

Barriers and Facilitators for Successful Integration of Nurse Practitioners into Interdisciplinary

Care Teams

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The United States' expanding and aging population has highlighted the primary care provider shortage. As the Affordable Care Act (ACA) provides an opportunity for the previously uninsured to gain coverage, the disparity between those needing care and those able to provide the care grows. Although it is projected primary care physicians will increase by 8% between 2010 and 2020, the demand will increase by 14%, equating to a projected shortage of 20,400 physicians (Department of Health and Human Services [DHHS], 2013). This discrepancy has encouraged the healthcare industry and legislators to recognize nurse practitioners (NP) as a viable option. If nurse practitioners continue to enter the workforce at their expected rate, the primary care provider shortage could be reduced to 6,400 providers (DHHS, 2013). In many areas, unfortunately, the rapid evolution of the NP role has clashed with slow changing policies and a physician dominant healthcare culture. Resulting barriers, such as scope of practice limitations, payer policy restrictions, role ambiguity, and incivility, undermine the NP's autonomous practice (Stankovic, 2016). Without organizational change at both the educational and professional levels, optimal utilization of NPs will not be attained due to decreased job satisfaction, inefficient interprofessional care teams, and suboptimal patient care.

Problem Statement

A lack of nationwide consensus regarding NP practice has led to confusion and their improper utilization. As stated earlier, it is well established NPs will be the answer to the physician shortage, but organizations have proven ill-prepared to properly implement them (De Milt, Fitzpatrick & McNulty, 2011; Park, Athey, Pericak, Pulcini & Greene, 2016; Poghosyan, Nannini, Stone & Smaldone, 2013; Poghosyan, Boyd & Knutson, 2014). The state of

Massachusetts has been used as an example of the problems that can be encountered when NPs are not utilized to the full extent of their license, especially regarding payer policies (Hansen-Turton, Ware, Bond, Doria & Cunningham, 2013). Improper implementation of NPs as primary care providers and active members of a collaborative team places people at risk for reduced access to care, fragmented care, and increased financial burdens.

Study Purpose and Research Question

An interprofessional approach to patient care can inherently face conflict due to multiple professions from various backgrounds collaborating; this is magnified in the primary care setting where patient needs are often complex and diverse, requiring care from multiple disciplines (Stankovic, 2016). The purpose of this integrative review is to explore the barriers of successful NP integration to a healthcare team and any interventions to overcome these barriers. Research aims are to study the evidence related to autonomy, empowerment, and physician oversight on NP practice; role ambiguity and incivility in healthcare teams; and interventions at the educational and professional levels to promote successful integration. The goal of this author is to answer what are the potential barriers encountered and progressive interventions to implement when integrating NPs to a collaborative team (Stankovic, 2016).

Methods

This paper is an integrative review of the literature on the barriers and facilitators to NP integration to practice. An initial search in Google Scholar was used to help identify and categorize keywords and phrases. Key terms, such as *interprofessional collaboration; care teams; physician; nurse practitioner; autonomy; and incivility* were then used in various combinations and Boolean phrases in the CINAHL and Medline databases. Limits were initially set to narrow the search to primary sources published within the last five years; however, after an

adequate number of articles were found, the search was expanded to include articles within ten years. Two studies (Stewart, McNulty, Griffin & Fitzpatrick, 2010; Smith, 2008) exceed five years and are used to incorporate the theoretical framework into the research. Some Canadian studies were also used acknowledging that Canada has different legislation regarding NPs than the United States; however, they are utilizing them in similar ways as they also face a primary care physician shortage (Brault et al., 2014; Brown et al., 2011; Heale, Dickieson, Carter & Wenghofer, 2014; Sangster-Gormley et al., 2015). This author ensured all primary sources used were approved by the Institutional Review Board (IRB), and reviewed any conflict of interests disclosed by the authors to avoid bias. Studies that achieved rigor through diverse sampling and data analysis were prioritized; this included peer review of the data to prevent bias, creating themes of the data, audio recordings and verbatim transcription of the interviews, etc.

