance body.

Variations found across the sites were few but significant. Sites one and two had implemented a peer nursing group that provided the initial review of candidate's applications. The groups include nursing leaders as well as nurse practitioners as role experts. These groups also supported the ongoing review and development of practice competencies for the advanced practice roles. Site three did not have a nurse credentialing committee as part of the process but they were exploring its development and implementation in the near future. The nurse leader at site three is involved at the other credentialing group meetings to represent the NP candidates.

Another variation was noted in the role of the governance board as the final source of approval for the NP candidate. The structure within sites one and two supported the role of the governance group as the final approval for NPs no matter where they entered the system. (Appendix G-I process maps). Site three processes differed in that the final approval of the NPs

employed by the facility was through the hospital human resources structure, rather than the governance body where practice employed NPs is approved. Modification of the process at site three was being evaluated at the time of the CBM interview.

Required Activities Nurse Practitioners Must Complete to Receive Organizational Approval to Practice in the Advanced Role.

The required activities NPs must complete to successfully complete credentialing did not vary across the three sites. The primary activity was completion of the credentialing packet for each organization. Required content was identical across settings and aligned with information required for all members of the medical staff who require privileges (See Table 6). Site one includes a financial application for CMS billing but this item was not discussed at the other two sites as being associated with the credentialing packet.

Table 6.

*Contents of the Credentialing Packet**

Contents	**Site #1**	**Site #2**	**Site # 3**
Application for Credentialing	X	X	X
Privilege Checklist/Request	X	X	X
Copies of Licenses	X	X	X
Educational Degrees	X	X	X
Certifications	X	X	X
Work Experience (Resume)	X	X	X
Peer References (3)	X	X	X
Liability Insurance	X	X	X
National Provider Data Bank	X	X	X

Contents	Site #1	Site #2	Site # 3
Collaborative Agreements	X	X	X
Financial Application – CMS Billing	X		

*Based on participant interviews

Timeliness in completing the process was influenced by the same factors across sites. Site one related delays while the NP completed their national certification but this step is required before the NP can be hired or begin the credentialing process. This was not a source of delay at either of the other two sites. All sites reported a range of three to six months to complete the initial credentialing process.

Core competencies were similar across sites and part of the initial credentialing application based on basic NP educational curriculum. Specialty competencies varied based on the type of practice setting of the NPs (See Table 5, p.50). The process for achieving those privileges were similar and included proof of supporting knowledge, psychomotor skills and ongoing steps to maintain the competency once achieved.

A source of variation across the sites was the people involved in the process. The identified steps in the credentialing process at sites one and two were reported using similar committee structures. The initial and final steps were different at site three. NPs employed by the organization entered into the credentialing process as part of the human resources departmental functions. Non-employed/practice-employed NPs began the process using the same entry point as the medical staff. The primary source verification for employed NPs is performed through the HR function and then submitted to the MSO where the practice-employed NPs primary source verification is through the MSO.

At the time of the study there was no nurse credentialing body at site three as was found at sites one and two. The chief of the medical department performed initial review of

credentialing packets rather than a nurse credentialing body. However, after the initial review, recommendations are sent on to a medical staff credentialing body at all sites.

The final variation is found in the last step of the credentialing process. Sites one and two reported the organizational governance body as having the final approval authority for credentialing all NPs. However in site three, the employed NPs are given final approval through the HR departmental function.

Credentialing process barriers. Barriers to the credentialing process did not vary across sites. Access to required information, delays in primary source verification, and responses to requests for peer feedback were reported at all three sites. The requirement for demonstration of a competency to receive specialty privileges also was identified as a barrier at all sites.

Nurse Practitioner Perceptions of the Credentialing Process

Similar emotional responses were identified across the three sites. (See p. 59) Confusion and frustration related to the credentialing process were identified. Exceptions were noted when NPs reported similar experiences when in other roles or settings. Two NPs at site three reported previous credentialing experiences. They did not express confusion or frustration associated with their most recent credentialing.

Participants at the three sites who are part of the credentialing bodies reported that the process was equal to the one used for physician credentialing. All participants agreed that the steps of the credentialing process likely wouldn't change if the state practice acts recognized the NP as an independent practitioner. As reported in the findings (pg. 65), concerns were expressed by participants at site one and two about NPs requesting changes in their scope of practice that were not aligned with their educational programs.

Across the three sites there was lack of knowledge by NPs of all the steps of the credentialing process and what people were involved. CBM members at sites one and two also expressed not knowing the composition of some of the groups involved in approval of NPs. Additionally, as reported in the findings (See p. 68). NPs reported concerns about the level of involvement of the medical staff in approval of NP privileges.

Enhancement of the Credentialing Process for the Nurse Practitioner

Suggestions for reducing barriers were provided by CBM and NP participants. Suggestions were similar across the three sites and included: enhanced discussion of organizational credentialing in NP educational settings, and collection of documentation of experience to support requests for specialty privileges. Additionally, the importance of having original documents easily available was stressed.

Dissatisfaction with the credentialing process was reported by NPs at site one and two. Based on this input sites one and two reported placing specific staff in place to assist NPs with completing the initial credentialing packet. Participants from the third site did not report this type of support or a concern about this issue.

Participants at site two and three suggested the use of a centralized credentialing service. A similar service is in place for physician credentialing information. The service provides primary source verified information eliminating need for repeated verification by each organization the NP may apply to for privileges.

Summary

The credentialing process at each individual site was described. To understand the credentialing process for Nurse Practitioners as designed in each site, three major areas were explored and themes were developed within each area. The three areas were: (a) required

activities that Nurse Practitioners must complete to receive organizational approval to practice in the advanced role, (b) Nurse Practitioner perceptions of the credentialing process, and (c) enhancement the credentialing process for the Nurse Practitioner. Quotes from the participant interviews were provided to support the selection of the themes. Cross case analysis was performed and the overall and theme-specific similarities and differences were presented.

Chapter Five

Introduction

The purpose of the multisite event-based case study was to understand and describe the processes by which Nurse Practitioners are credentialed and granted privileges to practice within the acute care hospital setting. The research questions focused on the experience of the Nurse Practitioner (NP) during the credentialing process; the privileges requested and their alignment with the educational content of their NP program; implicit and explicit rules guiding the credentialing structure; and how the experience has evolved.

Gaps in the literature for NP credentialing in acute care settings exist. The majority of the literature focused on specific information needed for credentialing and the functional groups (e.g., medical staff or governance body) required to be included in the process. Discussion of the experience by NPs or the appropriateness of the structure was not found in the credentialing literature.

Credentialing and privileging for practice in the acute care setting traditionally has been designed for physician roles. As additional disciplines request privileges to manage care for populations in the acute care setting, the existing medical structure often has been used to credential individuals from the other disciplines. Results of the study support that the NP credentialing structure is similar or the same as the credentialing structure used by the members of the medical staff and often is promoted by regulatory and accreditation entities. However, findings from this study reveal that there is some variation across sites and there continue to be concerns among NPs about the process and the professionals involved in the determination of NP privileges.

Discussion of Findings and Implications

The purpose of credentialing and privileging of health care providers is to protect society from unqualified practitioners (MacLean, 2001). Granting privileges assumes that those involved understand the scope of the knowledge and skill specific to the requesting practitioner. Organizational leaders could face legal and financial consequences when flawed credentialing processes exist. The discussion of the findings of this study will be presented by the major area and the corresponding themes within each area (See Table 2.)

Required Activities Nurse Practitioners Must Complete to Receive Organizational Approval to Practice in the Advanced Role

Required information for acute care credentialing. The three sites reported requiring the same credentialing information (See Table 6, p. 73.) All participants (*n*=12) described the information required for credentialing in their settings was the same as for the medical staff. The information and primary source verification requirements aligned with the literature. The majority of the existing literature described the types of information that must be provided and verified for credentialing to proceed. Klein (2003) and Magdic, Hravnak, and McCartney (2005) identified that the information required for granting of privileges for the medical staff and NPs was equivalent. Hravnak (2009), Hittle (2010), McLaughlin (2007), and Swan (2000) described the same information needs as well as the use of primary source verification of some data. The content also met the requirements of The Joint Commission's (2011) accreditation standards.

