NURSING PROFESSIONAL DEVELOPMENT IN
AMBULATORY CARE: WHAT IS IT?

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by
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DEDICATION

I am dedicating this dissertation to the nursing professional development community. This research was a labor of love, undertaken on behalf of all NPD practitioners who work in ambulatory care spaces. I hope our specialty finds it useful.

This dissertation would not have been possible without the love and support of my husband John; my children, Katrina and Jared; and my sisters, Sara and Susanna. They have provided strength and encouragement when I most needed it. They have stood by me through every phase of this journey, and completing this dissertation is not just my accomplishment, but ours.

Many others have supported me through this project, with love, prayers, and kindness. Although I cannot hope to name them all, I must acknowledge two groups of people. First, the ladies of my church have supported me with endless hugs, prayers, and encouragement. Second, the owners and staff of Connection Café and Literatus and Co., two of Watertown’s locally owned coffee shops, provided me with places of refuge where I spent countless hours reading, writing, and analyzing data. The space and atmosphere they provided greatly enhanced my ability to complete this work. I am thankful for the whole community of people who supported my work on this dissertation.

Finally, I would like to thank God. In I Corinthians 4:7, we read “What hast thou that thou didst not receive? Now if thou didst receive it, why dost thou glory, as if thou hadst not received it?” (KJV). I gratefully acknowledge that both the ability and the desire to do this work were given to me by God, and it is the grace of God that has brought me to the end of this project and the beginning of a new chapter.
ACKNOWLEDGEMENTS

Many people have contributed to this work. Foremost among these, I would like to thank my advisors, Dr. Amy Vogelsmeier and Dr. Laurel Despins. Their excellent guidance and mentorship has been crucial to the success of this study. I also want to thank the other members of my committee, Dr. Gina Oliver and Dr. Debbie Dougherty, who provided expertise related to nursing education and phenomenology, respectively. The wisdom and support of all my committee members has been invaluable to my dissertation research.

I also want to acknowledge the support of three professional organizations. The Association for Nurses in Professional Development and the American Academy of Ambulatory Care Nurses provided critical assistance in recruiting a sample of participants with the necessary experience to address the aims of this study. The Alpha Iota chapter of Sigma provided the necessary funding for this study. All three organizations were important to the success of this research.

Finally, I want to acknowledge the study participants for sharing their time and experience. This research could not have been done without their generosity. To the extent this study fills the gap in literature about nursing professional development in ambulatory care, it will be because of these nine nursing professional development practitioners.
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NURSING PROFESSIONAL DEVELOPMENT IN AMBULATORY CARE: WHAT IS IT?

Elizabeth Fritz

Drs. Amy Vogelsmeier and Laurel Despins, Dissertation Supervisors

ABSTRACT

Nursing professional development (NPD) practitioners play an important role in ensuring the quality and safety of nursing care and in guiding nurses through practice transitions. In recent years, an increasing number of NPD practitioners have been employed in ambulatory care settings, yet little is known about how the ambulatory practice setting affects or is affected by NPD practice. The aim of this descriptive phenomenology was to describe how the NPD role is experienced in the ambulatory care setting.

Nine NPD practitioners working in ambulatory care were interviewed. Data were analyzed using Priest’s method for descriptive phenomenology. Three themes emerged: Features of the ambulatory care setting that affect NPD practice; same, but different; and these are my people. The findings provide a rich description of NPD practice in ambulatory care, with implications for NPD practitioners in ambulatory care and the organizations that employ them. Results from this project will be used to design future research on optimizing NPD practice to improve nursing care in ambulatory settings.
Chapter 1: Introduction

The specialty of Nursing Professional Development (NPD) is devoted to the professional growth and development of nurses and other healthcare professionals. NPD practitioners (NPDPs) provide education and competency management to support nurses and other clinical staff in delivering safe patient care and meeting regulatory requirements (Harper & Maloney, 2016). While the NPD specialty was founded in 1928 (Maloney & Woolforde, 2019), the science underlying NPD practice remained scarce for many years. Since the 1989 inception of the National Nursing Staff Development Organization, now known as the Association for Nursing Professional Development (ANPD), NPD practice has been studied much more extensively (Maloney & Woolforde, 2019), leading to publication of the research-based NPD Practice Model in 2016 (Harper & Maloney, 2016). The NPD specialty can be practiced in any setting where nurses work, but nearly all research on NPD practice has been conducted in hospital settings. More recently, efforts have begun to expand the literature of the specialty to diverse practice settings (Association for Nursing Professional Development, 2017; Fritz, 2018; Harper, Aucoin, & Warren, 2016).