Theoretical Framework

Rosabeth Moss Kanter's Structural Empowerment Theory provides a framework for how healthcare organizations can empower their employees to achieve autonomy, cohesiveness, and quality patient care. Kanter's theory premises that regardless of individual propensities the specific characteristics of an organization can either inhibit or encourage optimal outcomes (Orgambidez-Ramos & Borrego-Ales, 2014). Structural empowerment is composed of formal and informal power; formal power is attained when employees exhibit extraordinary strengths and become visible through their job performance; informal power develops through alliances and relationships within the organization. Kanter delineates key components that relate to the success of an organization, which include opportunity, structure of power, and the organization's social component. Opportunity refers to the availability of forward movement, which may be through promotion or continuing education; structure of power is the ease in which an employee

can seek support and obtain resources through the informal and formal channels. Lastly, the social component denotes the importance of diversity within an organization to promote change and evolution (Smith, 2008). The absence of one or more of these components threatens the integrity of the organization's structural empowerment. Smith (2008) found project managers who are empowered display a greater commitment and loyalty to an organization. These findings can help organizations to better understand the important correlation between employee empowerment and productivity. Kanter's theory can be used as a conceptual framework for healthcare organizations to communicate to all members of the interprofessional team that their contributions are valid and essential.

Critique of Literature

Past Research

Overall, there is an abundance of research on the importance of NP autonomy and empowerment. Some research has shown, however, that these terms are not always interchangeable (Petersen, Keller, Way & Borges, 2015). A common theme was scope of practice laws, role ambiguity, and payer policies are the biggest barriers to NPs providing high quality, efficient care. Surprisingly, physician oversight did not always translate to less autonomy, and in fact one study found NPs felt more empowered having a physician to collaborate with (Petersen et al., 2015). The overall theme of the studies show that NPs who have open and trusting physician relationships, administrative support, and feel like their input is valued in decision making processes become proficient members of an interprofessional team (Poghosyan et al., 2013; Poghosyan et al., 2014; Stewart et al., 2010; Weiland, 2015). In regards to incivility in the workplace, the authors acknowledge that victims of abuse and professional burnout are more likely to participate in such a study because they have a vested interest

(Elmblad, Kodjebacheva & Lebeck, 2014; Small, Porterfield & Gordon, 2015); also, there is minimal research on effects incivility has on NPs specifically.

Autonomy and Empowerment Articles

Research on NP autonomy and empowerment is qualitative in nature, which can create bias and lack generalizability. Many articles consist of small, convenience samples and represent NPs from one state (Petersen et al., 2015; Poghosyan et al., 2013; Poghosyan et al., 2014; Stewart et al., 2010; Weiland, 2015). Unfortunately, the lack of national consensus regarding NP scope of practice laws makes it difficult to apply findings on a national level. Some studies obtained participants using a convenience sample from NPs attending a national conference with the intention of creating more valid and transferable results; however, the authors also note people who attend national conferences are often motivated and may have different perceptions (DeMilt et al., 2011; Maylone, Ranieri, Griffin, McNulty & Fitzpatrick, 2011; Park et al., 2016). Like most research on the nursing profession, many of the participants were Caucasian females (DeMilt et al., 2011; Maylone et al., 2011; Poghosyan et al., 2013; Stewart et al., 2010; Weiland, 2015); however, this is reflective of the national demographics where about 93% of NPs are female and about 86% are white or non-Hispanic (Chattopadhyay, Zangaro, & White, 2015). Petersen et al. (2015) and Poghosyan et al. (2014) had better representation of minorities with 81% and 69% Caucasian, respectively.