Importance of timeliness of completing the process. CBM participants from each of the three sites identified timeliness as a factor that influenced the ability of the NP to practice. Common to the three sites were delays related to obtaining the required information and getting feedback from peer references. An NP with previous experience in credentialing reported a

shorter time to complete credentialing of five weeks. This NP had all the required information ready when coming to the study site for employment. NPs reported a deficit in their knowledge of the information needed for organizational credentialing, and they cited that there was minimal content in their educational programs to assist in preparing for the process. No studies could be located that reported information about the consequences of delays in completing the credentialing process.

Steps for adding and maintaining competencies. Evidence of competence is an expected component in credentialing as defined within the regulatory and accreditation literature (TJC, 2011; & CMS, 2009). NP participants' at all three sites identified variation in how competency expectations were met for NPs and medical staff in this theme. Examples of these variations were differences in expectation for the documentation of their ability to perform a competency, particularly during their initial education programs. For example, NPs identified the need to prove competence for common procedures, such as removing foreign objects from the ear in the emergency department. However, physicians who rarely perform the same task, are not required to show continued competence.

Core competencies are expected to be present as a result of the initial education of the practitioner at all three sites. Specialty types of competencies are obtained with further education or training and must be verified before they are granted. Across the three sites, CBM participants reported the use of similar processes for members of the medical staff and NPs for obtaining competency certification. These include proof of a specific knowledge base, monitoring during skills acquisition, and finally successful performance that is verified by a competency content expert.

NPs who completed the acute care and neonatal practitioner programs stated they had performed specialty skills during their education. However, they were unaware of the future need for documentation of this experience that would be required at the time they applied and went through the credentialing process. Even though they had acquired a specific competency, the lack of documentation of the experience resulted in the need to repeat the performance of these skills to meet the credentialing requirements.

Development of criteria for commonly requested competences is an ongoing process across all three sites. As the advanced practice role has continued to evolve in the acute care setting, six NP participants across the three sites reported that they were or had been involved in the development of the competency criteria for the NP in their setting. They also reported that evidence-based standards are used whenever they are available. This indicates that work is needed to establish more specialty competency standards and disseminate them for broad use.

P**eople involved in the process**. Interviews supported that the required functional groups of the medical staff and governance body were involved in NP credentialing at all three sites. A nursing credentialing body is not required but is in place at two sites and being considered at the third site. Having a nursing body as part of the credentialing process is highly valued by the participants; as the nursing body often is comprised of other NPs who understand the role and have the knowledge base of the competencies required to perform the role in the acute care setting. The members of the nursing body also can provide clarifying information when presenting information to the next group that reviews the application (e.g., medical staff or the governing body); this is especially important as they have done the in-depth review and can advocate for the NP seeking credentialing.

No sources were found that provided recommendations regarding the background of the people involved in credentialing processes. However, specific functional groups are directed to be involved. The role of the medical staff and the governing body is defined in the regulatory and accreditation literature (TJC, 2011; & CMS, 2009).

Common barriers to the credentialing process. Barriers identified by all CBM and six of the nine NP study participants included: delays in getting the required primary source documentation including original degrees; timeliness of responses by peer references; and poor communication about the status of the application during the credentialing process along with delays in notification when privileges were approved.

Hansen-Turton et al. (2006) and Buppert (2010) identified barriers for NPs credentialing with managed care organizations but did not address the acute care setting. The barriers focused on the issue of Managed Care Organizations (MCO) that refused to credential nurse practitioners. Buppert (2010) suggests that change has been noted in the practices of some insurers. Plager and Conger's (2007) study included the acute care setting but focused on role fulfillment and not the credentialing process. No other sources were found that evaluated barriers to credentialing of NPs. The barriers identified during the study did not include those found in the literature.

Implications. Findings from this study support the following recommendations for enhancing the understanding of the required activities for NPs when completing the credentialing process in the acute care settings. First, required information is well defined and is incorporated into the credentialing processes of the three sites. The content allows the organization to support the credentialing of knowledgeable and competent practitioners. However, communication of needed information is not consistently presented to NPs during their educational experience prior

to graduation leading to potential delays in their later credentialing. Second, inconsistencies were identified with how core competencies and specialty competencies are determined across disciplines. The inconsistencies create negative perceptions of the equivalency of the credentialing processes. A third implication is the lack of clearly defined methods for obtaining and verifying psychomotor competencies. While some evidence-based content exists the remainder is defined and structured within each organization. Thus, leading to the potential for inappropriately approving a requested privilege by the NP. Finally the confusion and frustration experienced by NPs during their initial credentialing is related to their inexperience and understanding of the credentialing process. These emotional responses could be modified through additional course content and direction during the credentialing process.

CBM participants reported modifications of their programs are in the implementation process to address barriers presented in the findings. Actions include the designation of a central contact person to guide the NP through the process. A formal plan for periodic communication of the status of their request may be useful to decrease stress and facilitate timely resolution of barriers. Inclusion of description of the steps and groups that are involved in credentialing, (i.e., their backgrounds and appropriateness to be involved in the process) in the educational program would assist the NP during the initial credentialing request.

Nurse Practitioner Perceptions of the Credentialing Process

Emotional responses of Nurse Practitioners to the credentialing process. Participants in the study identified feelings of confusion, frustration and dissatisfaction during their initial experience of the credentialing process. Much of this was related to the length of time it took to complete the process as identified by all three CBMs and six of the nine NPs. Sources of these feelings also were linked to previously presented barriers including required primary source

documentation, timeliness of peer references, and communication and perceived variation in expectations for NPs and physician competencies.

However, the same feelings were not expressed as a concern during the re-credentialing process. This could be due to the fact that once the NP has experienced the process for the first time and knows what to expect, that they do not have the same apprehension or confusion about the process. It also could be that the requirements for re-credentialing are not as stringent as the initial process since primary source documents do not have to be collected again.

Fit of the credentialing process with the intended role of the NP. Accreditation organizations have standards that NPs need to be privileged either through a medical staff or equivalent procedure. All three CBM participants agreed that their NP credentialing process was equivalent to the process required for the members of the medical staff. Although participants reported initial confusion about the process using the medical model for credentialing, they were unable to identify a different process to replace the current one. Even if the state practice acts changed and restrictions to independent practice were removed, all CBM and eight of the NP participants expressed the belief that the organization and medical staff would remain in control of the process. This seems likely since the regulatory and accreditation requirements describe the functional groups (e.g., medical staff committees and governing bodies) that must be involved (TJC, 2011; & CMS, 2009).

A related concern was identified by two CBMs and a NP participant about NPs who were attempting to get credentialed for a role different from their original educational preparation (e.g., a family nurse practitioner [FNP] that now is requesting privileges to practice as an acute care nurse practitioner [ACNP]). In this case, the applicant would be required to meet the criteria for the specialty competencies, which would mean having the knowledge base and the skills to

practice in the ACNP role or developing a plan for acquiring the skill to perform successfully with proctoring and oversight.

Involvement of the right people in the credentialing process. For the most part, the expected groups (i.e., nursing, medical staff and governing body) are actively engaged in credentialing NPs across the three sites, with the exception of one site that is still in the process of developing a nurse credentialing body. However, there was uncertainty among the NP participants' at all three sites regarding the roles of the people in the groups and their understanding of the NP scope of practice. It was identified by the three CBMs that education is provided as needed to credentialing group members; however, the participants indicated a concern that a gap in understanding of the role still exists in some of the groups that are responsible.

Implications. Findings from this study support the following recommendations for the nurse practitioner perceptions of the credentialing process. First, confusion and frustration appear to be linked to NPs not being familiar with the credentialing process. NPs with longer practice histories or with schooling outside of the country had more difficulty in retrieving information about their initial education. NP educational programs should consider a more active role in preparing the NP for practice in or affiliated with acute care settings.

Second, concerns exist when NPs request privileges that are outside their specialty education. While two CBMs reported advising medical practices not to hire NPs with fewer acute care skills, there is not a clear approach of what must happen to acquire additional skills. Acute care NPs report that working in the role is more than simply being able to perform additional skills, but also includes the acquisition of a different knowledge base as well. If a state standard does not exist requiring re-education, consideration should be given by each site to

establishing a clearly defined approach for this type of request by an NP or their sponsoring physician(s).