Ambulatory care (AC) nursing is described as a unique specialty focusing on primary and specialty care of patients, both as individuals and as members of populations. Ambulatory care nursing is practiced in non-acute settings and includes telehealth and virtual environments (American Academy of Ambulatory Care Nursing, 2020). Recent changes in American health systems and payment models are leading more nurses to work in AC settings, while simultaneously driving an expansion of nursing responsibilities within AC settings (Larson et al., 2017; Paschke, 2017). These changes
include a shifting emphasis from illness care toward preventive care and a commensurate shifting of wellness-oriented responsibilities from providers to registered nurses, as part of a move toward ensuring nurses work to the highest level of their education and licensure. Preventive measures that are increasingly performed by nurses include interventions like group coaching for management of chronic conditions, medication reviews, and completion of Medicare wellness visits. (Bauer & Bodenheimer, 2017). Such changes in the environment of AC nursing contribute to an increased need for NPD support (Fritz, 2017a; Moorer & Kirkley, 2019).

NPD practitioners play a critical role in supporting nurses to provide high quality, safe nursing care (Harper et al., 2016). Understanding how the NPD role is enacted in the AC setting is important to enable NPD practitioners to support ambulatory care nurses effectively. Well supported nurses will be better prepared to deliver safe and effective care to the public (Harper and Maloney, 2016). Lack of research on how NPD work is conducted in the ambulatory setting limits the ability of NPD practitioners to transition into AC settings to provide the necessary support.

**Problem Statement**

NPD practitioners increasingly work in AC settings such as outpatient clinics, yet little is known about how they enact their role to influence nurses and other clinic staff in patient care delivery (Association for Nursing Professional Development, 2017). The NPD specialty fulfils a critical role in ensuring nurses have the requisite knowledge and skills, both upon entry into nursing and on an ongoing basis throughout their careers. The practice of NPD encompasses six key responsibilities (Harper & Maloney, 2016; Rheingans, 2016); education, orientation and onboarding, competency management,
collaborative partnerships, role development, and research/evidence-based practice/quality improvement.

Nurses and other clinical staff working in AC settings need the same access to NPD support as hospital-based nurses (Moorer & Kirkley, 2019), yet it is unknown whether NPD practitioners provide the same level of support to nurses in the AC practice setting. There is very little literature about the practice of NPD in outpatient settings, but the sources that tangentially mention this issue (Fritz, 2017a; Moorer & Kirkley, 2019; Warren & Harper, 2017) hint at distinct differences that require adjustments in NPD practice, including a different mix of staff skill levels, different workflows, and different challenges faced in patient care. Research to delineate the NPD role was primarily conducted with hospital-based NPD practitioners (Warren & Harper, 2017). Additional research is needed to clarify how the AC setting affects implementation of the six responsibilities of the NPD role.

To describe NPD practice in AC, a descriptive phenomenology using Priest’s data analysis method was proposed. This approach is particularly well-suited to provide understanding of phenomena that have not been previously studied, as it uses the lived experiences of those who are directly involved with the phenomenon of interest to provide insight into the essence of that phenomenon (Matua & Van Der Wal, 2015). The NPD Practice Model (Harper & Maloney, 2016) provided the framework for semi-structured interviews to explore how NPD practice occurred in AC, with particular attention to those aspects of NPD practice that were unique to the AC practice setting.

**Study Purpose**
This study was a descriptive phenomenology (Bevan, 2014; Dowling, 2007; Priest, 2003) using the NPD Practice Model (Harper & Maloney, 2016) as a guiding framework. The study premise was that NPD practice has distinct yet poorly understood characteristics within the AC setting. Therefore, the purpose of this study was to provide a rich description of NPD practice in AC to guide NPD practitioners in supporting these staff to provide safe, high quality care. Participants who had experience as NPD practitioners in both acute and ambulatory care were recruited since they were expected to have the best ability to identify characteristics unique to the AC setting that influence NPD practice.