Multiple tools and surveys were used to measure NP autonomy and empowerment; all were validated and proved reliable by calculating Cronbach alpha coefficients, which resulted in a minimum score of 0.8 (DeMilt et al., 2011; Maylone et al., 2011; Petersen et al., 2015; Poghosyan et al., 2014; Stewart et al., 2010;). DeMilt et al., (2011) also used the Anticipated Turnover Scale (ATS) with a Cronbach alpha of 0.68 making it less reliable, which the authors

attribute to using a smaller sample size. Some researchers obtained data through group and individual interviews, and achieved rigor through a thorough and exhaustive analysis process (Brown et al., 2011; Weiland, 2015). Weiland (2015) and Poghosyan et al. (2013), achieved data saturation; the interviews were audio recorded and transcribed; and analysis of the data was given to a peer to review and detect any bias, all which creates trustworthiness and dependability. Furthermore, both studies demonstrated credibility and confirmability when the researchers contacted participants to review the data and ensure the analysis was reflective of their answers and feelings (Poghosyan et al., 2013; Weiland, 2015).

Team Conflict Articles

The pressure to create interprofessional care teams is relatively new within the healthcare industry; furthermore, how to properly implement NPs into these teams is somewhat uncharted territory. The rapid evolution of healthcare may render some older studies obsolete; for example, Brown et al. (2011) collected data in 2004-2005, which may no longer correlate to the current issues. This author, however, felt the study was relevant since it is one of the few studies that researched the functionality of an interprofessional team at the primary care level; also, important to note two studies took place in Canada where laws regarding NPs may differ (Brown et al., 2011; Heale et al., 2014).

Research on incivility experienced by NPs is limited. Elmlad et al. (2014) and Small et al. (2015), were the only two relevant, primary sources this author could find. Elmlad et al. (2015) only focused on certified registered nurse anesthetists (CRNA) and was limited to the state of Michigan, greatly decreasing transferability; Small et al. (2015) had many limitations, including the authors developing their own tool for the study without pilot testing. Technical malfunctions on the computer while administering the survey prevented the participants from

selecting certain answers. These limitations diminish the reliability and validity of the study.

Rainford, Wood, McMullen & Philipsen (2015) performed a systematic review of the literature on lateral violence within healthcare, and found that although lateral violence is prevalent within nursing, very little research has been done on NPs.

Synthesis of Literature

Barriers to Integration

Autonomy and empowerment. The phenomena of autonomy and empowerment are often used interchangeably; however, the meanings differ. For NPs, autonomy is the ability to practice to the full extent of their license, including prescriptive practice, and is legislative in nature. Empowerment; however, is achieved through the NP's ability to influence outcomes and effect positive change in patient care and their work environment. Although separate phenomena, autonomy and empowerment are highly linked concepts (Stewart et al., 2010).

Physician oversight. Autonomy is the cornerstone of the NP career; however, state by state legislation requiring various amounts of physician oversight have prevented NPs from practicing to the full extent of their license, which negatively impacts the NP role. Several studies have shown autonomy is vital to NP's job satisfaction and valuation (Poghosyan et al., 2013; Poghosyan et al., 2014; Stewart et al., 2010; Weiland, 2015). De Milt et al. (2011) surveyed NPs who stated they were planning on leaving their job, and one of the most common reasons reported was lack of control over their practice. To avoid burnout and a high turnover rate it is important organizations understand how NPs view autonomy.

Weiland (2015) surveyed nine primary care NPs to understand their interpretation of autonomy and reached data saturation after seven. The participant's shared meaning of autonomy is achieved when the NP acts independent of the physician and is alone with a patient

in the exam room; they see themselves as accountable to their patient not to the physician.

Although NPs typically see patients independently from a physician, several studies found that many NPs reported they share a panel with a physician regardless of the state's scope of practice laws; additionally, the majority of NPs do not have hospital admitting privileges leading to gaps in continuity of care (Park et al., 2016; Poghosyan et al., 2013; Poghosyan et al., 2014). Lack of follow up and required physician oversight can greatly impact empowerment and autonomy when legislation dictates physician supervision and takes away the NPs ability to collaborate as they see necessary (Weiland, 2015). Interestingly, Petersen et al. (2015), found NPs with physician oversight reported less autonomy, but had higher empowerment scores than NPs with less physician oversight.