A third implication is whether the right people, not just functional groups are involved in the credentialing process. NPs at Site 1 and Site 2 voiced concern about whether credentialing body members understand the NP role well enough to determine appropriateness of their privileges. CBM members did not always know the background of the membership of the committees, but believed that they received education about the NP role.

In line with the primary role of credentialing to assure only competent practitioners receive practice privileges; it is important that the members are confident they make the correct decisions. Just-in-time training covering the role and responsibilities of the NP is provided to the credentialing committees prior to credentialing discussions. However, additional information on NP education and roles should be provided periodically to maintain the ability of the groups to make appropriate recommendations for privileges.

Enhancement of the Credentialing Process for the Nurse Practitioner

The participants did have suggestions for how the credentialing process for NPs could be enhanced. The last two themes include their recommendations.

Reduction of barriers in the NP credentialing process. Barriers reported resulted in delays and required additional actions by NPs to complete the credentialing process. The common barriers to credentialing were recognized and agreed upon by all the credentialing body members as well as six NPs. Participants provided recommendations for removing or minimizing effects of the barriers. First, the addition of a specific person to guide the person through the NP credentialing was recommended, and having that person as a member of the nurse credentialing committee was beneficial. This person is the contact to answer questions,

shepherd the application through the process, and communicate the status or give updates to the NP requesting the privileges. They also can contact the NP if further information is needed to help expedite the process.

Another key suggestion was the modification of content and format of the forms being used to monitor the documentation of the required competencies. NPs at Site 1 and Site 2 reported content on privileging forms did not always support their educational preparation or psychomotor skills. Examples of basic nursing skills were found on the privilege forms. The forms should be reviewed and modified to accurately reflect the practice of the NP.

External Factors Impacting the NP Credentialing Process

Centralization of information and automation of processes. Wilson & Iacovella, (2000) described the use of a centralized source to obtain required information. The use of these organizations, known as Credential Verification Organizations (CVO), is common for physician credentialing. CVOs allow healthcare organizations to gather the needed information from one location and minimize the need for practitioners to supply the same documents to multiple facilities. Participants at two sites recommended the use of a CVO for the purposes of NP credentialing. Streamlining the process in this way would eliminate barriers for timely progression through the credentialing process and also standardize the process across organizations.

Inclusion of organizational credentialing in educational curriculum. Of the nine NP participants seven described their educational curriculums as having minimal to no discussions on the topic of credentialing. Consequently, they did not know what to expect when they started the credentialing process. Although there may be variations in specificity of the requirements

across acute care settings, some training in their educational preparation would help them to know what they need to have to start their application process.

The natural starting point for action would be inclusion of an educational component that prepares the NP for organizational credentialing not simply their national certification. The education should include keeping the resume, licensure, and credentialing updated; keeping documentation of competency; and developing a file to organize required materials for future use. Structure of the credentialing process across organizations may vary. However, the basic requirements that are established in the regulatory and accreditation literature could provide a starting point for educators. Incorporation of detailed documentation of specialty knowledge and skills should be included to facilitate future requests for privileges. NPs should expect to keep these documents ready to be presented to their organizations. Even identifying the primary source documents (e.g., BSN graduation certificate, etc.) is something they probably do not consider until they get the application. Also, information about the length of time to get credentialed as well as the procedures, committees, and other groups involved in the process. The other component would be the specific competencies that would expected for the different roles of advance practice nurses. Additionally experience in their programs in gaining the required skills and competencies need to be documented and often is not. This is important for future use in establishing specialty privilege competencies that may be required in the acute care setting.

Implications. Findings from this study support the following recommendations for the enhancement of the credentialing process for NPs. Two sites reported the addition of a contact person for NP credentialing. The contact person's role seeks to close communication gaps between the NP and the medical staff office.

All three sites reported efforts to automate their processes and these efforts should continue. Automation would allow for quick and easy access to application information, especially if the prospective applicant is outside of the local community. Streamlining required paperwork, removing confusing language, focusing privilege forms on the specialty education of the NP, and improving communication between the NPs and medical staff office will minimize confusion and frustration.

The processes for gaining initial and ongoing maintenance of competencies, core and specialty, are not well defined. Given the geographic locations, study NPs may practice in more than one site. Consistency through standardization of requirements for approval of privileges, specifically for the task or psychomotor skills, would likely decrease confusion and frustration for NPs.

It is not likely that the need for credentialing for NPs will be discontinued. Considering the likelihood that the NP-like the physician will apply at multiple organizations, the use of a central verification organization (CVO) is recommended. The value of a CVO to include NP documents should be promoted to the national organizations that represent advance practice nurses.

Summary

The majority of the literature on credentialing has focused on required documents, and involvement of specific functional groups (e.g., medical staff and acute care setting governing bodies). The sites studied have established their NP credentialing structures using the medical staff structure and the requirements of the regulatory and accreditation bodies. Areas of concern include the confusion and dissatisfaction of the NPs when involved in their initial credentialing episode, concern that the right people are involved in the decision making process, and lack of

ongoing communication throughout the credentialing process about what is needed to move the application forward to obtain final approval. Recommendations for the further evolution of the credentialing process of the NP involve their educational programs, the credentialing body members, organizational leadership and the NPs themselves.

Study Strengths and Limitations

Strengths

Strengths of the study include two major elements. The first strength is the presentation of institutional credentialing from the NP perspective. This topic is missing from the nursing literature and provided an opportunity to begin the exploration of how NPs perceive the process and the structures that surround it. Barriers were identified that may contribute to modifications to enhance the experience for the NP.

The second strength is related to the geographic location of the participating sites. The Midwestern location and the proximity of the sites across two bordering states contribute to broader use of the findings. NPs from a variety of backgrounds, and from other geographic locations bring their unique perspective to the understanding of the credentialing structures.

Limitations

The geographic location has been identified as strength however; it also contributes to potential limitations to the study. The three sites were located within the same large metropolitan area. While Site One was in a different state than Sites Two and Three, it is common for nursing staff to be licensed in both states and to have experience working in facilities across the states. This free movement of staff also may result in movement of similar processes and philosophies relative to the credentialing process. Institutional credentialing may vary across states depending on different requirements of state boards for certification, licensure, and scope of practice.

Professional organization standards, such as the American Association of Nurse Practitioners, may influence the type of privileges requested.

The NPs interviewed in this study were employed by the acute care organizations. Even though a few of the NPs practice settings had previously been private practice groups they are now owned by the hospital or the acute care setting. The NPs in a private practice which is not owned by a hospital may have different perceptions about the credentialing process and the findings from this study may not be applicable.

The credentialing body members (CBM) who participated in the study filled different roles in their organizations credentialing process. Two were advanced practice nurses who are members of the nursing credentialing committees. Their advanced practice backgrounds and previous personal experience with the credentialing process may have biased their identification of its strengths and weaknesses since they currently are part of the process. The other CBM is a credentialing specialist in the medical staff office function and is engaged throughout the credentialing process. Their lack of personal experience of being credentialed may have influenced their view of credentialing.

Another group that was not interviewed includes members of the MEC and governance committees involved in credentialing. Physician and lay members of the credentialing body may have other perceptions of the process and its relevance to the NP, and their views are not included in this study.

Recommendations for Future Research

Future studies on the credentialing process for NPs should concentrate on the following areas. First, what is the process for NPs receiving privileges beyond their original educational focus? Second, what are the appropriate ways to measure competence for specialty privileges?

Finally, are there other alternatives to credentialing that would be more appropriate for the NP role? Additionally, future studies should be designed to evaluate the process in diverse geographic locations and observe for variation.

The political aspects of institutional credentialing were addressed minimally by the participants in this study. Future studies should explore in more detail the NPs understanding of the political aspects of credentialing and potential implications. One issue pertains to the involvement of the physician, who fully does not understand the role of the NP, yet is guiding the process of institutional credentialing in the acute care hospital setting. Comments from participants were not explored in-depth for this study because the focus was on the process and structure for the NP obtaining institutional credentialing. Consequently, there were not enough comments generated to lead to the development of a theme around this topic. However, it would be important to include the physician perspective in a future study, to understand this process completely. Additionally the state requirement for collaborative agreements may influence the credentialing structures within the acute care hospital setting along with the types of privileges granted. Future studies should focus on the variations identified when physician and NP collaboration in practice is less prescribed and based more on the scope of practice for each discipline.

Researcher reflection

The idea for the study originated several years before I completed my required curriculum. Health care changes during this time have altered my initial concerns about the appropriateness of the traditional model of credentialing. The changes also decreased concerns that inappropriate privileging of NPs might occur within the physician model.

I have 30 years of experience working in nursing related roles in the acute care setting. During ten of those years I was involved closely in data collection for use during re-credentialing of the medical staff. I participated in the routine meetings of the medical staff credentialing body. The Joint Commission established standards that altered previous practices for NPs who were employed by the acute care facility. I was involved in establishing the new process for credentialing for these nurse practitioners and participated in the early meetings of the NP credentialing committee. This experience may have influenced or biased my interpretation and understanding of the responses of the participants and result in assumptions based on my experience.

As a nurse I worked clinically with nurse practitioners associated with physician practices and nurse practitioners employed in the acute care setting. I participated in conversations about the role of the NP, relationships with their collaborating physicians, and opinions of the credentialing process prior to beginning the research journey. This has resulted in strongly formed opinions about the ideal structure and relationship for these two disciplines. The researchers bias was balanced through use of discussions with a peer debriefer and review of implications by members of the committee.

During the study interviews I heard concerns and issues expressed that had been anticipated based on previous experience. My perception of the intensity of some of the frustrations and confusions verbalized at Site 1 and Site 2 were less prominent at Site 3. This may be related to several differences in the culture of Site 3 including its size, number of NPs and its non-academic status.

Additionally I heard responses that modified my previous concerns that the process might allow NPs to acquire privileges that were outside their scope and educational background. Thus

the research was able to influence me to view the process somewhat differently today than when the project began. My concerns regarding granting of privileges outside of the NPs education and skill set were minimized though not completely removed.

Conclusion

The credentialing process in the acute care sitting still is in an evolving state. Previously NPs were employed by physician practices that would follow patients that were admitted to the acute care setting; they were credentialed through the well-established medical staff credentialing process. NPs employed by the acute care setting practiced with a job description and collaborative agreement required by the state nursing board. Efforts by regulatory and accreditation entities to ensure safe practice required an equivalent process be established for all NPs requesting privileges in the acute care setting.

New credentialing structures have developed over time and have been set in place, such as the nurse credentialing committees. This step still is relatively new for NPs who practice in the acute care setting. While NPs are comfortable with the concept of certification for their role through their national organizations they are not well versed on credentialing for practice in an acute care setting. Continued refinement of the credentialing process as well the implementation of strategies (e.g., preparation during education, familiarity and involvement with the process, working with an on-site person to coordinate the process) to enhance the process may assist in reducing some of the barriers and frustrations identified in this study.

References

A comparison of changes in the professional practice of nurse practitioners, physician assistants, and certified nurse midwives: 1992 and 2000. US Dept of HHS Retrieved 9/2008 from: www.bhpr.hrsa.gov/healthworkforce/reports/scope/scopeapph.htm.

AMA scope of practice data series: A resource compendium for state medical associations and national medical specialty societies. (2009). AMA. Retrieved January 13, 2014 from: http://www.aanp.org/images/documents/state-leg-reg/08-0424SOPNurseRevised%2010-09.pdf

Anderson, R. A., Crabtree, B.F., Steele, D.J., & McDaniel, R.R., (2005). Case Study research: The view from complexity science. *Qualitative Health Research, 15,* 669 – 684. DOI: 10.1777/1049732305275208.

APRN Factsheet. (2011) Retrieved February, 2011 from: http://www.nacns.org/docs/APRN-Factsheet.pdf

Ayers, L., Kavanaugh, K., & Knafl, K. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative Health Research. 13*(6), 871-883. DOI: 10.1177/1049732303255359.

Balogh, R. & Cook, M. (2006). Achieving magnet accreditation in the UK: A case study at Rochdale NHS Trust. *Journal of nursing management. 14* (5), 366-76.

Barnes, T.A., Gale, D.D, Kacmarek, R.M., & Kageler, W.V., (2010). Competencies needed by graduate respiratory therapists in 2015 and beyond. *Respiratory Care. 55* (5), 601-16.

Barrella, M., Gravlin, G., McDonough, K. Merrill, C., Noga, P.N., Shanteler, P., & Williams, L. M. (2007). The magnetic pull: Massachusetts nurse leaders share best practices. *38* (1), 42, 44-6.

Beck, S., Epner, P., & Briden, M. (2007). Practice levels and educational needs for laboratory personnel. *Clinical Leadership & Management Review. 21(6),* E1 – E13.

Beckstead, J. (2010). DNP = PhD-light, or old wine in new bottles?. *International Journal of Nursing Studies. 47*(6). 663 – 664.

Blankenship, C., & Boissonneault, G. (2006). *Journal of Physician Assistant Education*. *17* (2), 48- 49.

Broom, C., & Tilbury, M.,S., (2007) Magnet status: A journey, not a destination. *Journal of Nursing Care Quality*, *22* (2), 113-118.

Buppert, C. (Nov/Dec 2010). Most payers now reimburse NPs. *Nurse Practitioner World News*. *12* (11/12).

Caldwell, S.D., Roby-Williams, C., Rush, K., & Ricke-Kiely, T. (2009). Influences of context, process and individual differences on nurses' readiness for change to Magnet status. *Journal of Advanced Nursing. 65* (7), 1412-22 .

Centers for Medicare and Medicaid Services (CMS). (2009). *State Operations Manual*. Retrieved February 2011 from: www.gov

Certification. (2014). Retrieved January 11, 2014 from: www.aanp.org

Cohen, M.H., Hrbek, A,, Davis, R. B., Schachter, S.C., & Eisenberg, D.M. (2005). Emerging credentialing practices, malpractice liability policies, and guidelines governing complementary and alternative medical practices and dietary supplement recommendations: a descriptive study of 19 integrative health care centers in the United States . *Arch Intern Med, 165*(3), 289-295. doi:10.1001/archinte.165.3.289.

Consensus model for APRN regulation: Licensure, accreditation, certification & education. (2008). AACN website. Retrieved on January, 15, 2014 from: www.aacn.nche.edu/education-resources/APRNReport.pdf

Cook, A.F., & Hoas, H. (2008). Ethics and rural healthcare: what really happens? What might help?. *American Journal of Bioethics. 8* (4), 52 – 56.

Creswell, J. (1998). Qualitative inquiry and research design: Choosing among five traditions. Sage. Thousand Oaks, Ca.

CRNA Scope of Practice (2014). Retrieved January 13, 2014 from: http://www.aana.com/aboutus/Documents/scopeofpractice.pdf

DNP Fact Sheet. (2013). Retrieved January 11, 2014 from: www.aacn.nche.edu.

Ellis, B., & Gates, J. (2005). Achieving Magnet status. *Nursing Administration Quarterly. 29* (3), 241-4.

Finnell, D., Garbin, M., & Scarborough, J. (2004). Advanced practice addictions nursing specialty certification. *Journal of Addictions Nursing. 15*(1), 37-40.

Ford, L. Nurse practitioner: history of a new idea and predictions for the future. In: Aiken, L.H. Gortner SR, eds. (1982). *Nursing in the 1980s: Crisis, Opportunities, Challenges*. Philadelphia. Lippincott.

Frakes, M., & Evans, T. (2006). An overview of Medicare reimbursement regulations for advanced practice nurses. *Nursing Economics*. *24* (2), 59 – 65.

General testing and renewal handbook. (2014). Retrieved January 11, 2014 from: www.nursecredentialing.org.

Graneheim, U.H. & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today. 24*, 105-112.

Hamric, A., Spross, J. & Hanson, C. (1996). *Advanced Nursing Practice: An Integrative Approach*. Philadephia. W.B. Saunders Company.

Hansen-Turton, T., Ritter, A., Begun, H., Berkowitz, S., Rothman, N., & Valdez, B. (2006). Insurer's contracting policies on nurse practitioners as primary care providers: The current landscape and what needs to change. *Policy, Politics & Nursing Practice*. *7*(3), 216-226.

Hart, A., Macnee, C. (2007). How well are nurse practitioners prepared for practice: Results of a 2004 questionnaire study. *Journal of the American Academy of Nurse Practitioners. 19*(1), 35 – 41.