The specific empowerment subscales with the most discrepancies were resources and informal power suggesting NPs see physicians as a valuable resource for acquiring equipment and tools necessary for quality patient care, but lack of physician presence can negatively affect empowerment when presented with less opportunity for a team based approach and collaboration. Stewart et al. (2010) found psychological empowerment results from a feeling of autonomy in the workplace; more specifically competence, self-determination, and impact on outcomes. It is important to understand the characteristics that lead to NP autonomy and empowerment as studies have found a positive correlation between NP autonomy and teamwork in primary care offices (Petersen et al., 2015; Poghosyan et al., 2014; Stewart et al., 2010). Structural empowerment increases communication, trust, and mutual respect among co-workers, which leads to lower job strain and increased collaboration. Maylone et al. (2011) surveyed NPs and found the vast majority felt they were well prepared with clinical knowledge and confident in providing direct patient care; however, empowerment was rated the lowest of all the subscales.

As NPs become involved in the team approach and decision making process their empowerment will be enhanced creating an effective cycle (Stewart et al., 2010).

Coinciding with Kanter's Structural Empowerment Theory, Weiland (2015) also uncovered a self-empowerment component that defined autonomy not only in the tasks NPs perform, but also in their ability to be a competent provider. Although NPs are restricted legislatively they can still view autonomy as the opportunity to fulfill their professional obligations to their patients, which can be intrinsically rewarding and genuine. Autonomy also increases through growth and educational opportunities, and through mutual respect and trust from peers (Weiland, 2015). Stewart et al. (2010) used the Psychological Empowerment Scale (PES) and found a positive correlation with the structural empowerment subscales of access to support; opportunity; and formal power. Formal power encompasses formal job characteristics including prominence, innovation, autonomous decision making, and an ability to utilize creative thinking in critical times; formal power positively correlated with the self-determination, impact and competence subscales on the PES. Therefore, the more flexibility and opportunities NPs have to apply their knowledge and training, the more autonomous they will feel.

Payer policies. As NPs advocate to obtain full practice authority across the nation, insurance companies are also contributing to the NP's inability to practice independently. Currently, Medicare reimburses NPs at 85% of the rate physicians are reimbursed for the same billing codes (DHHS, 2016). Park et al. (2016), found 53.4% of NPs, including those working in states with full practice and prescriptive authority, reported billing under a physician's provider number. Referred to as incident to billing, it is an attempt by organizations to avoid decreased reimbursement rates (Park et al., 2016). Incident to billing prevents NPs from billing under their own provider number, which causes an interruption in continuity of care; makes patient follow

up more difficult; and creates a gap in the research of NP performance and efficiency (Hansen-Turton et al., 2013; Poghosyan et al., 2013). Hansen-Turton et al. (2013) surveyed 258 health maintenance organizations (HMO) and found 74% of them qualified NPs as PCPs. The study then looked closely at 144 of the HMOs that credentialed NPs as PCPs and found only 27% reimburse NPs at the same rate as physicians. Interestingly, the authors used Massachusetts (MA) as a microcosm for the health care problems the nation is currently facing; after MA enacted their statewide health care reform many managed care organizations (MCO) refused to recognize NPs as PCPs, which left many newly insured patients unable to secure a PCP due to the physician shortage (Hansen-Turton et al., 2013). Ultimately, insurance reimbursement restrictions are causing NPs to be underutilized and placing patients at risk due to unavailable providers.

Team Conflict.

Role ambiguity. Another barrier to successful NP integration is a misunderstanding of how they contribute to the team. Lack of consensus between state legislation; confusion between NPs and physician assistants who do not practice under their own license, and overlapping duties of a physician and NP increase the risk for role ambiguity and team conflict. The rapid influx of NPs into health care has left organizations ill-prepared to implement them successfully. Studies have shown the majority of NPs feel there is a lack of understanding and support from their administration, which is often due to a lack of NP representation in the administrative role (Metzger & Rivers, 2014; Poghosyan et al., 2013). Brown et al. (2011) found when new professions are added to the team, and their roles and responsibilities overlap with other established members, insecurities surface and conflict enhances. Poor understanding of the role NPs serve can directly inhibit integration. One survey found acceptance of the NP role,