Hathaway, D., Jacob, S., Stegauer, C., Thompson, C., & Graff, C. (2006). The practice doctorate: Perspectives of early adopters. *Journal of Nursing Education. 45*(12), 487 – 495.

Hellier, S., & Ramponi, D. (2013). What NP graduates need to know about certification: Changes are on the horizon. Retrieved January 14, 2014 from: http://nurse-practitioners-and-physician-assistants.advanceweb.com/Student-and-New-Grad-Center/Student-Top-Story/What-NP-Graduates-Need-to-Know-About-Certification.aspx

Hittle, K. (2010). Understanding certification, licensure, and credentialing: A guide for the new nurse practitioner. *Journal of Pediatric Health Care*. *24* (3), 203 – 206.

Holden, L. (2005). Complex adaptive systems: concept analysis. *Journal of Advanced Nursing. 52* (6), 651 – 657.

Housel, N., Gandy, J., (2008). Clinical instructor credentialing and its effect on student clinical performance outcomes. *Journal of Physical Therapy Education. 22*(3), 43 - 51.

Housel, N., Gandy, J., & Edmondson, D. (2010). Clinical instructor credentialing and student assessment of clinical instructor effectiveness. *Journal Of Physical Therapy Education, 24* (2), 26-34.

Hravnak, M. (2009). Credentialing and privileging for advanced practice nurses. *AACN Advanced Critical Care*. *20* (1), 12 – 14.

Improving patient access to high quality care: How to f ully utilize the skills, knowledge,and experience of Advanced Practice Registered Nurses. (June, 2013). Charting Nursing's Future. *20*, p. 5. Retrieved January 11, 2014 from: www.RWJF.org/goto/CNF

James, K.M.G. (2010). Incorporating complexity science theory into nursing curricula. *Creative Nursing*. *16* (3), 137–142. DOI:10.1891/1078-4535.16.6.137.

Klein, C. (2003) The scoop on credentialing. *The Nurse Practitioner*. *28*(12).

Lindberg, C., Nash, S. & Lindberg, C. (2008). *On the Edge: Nursing in the Age of Complexity*. PlexusPress. New Jersey.

Lumb. E. W. & Oskvig, R. M. (1998). Multidisciplinary credentialing and privileging: A unified approach. *Journal of Nursing Care Quality*. *12*(4), 36-43.

Ma, C., Hwang, P., & Alexander, J. (2010) Taiwanese nurses' cognition and attitudes towards the Magnet Hospitals Recognition Programme. *International Nursing Review*. *57* (1), 78-84. Doi:10m1111/j. 1466-7657.2009.00746x.

Magdic, K., Hravnak, M., & McCartney, S. (2005). Credentialing for nurse practitioners: An update. *AACN clinical issues: Advanced Practice in Acute Critical Care*. *16*(1), 16 – 22.

Maring, J., & Costello, E. (2009). Education program and student characteristics associated with pass rates on the National Physical Therapy Examination for physical therapist assistants. *Journal of Physical Therapy Education. 23*(1): 3-11

MacLean, D. (2001) Credentialing and privileging: One size doesn't fit all. *Caring for the ages.* 2(8).

McLaughlin, R. (2007). Preparation for negotiating scope of practice for acute care practitioners. *Journal of the American Academy of Nurse Practitioners. 19.* 627 – 634.

McShane, F., & Fagerlund, K. (2004). A report on the Council on Certification of Nurse Anesthetists 2001 professional practice analysis. *AANA Journal, 72*(1), 31-52.

Middleton, S., Griffiths, R., Fernandez, R., & Smith, B. (2008). Nursing practice environment: how does one Australian hospital compare with magnet hospitals? *International Journal of Nursing Practice, 14*(5), 366-372.

Miller, M., Snyder, M., & Lindeke, L., (2005). Forces of Change: Nurse Pracitioners: Current status and future challenges. *Clinical Excellence for Nurse Practitioners. 9*(3), 162 – 169.

Min, E., Comstock, H., Dickey, B., (2009). Assessing the correlation of student clinical encounters and PANCE performance... Physician Assistant National Certifying Examination. *Journal of Physician Assistant Education. 20* (1), 39-41.

Mundinger, M. (2008). American board of comprehensive care certification (ABCC): Too close to medicine? *Clinical Scholars Review. 1*(2), 67 – 68.

Nedrow, A. (2006) Status of credentialing alternative providers within a subset of U.S. academic health centers. *The Journal of Alternative and Complementary Medicine. 12(*3), 329 – 335.

National Organization of Nurse Practitioner Faculties (NONPF), (2013), Nurse practitioner core competencies, Independent practice competencies. Retrieved November, 2013 from: http://c.ymcdn.com/sites/www.nonpf.org/resource/resmgr/competencies/npcorecompetenciesfinal2012.pdf

Paley, J. (2007). Complex adaptive systems and nursing. *Nursing Inquiry*. *12*(3), 233-242.

Patton, M.Q. (2002). *Qualitative research & evaluation methods* (3rd Ed). Sage Publications. Thousand Oaks.

Pearson, L (2011). The Pearson report. *The American Journal for Nurse Practitioners*. *http://www.pearsonreport.com/*

Peirce, J. (2000). The paradox of physicians and administrators in health care organizations. *Health Care Management Review*. *25*. 7 – 28.

Phillips, S. (2014). 26th annual legislative update: Progress for APRN authority to practice. *The Nurse Practitioner*. *39*(1), 29 – 51.

Plager, K.A., & Conger, M.M. (2007). Advanced Practice Nursing. *Internet Journal of Advanced Nursing Practice*. *9*(1). (13 p).

Resnick, B. Sheer, B., McArthur, D., Lynch, J.S., Longworth, J.C.D., & Provencio-Vasques, E. (2002). The world is our oyster: Celebrating our past and anticipating our future. *Journal of the American Academy of Nurse Practitioners*. *14* (11), 484 – 491.

Richmond, T., & Becker, D., (2005). Creating an advance practice nurse-friendly culture: A marathon, not a sprint. *AACN clinical issues: Advanced practice in acute critical care*. *16*(1), 58 - 66.

Safriet, B. (2011). Federal options for maximizing the value of advanced practice nurses in

providing quality, cost-effective health care. In *The Future of Nursing: Leading Change, Advancing Health*. Washington: National Academies Press.

Scope of Practice for Nurse Practitioners (2014). Retrieved January 11, 2014 from: http://www.aanp.org/images/documents/publications/scopeofpractice.pdf

Spall, S. (1998, June) Peer debriefing in qualitative research: emerging operational models. *Qualitative Inquiry*. *4*, 280 - 292. doi:10.1177/107780049800400208.

Sochalaski, J & Weiner, J. (2011). Health care system reform and the nursing workforce: Matching nursing practice and skills to future needs, not past demands. In *The Future of Nursing: Leading Change, Advancing Health*. Washington: National Academies Press.

Swan, B.A. (2000). Perspectives in ambulatory care. Credentialing, contracting, and reimbursing nurse practitioners. *Nursing Economics*. *18* (5), 267 – 270.

Taylor, N.T. (2004). The magnetic pull: Administrators share how their facilities gained magnet status. *Nursing Management*. *35* (1). 38 – 40.

The Joint Commission. (2011). *2011 Hospital Accreditation Standards*. Joint Commission Resources, Inc. Oakbrook Terrace.

The registered nurse population: Findings from the 2008 national sample survey. Retrieved January 13, 2014 from: http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf

Torre, C. (2008). New Jersey nurse: practice/regulatory update: May/June, 2008. *New Jersey Nurse*. *38* (3), 4.

Towers, J. (2005). After forty years. *Journal of the American Academy of Nurse Practitioners*. *17* (1), 9 – 13.

Trossman, S. (Nov/Dec., 2009). APRN regulatory model continues to advance. *The American Nurse . 41*(6), 12-13.

What is a certified nurse midwife? (2013). *University of Utah School of Nursing*. Para 1. Retrieved January 13, 2014 from:. http://nursing.utah.edu/clinical-services/birthcare/certified-midwife.php

What's in health care reform for nurse practitioners and their patients? (2011). Retrieved May, 2011 from: http://www.aanp.org/AANPCMS2/LegislationPractice/FederalLegislation/IOM+Report+on+the+Future+of+Nursing.htm

What is an NP? (2014). Retrieved January 13, 2014 from: http://www.aanp.org/all-about-nps/what-is-an-np

Wilson, C., & Iacovella, A. (2000). Physician credentialing. *Hospital Topics*. *78*(4), 15.

Wolf, Z. (2003). Exploring the audit trail for qualitative investigations. *Nurse Educator*. *28*(4), 175 – 178.

Zimmerman, B., Lindberg, C. & Plsek, P. (2001). *Edgeware: Insights from complexity science for healthcare leaders*. (2nd Ed.). VHA Inc. Irving.

Appendix A

Nurse Practitioner Demographics:

Educational background: Masters _____ DNP _____ Other _____

State of licensure: Ks _____ Mo _____ Other _____

Specialty certification: Acute Care Nurse Practitioner _____, Adult Nurse Practitioner _____,

Family Nurse Practitioner _____, Adult/Gero Nurse Practitioner _____, Gerontological Nurse

Practitioner _____ Pediatric Nurse Practitioner _____, Neonatal Nurse Practitioner _____,

Adult Psychiatric and Mental Health Nurse Practitioner _____,

Family Psychiatric and Mental Health Nurse Practitioner _____

Educational focus of program: Primary Care _____ Acute Care _____

Current employment status: Facility-based _____ Physician Group _____ Independent Practice _____

Year of first credentialing: _____ Year of most recent credentialing: _____

Years of practice as a NP: _____

Privileges requested at credentialing: Core _____ Specialty focused privileges: _____

Were requested privileges granted without modifications? Yes _____ No _____.

What modifications were requested? _____

Appendix B

Nurse Practitioner Interview Guide:

Tell me about the first time you were credentialed at this facility.

1) What parts of the credentialing process were consistent with how you pictured the NP role would work in the acute care setting?

   Probes: Tell me about what you didn't expect during the process.

   What didn't seem to match with how an NP might function in the hospital setting?

2) What did you perceive to be barriers to the credentialing process?

   Probe: Did you face any obstacles?

3) What were enablers to the process?

   Probe: What did you think facilitated the process?

4) Think about your NP education. Tell me how it prepared you for the privileges you requested during credentialing.

   Probes: What privileges did you consider to be core to the role of the NP in the hospital setting?

5) Tell me about why you requested specific privileges.

Probes: What privileges were specific to your scope of practice?

What privileges did you think were not specific to your practice?

Were the privileges consistent with your educational background?

Tell me which steps in the credentialing process were easy to complete and which steps were harder to meet. Was this the same when you were re-credentialed?

Think about the credentialing process. Tell me how it:

Supported your goals for practice

Prepared you to practice within the full scope of your education

Is there anything I have not asked that you think is important to understanding the credentialing process as it applies to NPs in acute care settings?

Appendix C

Facility Demographics Survey

Teaching _____ Non-Teaching _____

Profit _____ Non-Profit _____

Urban _____ Suburban _____ Rural _____

Staffed Beds _____

Catchment area _____

Joint Commission accredited? Yes _____ No _____

Magnet status? Yes _____ No _____

Key Hospital Services _____

(Example: Cardiology, Trauma, Medical/Surgical, Transplant Center)

Medical Staff: number of members

Active Staff _____ Courtesy _____ Allied Health Staff _____

Nurse Practitioners: facility employed _____ non-facility employed _____

Specialties

Family Practice _____ Internal Medicine _____

Obstetrics/Gynecology _____Pediatrics _____

Surgery _____ Radiology _____

Emergency Medicine _____

Credentialing Body Documents Request

Organizational policies that address:

- Credentialing of the Medical Staff
- Credentialing of the Nurse Practitioner
- Composition of the credentialing body
- Required supportive documentation (original source documents, insurance, NDB, etc)

Sample forms:

- Privilege request form for NPs

Appendix D

Interview Guide: Credentialing Body Member

Credentialing Committee Structure

Describe the credentialing process for Nurse Practitioners.

Is the credentialing process an equivalent but different process than the one used to credential physicians?

Yes _____ No _____

Does the Credentialing Committee contain members of the Allied Health Staff?

Yes _____ No _____

If Yes, which members?

Nurse Practitioners _____ CRNAs _____ CNMs _____ Psychologists _____

Physician Assistants _____ Dentists _____ Other _____

Are there members of the Medical Staff on the Credentialing Committee?

Yes _____ No _____

If yes, who are the members?

Interview Topics:

Describe the process for reviewing requests for approval of credentials for NPs.

How is it different from the medical staff? Members of the allied health staff?

How are credential committee members educated about the roles of NPs prior to consideration for credentialing approval?

Appendix E

Email or phone script content

Credentialing of Nurse Practitioners in Acute Care Settings: Research Study

I am inviting you as a Nurse Practitioners to participate in this voluntary research study.

BACKGROUND

The role of the Nurse Practitioner (NP) is expanding. The NP in the acute care setting is becoming more common. The credentialing process was initially developed for the medical staff but is being applied to the NP role. There is a gap in the literature regarding the appropriate mechanisms for credentialing and granting of practice privileges for NPs.

PURPOSE

By doing this study, researchers hope to understand the current credentialing practices. This understanding may potentially provide guidance for further study and development of appropriate credentialing practices at a local, regional, or national level.

If you decide to participate in this study, your participation will last approximately 90 minutes. Your participation will involve:

- Completion of a demographic form to provide the researchers with information about your educational background and experience in the credentialing process.
- Completion of an approximately 60 minute interview. The interview will capture your unique perspective about credentialing and privileging of NPs.

If follow up questions evolve during the study you may be contacted to provide feedback by short phone interview.

The study is not associated with this facility. Participation choice will not influence employment status.

Interviews will not take place during scheduled work hours.

Contact Information

I would like to interview three to five Nurse Practitioners at each site.

If you are interested please contact:

Carla Hronek, RN, MSN
Study Coordinator
chronek@kumc.edu

Appendix F

Consent for Nurse Practitioner Participant and Credentialing Body member

(Follows on next page)

RESEARCH CONSENT FORM

Credentialling of Nurse Practitioners

Protocol #

You are being asked to join a research study. You are being asked to take part in this study because of your role as a Nurse Practitioner or your role in the credentialing committee in an acute care hospital setting. You do not have to participate in this research study. The main purpose of research is to create new knowledge for the benefit of future nurse practitioners. Research studies may or may not benefit the people who participate.

Research is voluntary, and you may change your mind at any time. There will be no penalty to you if you decide not to participate, or if you start the study and decide to stop early.

This consent form explains what you have to do if you are in the study. It also describes the possible risks and benefits. Please read the form carefully and ask as many questions as you need to, before deciding about this research.

You can ask questions now or anytime during the study. The researchers will tell you if they receive any new information that might cause you to change your mind about participating.

This research study will take place at the University of Kansas Medical Center (KUMC) with Marge Bott and Diane Ebbert as the primary researchers and Carla Hronek as the study coordinator. A total of about 15 people will be in the study at three acute care facilities in a Midwestern city of the United States.

BACKGROUND

The role of the Nurse Practitioner (NP) is expanding. The NP in the acute care setting is becoming more common. The credentialing process was initially developed for the medical staff but being applied to the NP role. There is a gap in the literature regarding the appropriate mechanisms for credentialing and granting of practice privileges for NPs.

PURPOSE

By doing this study, researchers hope to understand the current credentialing practices. This understanding may potentially provide guidance

for further study and development of appropriate credentialing practices at a local, regional, or national level.

PROCEDURES

If you are eligible and decide to participate in this study, your participation will last approximately 90 minutes. Your participation will involve:

- Nurse Practitioners - Completion of a demographic form to provide the researchers with information about your educational background and experience in the credentialing process.
- Completion of an approximately 60 minute interview. The interview will capture your unique perspective about credentialing and privileging of NPs.
- Credentialing body members: completion of an interview regarding your experience in credentialing NPs. It is anticipated the interview will last no more than 60 minutes.
- If follow up questions evolve during the study you may be contacted to provide feedback by short phone interview.
- This is a qualitative study. There is no randomization involved in selection of participants. Participants will self-select based on meeting study parameters:
    - Participants will be Nurse Practitioners who have been credentialed to practice in an acute care setting.
    - Other participants in the study include members of the organization's credentialing body.
    - Documents that provide information regarding the actual structure of the credentialing body, sample forms, and policies that support the credentialing process will be collected. No confidential credentialing information about the participants will be collected.
    - The identities of NPs or credentialing body members who participate in the interviews will be confidential.
    - The transcriptions of the interviews, documents, policies, demographic forms will be kept in a secure locked file. Files will be maintained per KUMC policy and then destroyed.