knowledge and abilities of the NP, and a supporting relationship with the physician are top factors to facilitating successful integration (Sangster-Gormley et al., 2015). The authors surveyed 68 co-workers of NPs, including administrators, nurses, physicians and medical assistants. Results show NPs are not duplicating tasks, and most believe NPs should have a broadened role that includes increased prescriptive authority and less restrictions on forms they can complete, such as disability paperwork. Overall, co-workers perceived collaboration and consultation to be very effective with NPs (Sangster-Gormley et al., 2015). Street and Crossman (2010) studied 563 physicians in Mississippi and found physicians who work closely with NPs have more favorable attitudes about them than those that do not have NPs in their practice; physicians who do not work with NPs, and do not fully understand their contribution to the healthcare team, perceive NPs as a liability, which increases their risk of being sued. Poghosyan et al. (2013) found role clarification as an important component to increased psychological empowerment, a concept discussed earlier.

It has become imbedded in our healthcare culture that physicians are the head of all patient care teams, and some physicians often describe themselves as solely being responsible for patient care and outcomes; however, healthcare has since shifted to a collaborative, patient centered approach which dictates that all members are responsible for the care they provide. Although physicians who have NPs in their practice recognize their ability to perform similar duties and attract new patients; physicians inexperienced with NPs believe they provide low quality care and are unnecessary for improving access to care (Street & Crossman, 2010). While many of the physicians studied understand the value NPs could provide to their practice, almost all rejected the idea that restrictions should be lifted off their licenses (Street & Crossman, 2010). The education provided to the NP, and their licensing body clarify their role and potential

contribution to the healthcare team; unfortunately, conflicting legislation, an underrepresentation of NPs in administrative roles, and a lingering physician dominant culture create conflicting messages to the NP and other healthcare members.

Incivility. Many studies have highlighted incivility within healthcare, and the detrimental effects it can have on the work environment and patient care (Brown et al., 2015; Elmlad et al., 2014; Small et al., 2015). Small et al. (2015) surveyed 2,821 nurses, including licensed practical nurses (LPN), registered nurses (RN) and advanced practice nurses (APN). Results showed 85% of participants reported verbal abuse, the most common being gossiping, blaming and accusing; 54% of these participants filed a formal complaint. Unfortunately, the majority who reported were unaware of the organizational policies regarding abuse, which most often resulted in a verbal reprimand. Although Small et al. found a correlation between advanced education and decreased instances of abuse, Elmlad et al. (2014) surveyed certified registered nurse anesthetists (CRNA) who reported moderately high levels of incivility from employees, nonemployees, and physicians; moderate levels from other CRNAs, and low levels from supervisors. Discord within the workplace can lead to employee burnout and team disruption which can inherently effect patient care, and ultimately cost to the organization (Elmlad et al., 2014).

Incivility within the healthcare system is a well-known problem. Brown et al., (2011) highlighted the barriers that perpetuate this behavior within primary healthcare teams. These barriers include time and workload constraints, subordinate positions, perception that reporting incivility will not make a difference, and avoiding inevitable discomfort felt by the confronted co-worker. Consistent with the theme of a traditionally physician dominated healthcare culture, one physician noted the one who has the power inherently has the responsibility. Disagreeing

with a physician who feels they did nothing wrong is going to be very difficult to resolve (Brown et al., 2011). Fear of causing an emotional disturbance is also important to note. Encouraging primary care organizations to formulate a team based approach to patient care requires increased collaboration and face to face time. Inherently, this can lead to an overlap of professional and personal relationships; therefore, the hesitancy to offend a co-worker by confronting them with a perceived wrong doing is understandable. Professional and personal lives become blurred making conflict resolution difficult, which often leads to avoidance (Brown et al., 2011).