RISKS

There are no known risks or discomforts of study participation.

It is not anticipated that you might be embarrassed by the questions the researchers ask you. You are free not to answer any questions that make you uncomfortable.

There may be other risks of the study that are not yet known.

NEW FINDINGS STATEMENT

You will be told about anything new that might change your decision to be in this study. You may be asked to sign a new consent form if this occurs.

BENEFITS

You will not benefit from this study.

Researchers hope that the information from this research study may be useful in informing local, regional, or national policies regarding the credentialing processes for Nurse Practitioners.

ALTERNATIVES

Participation in this study is voluntary.

COSTS

There is no cost for being in the study.

PAYMENT TO SUBJECTS

There is no payment for this study.

IN THE EVENT OF INJURY

No risk of injury is anticipated with this study.

INSTITUTIONAL DISCLAIMER STATEMENT

If you think you have been harmed as a result of participating in research at the University of Kansas Medical Center (KUMC), you should contact the Director, Human Research Protection Program, Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160. Under certain conditions, Kansas state law or the Kansas Tort Claims Act may allow for payment to persons who are injured in research at KUMC.

CONFIDENTIALITY AND PRIVACY AUTHORIZATION

The researchers will protect your information, as required by law. The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study.

QUESTIONS

Before you sign this form, Marge Bott, Carla Hronek, or other members of the study team should answer all your questions. You can talk to the researchers if you have any more questions, suggestions, concerns or complaints after signing this form. If you have any questions about your rights as a research subject, or if you want to talk with someone who is not involved in the study, you may call the Human Subjects Committee at (913) 588-1240. You may also write the Human Subjects Committee at Mail Stop #1032, University of Kansas Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160.

SUBJECT RIGHTS AND WITHDRAWAL FROM THE STUDY

You may stop being in the study at any time. The entire study may be discontinued for any reason without your consent by the investigator conducting the study.

CONSENT

Dr. Marge Bott, Carla Hronek or the research team has given you information about this research study. They have explained what will be done and how long it will take. They explained any inconvenience, discomfort or risks that may be experienced during this study.

By signing this form, you say that you freely and voluntarily consent to participate in this research study. You have read the information and had your questions answered.

You will be given a signed copy of the consent form to keep for your records.

_____

Print Participant's Name

_____ _____ _____

Signature of Participant Time Date

_____

Print Name of Person Obtaining Consent

_____ _____

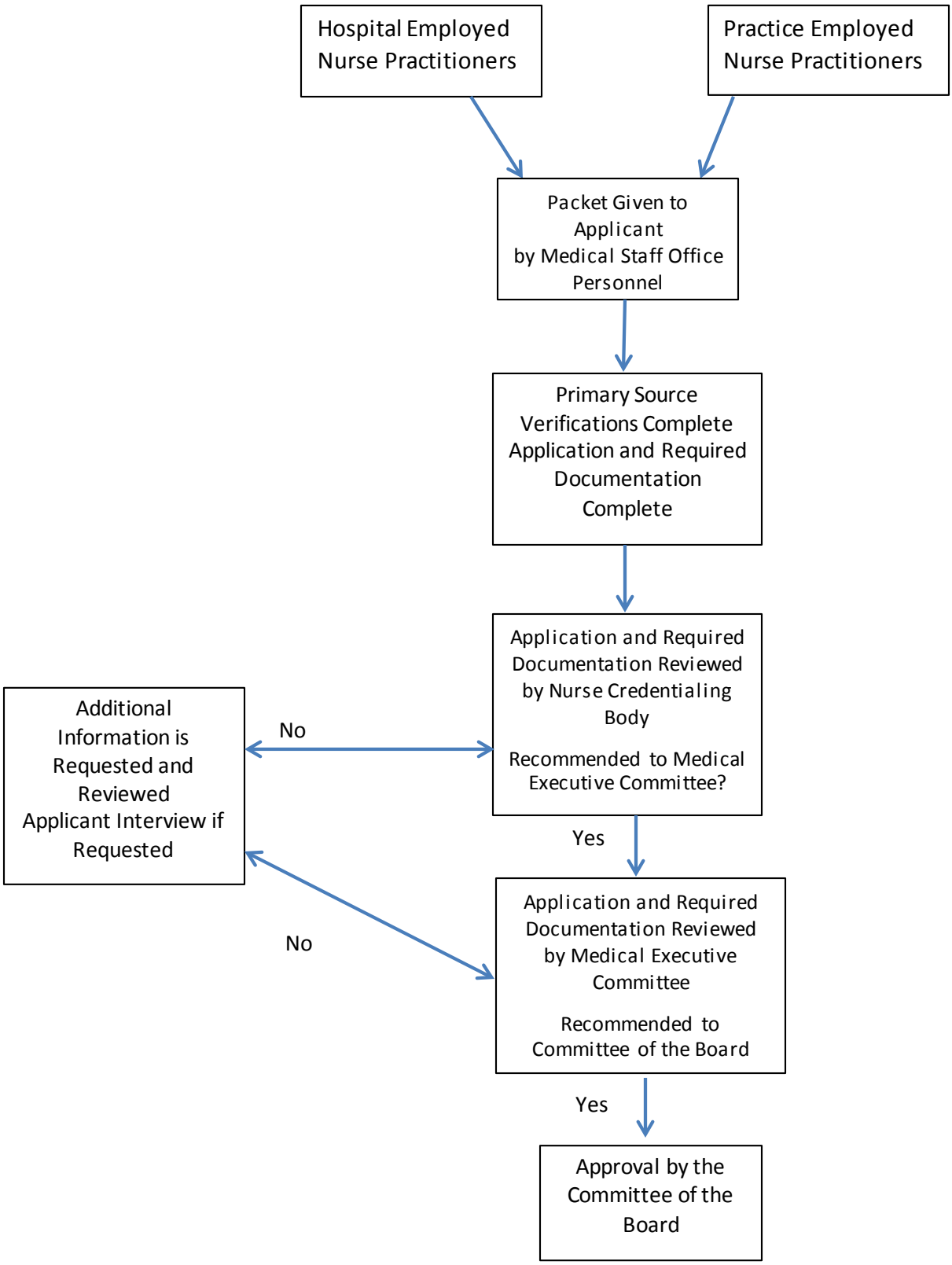
Signature of Person Obtaining Consent Date

Appendix G

Site One Process Map

(Follows on next page)