Although, organizational policies are important when addressing incivility, identifying individual coping mechanisms is also helpful. Individuals can reduce conflict through open communication, and exhibit the willingness and humility to assume some of the responsibility in the conflict. In addition to face to face conversations, some attempt to change their behavior by focusing more on their work and their patients hoping to avoid being a target. Ultimately; however, avoidant behavior can lead to frustration and an escalation of conflict (Brown et al., 2011; Elmlad et al., 2014).

Facilitating Integration

Student collaboration. As healthcare pushes for an interprofessional team approach, professional education is slowly recognizing the important role they can play. As noted above, Street and Crossman (2010) found physician familiarity with NPs leads to positive attitudes. Universities can create an atmosphere of familiarity at the educational level by implementing simulation days with multiple disciplines. Also, all healthcare professions require a certain number of practical hours, which gives healthcare organizations an opportunity to coordinate interprofessional clinical experiences (Heale et al., 2014). In a study of NP's perceptions of interprofessional team functioning, participant's scores indicate they have a low perception of

their professional education preparing them to work in a team environment; even when training in the same facility they often practiced discretely (Heale et al., 2014). Most universities and clinical sites teach multiple disciplines making such an important intervention relatively seamless.

Organizational leadership.

Role ambiguity. Kanter (as cited in Smith, 2008) noted the purpose of management is to create a culture within an organization that promotes opportunities for development and the resources necessary to garner support and achieve goals. Organizations that clarify the definition and proper implementation of each team members' role will lead to quality, effective patient care. Administrators also need to be knowledgeable about the NP's scope of practice to properly assign patients and responsibilities. Assigning patients that required care out of the NP's scope of practice led to decreased autonomy, and increased physician collaboration. The most successful organizations used legislative practices and other members of the team to guide their decision making in patient assignments, which ultimately led to efficient patient care (Brault et al., 2014).

Heale et al. (2014) found that inadequate team functioning is most often attributed to organizational systems, including lack of orientation to care teams and time constraints to develop a cohesive team. Brault et al. (2014) developed valid interventions managers and administrators can implement to ensure a smooth transition to an interprofessional team. They found the most successful settings encouraged continuous communication, through both formal and informal meetings, to discuss any confusion about roles and responsibilities as they arise. Settings that used only documents prepared by the organization to clarify roles were ineffective. Other interesting and successful interventions were developing a matrix to visually show each

member's role and any overlap that may occur, and providing NPs an opportunity to lead special projects or clinics to serve their community and promote their distinct role and abilities (Brault et al., 2014). Such interventions encourage autonomy, which is consistent with recommendations from Stewart et al. (2010). Management should encourage empowering opportunities in the workplace to enhance the NP's feelings of meaning and the belief their work has an impact on their team and patients. Simple gestures, such as including NPs on business cards and other advertisements can also increase their psychological empowerment (Brault et al., 2014; Metzger & Rivers, 2014).

As discussed above, there is a need for more advanced practice nurses (APN) to enter administrative roles; most NPs are under the management of an RN and receiving clinical input from physicians (Metzger & Rivers, 2014; Poghosyan et al., 2013). APNs in an administrative leadership role could actively be involved in the hiring process of NPs to ensure proper job qualifications are being met, and there is a smooth orientation to the organization and their policies regarding NP practice. APNs who represent NPs within the organization can reduce errors in credentialing paperwork, draft proper practice agreements, and stay current on scope of practice laws (Metzger & Rivers, 2014).

Incivility. As discussed earlier, individuals can address incivility on a case by case basis; however, it is vital that organizations develop team strategies for handling conflict. Brown et al. (2014) found that teams were often lead by physicians, which made dealing with conflict difficult due to time constraints. The authors suggested an administrative role with no clinical obligations may be better suited for the position to develop conflict resolution protocols. Elmblad et al. (2014) and Small et al. (2015) agreed educating the staff on policies regarding any kind of abuse or incivility should be a priority; team building workshops and administrative

visibility were also suggested. Several studies stress the importance of team building through frequent formal and informal meetings, which may create an atmosphere to openly and comfortably discuss conflict as it comes (Brault et al., 2014; Brown et al., 2014; Elmblad et al., 2014; Heale et al., 2014). Rainford et al. (2015), noted that as NPs enter the workforce and gain independent practice the hierarchal culture of healthcare shifts, which allows nurses to be viewed as members of a collaborative team. NPs are in a unique position to advocate for nurses by entering leadership roles and implementing policies addressing workplace incivility (Rainford et al., 2015).

Discussion

Implications for Practice

Although the research has some limitations, the findings can have a profound impact on APRN practice. Healthcare has shifted to a more patient centered model, which is evident by the development of Accountable Care Organizations and Patient Centered Medical Homes. Although all of healthcare is expected to participate in interprofessional collaboration, focus is placed on primary care to be the leader of these teams. An interprofessional team approach can inherently face conflict due to multiple professions from various backgrounds collaborating; this is magnified in the primary care setting where patients are often complex and diverse, requiring care from multiple disciplines (Stankovic, 2016). Healthcare organizations can greatly impact the quality of care their employees provide by creating a culture of empowerment and autonomy within the workplace. This can be achieved through optimization and understanding of the NP scope of practice, clearly outlining each member's role, and organizing formal and informal team meetings (Brault et al., 2014; Smith, 2008; Stewart et al., 2010; Weiland, 2015). On an individual level, NPs should understand the importance of advocating for their right to practice

to the full extent of their license; ideally, this should be introduced during their professional education. State regulations and insurance restrictions on NP practice inhibit them from fully using their advanced knowledge and skills, which can threaten their perception of autonomy. Several studies have shown the effects an autonomous role can have on NP practice (Poghosyan et al., 2014; Stewart et al., 2010; Weiland, 2015). Implementing policies for interprofessional collaboration at both the educational and professional levels can lead to positive progression within the new healthcare world.

Implications for future research

The original intent of this author was to study the effects workplace incivility had on integrating NPs into an interprofessional team; however, autonomy and empowerment were the two most prevalent themes. It is well known incivility exists in nursing indicating a potential gap in the literature regarding NPs and lateral violence. This research revealed one of the most proficient ways to overcome collaboration barriers is to integrate NPs into organizational leadership roles; management is often lead by registered nurses or physicians and health care could benefit from more research in this area.

Conclusion

In conclusion, implementing Kanter's Theory of Structural Empowerment within professional and educational healthcare organizations can lead to the development of policies and protocols for administrators to implement, which would benefit all members of the healthcare team. Increasing NP's autonomy through inclusion in care team meetings, role clarification, proper patient assignments, and formal procedures for integrating new members to the interprofessional team can greatly reduce any apprehension, conflict, or redundancy. As

more patients seek access to care it is the healthcare system's responsibility to ensure they are provided quality care through the proper utilization of all members of the healthcare team.

Reference

- Brault, I., Kilpatrick, K., D'Amour, D., Contandriopoulos, D., Chouinard, V., Dubois, C.,...
Beaulieu, M. (2014). Role clarification processes for better integration of nurse
practioners into primary healthcare teams: A multiple case study. *Nursing Research and
Practice, 2014*, 1-9. doi: 10.1155/2014/170514
- Brown, J., Lewis, L., Ellis, K., Stewart, M., Freeman, T., & Kasperski, J. (2011). Conflict on
interprofessional primary health care teams- can it be resolved? *Journal of
Interprofessional Care, 25*, 4-10. doi: 10.3109/13561820.2010.497750
- Chattopadhyay, A., Zangaro, G. & White, K. (2015). Practice patterns and characteristics of
nurse practitioners in United States. *Journal for Nurse Practitioners, 11*(2), 170-177.
- De Milt, D., Fitzpatrick, J. & McNulty, S. (2011). Nurse practitioners' job satisfaction and intent
to leave current positions, the nursing profession, and the nurse practitioner role as a
direct care provider. *Journal of the American Academy of Nurse Practitioners, 23*,
42-50.
- Department of Health and Human Services, Centers for Medicare and Medicaid Services.
(2016). *Advanced practice registered nurses, anesthesiologist assistants, and physician
assistants*. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicre-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf>
- Department of Health and Human Services, National Center for Health Workforce Analysis.
(2013). *Projecting the supply and demand for primary care practitioners through 2020*.
Retrieved from