Site # 1

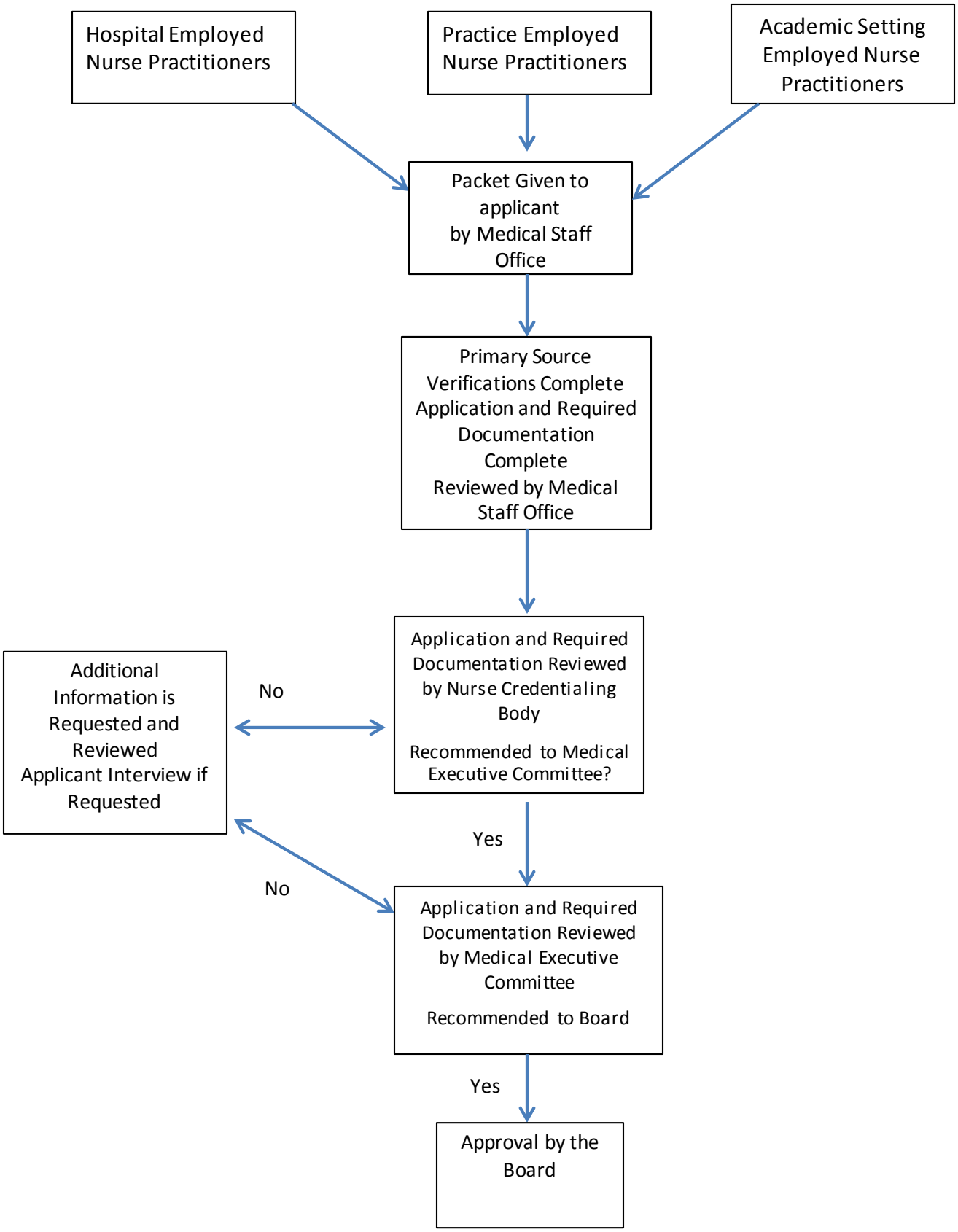

Hospital Employed Nurse Practitioners
Practice Employed Nurse Practitioners
Packet Given to Applicant by Medical Staff Office Personnel
Primary Source Verifications Complete Application and Required Documentation Complete
Application and Required Documentation Reviewed by Nurse Credentialing Body
Recommended to Medical Executive Committee?
No
Additional Information is Requested and Reviewed Applicant Interview if Requested
Yes
No
Application and Required Documentation Reviewed by Medical Executive Committee
Recommended to Committee of the Board
Yes
Approval by the Committee of the Board

Appendix H

Site Two Process Map

(follows on next page)

Site # 2

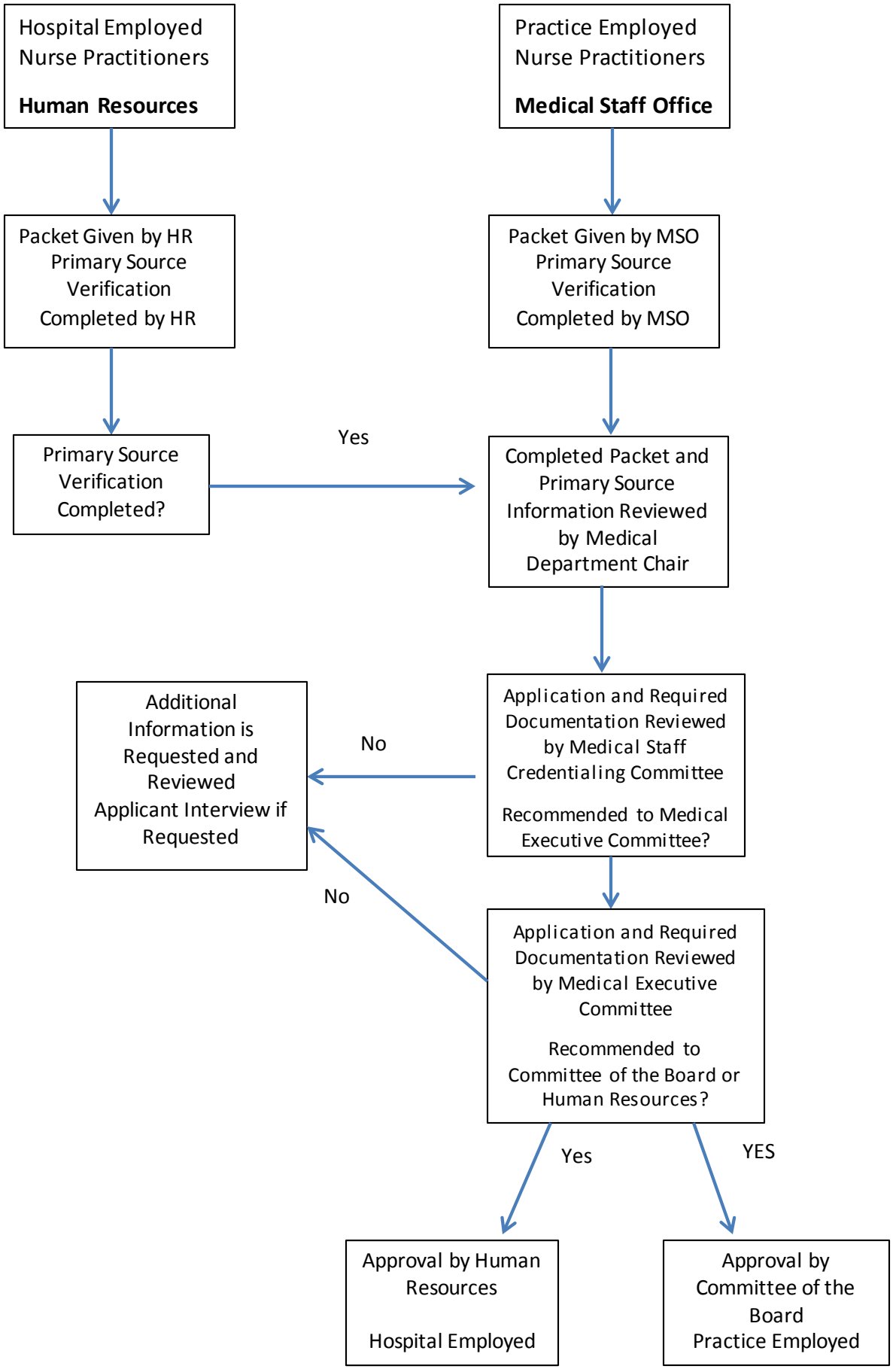

Hospital Employed Nurse Practitioners
Practice Employed Nurse Practitioners
Academic Setting Employed Nurse Practitioners
Packet Given to applicant by Medical Staff Office
Primary Source Verifications Complete Application and Required Documentation Complete Reviewed by Medical Staff Office
Application and Required Documentation Reviewed by Nurse Credentialing Body
Recommended to Medical Executive Committee?
No
Additional Information is Requested and Reviewed Applicant Interview if Requested
Yes
No
Application and Required Documentation Reviewed by Medical Executive Committee
Recommended to Board
Yes
Approval by the Board

Appendix I

Site Three Process Map

(follows on next page)

Site # 3


Hospital Employed Nurse Practitioners
Human Resources
Practice Employed Nurse Practitioners
Medical Staff Office
Packet Given by HR Primary Source Verification Completed by HR
Packet Given by MSO Primary Source Verification Completed by MSO
Primary Source Verification Completed?
Yes
Completed Packet and Primary Source Information Reviewed by Medical Department Chair
Additional Information is Requested and Reviewed Applicant Interview if Requested
No
Application and Required Documentation Reviewed by Medical Staff Credentialing Committee
Recommended to Medical Executive Committee?
No
Application and Required Documentation Reviewed by Medical Executive Committee
Recommended to Committee of the Board or Human Resources?
Yes
YES
Approval by Human Resources
Hospital Employed
Approval by Committee of the Board
Practice Employed