<http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf>

- Elmblad, R., Kodjebacheva, G. & Lebeck, L. (2014). Workplace incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed interventions. *American Association of Nurse Anesthetists Journal*, 82(6), 437-445.
- Hansen-Turton, T., Ware, J., Bond, L., Doria, N., & Cunningham, P. (2013). Are managed care organizations in the United States impeding the delivery of primary care by nurse practitioners? A 2012 update on managed care organization credentialing and reimbursement practices. *Population Health Management*, 16(5), 306-309.
- Heale, R., Dickieson, P., Carter, L. & Wenghofer, E. (2014). Nurse practitioners' perceptions of interprofessional team functioning with implications for nurse managers. *Journal of Nursing Management*, 22, 924-930.
- Maylone, M., Ranieri, L., Griffin, M., McNulty, R., & Fitzpatrick, J. (2011). Collaboration and autonomy: Perceptions among nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 23, 51-57.
- Metzger, R., & Rivers, C. (2014). Advanced practice nursing organizational leadership model. *The Journal for Nurse Practitioners*, 10(5), 337-343.
- Orgambidez-Ramos, A. & Borrego-Ales, Y. (2014). Empowering employees: structural empowerment as antecedent of job satisfaction in university settings. *Psychological Thought*, 7(1), 28-36.
- Park, J., Athey, E., Pericak, A., Pulcini, J., & Greene, J. (2016). To what extent are state scope of practice laws related to nurse practitioners' day-to-day practice autonomy? *Medical Care Research and Review*, 1-22.

- Petersen, P., Keller, T., Way, S., & Borges, W. (2015). Autonomy and empowerment in advanced practice registered nurses: Lessons from New Mexico. *Journal of the American Association of Nurse Practitioners*, 27, 363-370.
- Poghosyan, L., Nannini, A., Stone, P., & Smaldone, A. (2013). Nurse practitioner organizational climate in primary care settings: Implications for professional practice. *Journal of Professional Nursing*, 29(6), 338-349.
- Poghosyan, L., Boyd, D., & Knutson, A. (2014). Nurse practitioner role, independent practice, and teamwork in primary care. *The Journal for Nurse Practitioners*, 10(7), 472-479.
- Rainford, W., Wood, S., McMullen, P., & Philipsen, N. (2015). The disruptive force of lateral violence in the health care setting. *The Journal for Nurse Practitioners*, 11(2), 157-164.
- Sangster-Gormley, E., Griffith, J., Schreiber, R., Borycki, E., Feddema, A. & Thompson, J. (2015). Interprofessional collaboration: Co-workers' perceptions of adding nurse practitioners to primary care teams. *Quality in Primary Care*, 23(3), 122-126.
- Small, C., Porterfield, S. & Gordon, G. (2015). Disruptive behavior within the workplace. *Applied Nursing Research*, 28, 67-71
- Smith, S. (2008). The impact of structural empowerment on project manager's organizational commitment. *Journal of Academy of Business and Economics*, 8(1), 1-7.
- Stankovic, L. (2016). *Barriers and facilitators for successful integration of nurse practitioners into interdisciplinary collaboration*. Unpublished manuscript, School of Nursing, MCPHS University, Worcester, MA.
- Stewart, J., McNulty, R., Griffin, M., & Fitzpatrick, J. (2010). Psychological empowerment and structural empowerment among nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 22, 27-34.

Street, D. & Crossman, J. (2010). Does familiarity breed respect? Physician attitudes toward nurse practitioners in a medically underserved state. *Journal of the American Academy of Nurse Practitioners*, 22, 431-439.

Weiland, S. (2015). Understanding nurse practitioner autonomy. *Journal of the American Association of Nurse Practitioners*, 27, 95-104.