**Specific Study Aims**

Aim 1: Describe AC NPD practice in the context of the broader NPD specialty.

Research Question 1: How is NPD practiced in AC?

Research Question 2: How does NPD practice in AC fit within the broader context of the NPD specialty?

Research Question 3: How do NPD practitioners perceive their role’s influence on the practice of AC staff?

Aim 2: Identify areas in which NPD practice in AC diverges from NPD practice in acute care, if such areas exist.

Research Question 4: How do NPD practitioners who have worked in both acute and AC describe the differences in practice between settings?
Chapter 2: Literature Review

Nursing Professional Development

Nursing professional development (NPD) is one of nearly 40 nursing specialties recognized by the American Nurses Association (American Nurses Association, 2021). NPD is concerned with the ongoing professional role development of nurses and other clinical care staff (Harper & Maloney, 2016). The Nursing Professional Development Scope and Standards of Practice (3rd ed.) lists seven roles and six responsibilities of NPD practitioners. The roles are learning facilitator, change agent, mentor, leader, champion for scientific inquiry, advocate for NPD specialty, and partner for practice transitions. The responsibilities are onboarding/orientation, competency management, education, professional role development, research/evidence-based practice/quality improvement, and collaborative partnerships (Harper & Maloney, 2016, p.16-20). Together, these roles and responsibilities make up the defining characteristics of the scope and standards of practice for the NPD specialty.

Although there is no published estimate of how many NPD practitioners currently practice in this specialty, the Association for Nursing Professional Development (ANPD) has nearly 5,000 members (Maloney & Woolforde, 2019). Additionally, there are 61 local affiliates currently listed on ANPD’s website (ANPD, 2021). There is growing interest in developing the scope and visibility of the NPD specialty in countries outside the United States, (J. Floro and Z. Youl, personal communication, November 15, 2019).

Ambulatory Care Nursing
Ambulatory care is a growing nursing specialty practiced in non-acute care settings, including telehealth and virtual patient care environments (American Academy of Ambulatory Care Nursing, 2020). In contrast to the illness focus of acute care nursing (Mason, 2016), AC nursing focuses heavily on prevention, wellness, management of chronic conditions, and population health (Fritz, 2017a; Jessie & Swan, 2017). In her 2016 article, Allen reported that patient care was shifting from inpatient to outpatient settings, thus increasing the need for highly skilled and supported nurses in ambulatory care settings.

Recent literature has highlighted a growing need for NPD support in AC settings. Allen (2016) emphasized the need for better orientation, onboarding, and competency verification of new AC nurses. Batiste (2018) also wrote of increased need for competency management and education, both initial and ongoing, for ambulatory care staff. She attributed these needs to increased patient care volumes in the AC setting. In late 2017 and early 2018, Nursing Economic$ published a three-part series on the growth of transition to practice programs in ambulatory care (Jones-Bell et al., 2018; Levine, 2017; More, 2017), in recognition of the increasing number of nursing jobs in AC. The growth of AC nursing is driving an increased need for NPD support in AC.

**Conceptual Framework: NPD Practice Model**

The NPD Practice Model was published in the 3rd edition of the *Scope and Standards of Practice for Nursing Professional Development* (Harper and Maloney, 2016), and has been used extensively since then in publications related to the NPD specialty (Cobb, 2017; Harper, Burke, Keim, Morgan, & Maloney, 2019; Harper,
Warren, Bradley, Bindon, & Maloney, 2019). The model is shown below, used with permission. Although phenomenology does not typically use a guiding framework or theoretical model because its purpose is to let the experiences of participants speak for themselves (Willis et al., 2016), the throughputs of the NPD Practice Model were used to provide the structure of the interview guide. This model offers a means of understanding the core functions of the nursing professional development specialty (Price, 2017). Use of the model in structuring interviews allowed results of the study to be contextualized within the broader sphere of NPD practice.

The NPD Practice Model was designed using a cyclical systems model (Katz & Kahn 1978). The model contains inputs drawn from the interprofessional practice and learning environment, throughputs reflecting the work done inside the system, and outputs being released into the environment. In responding to the outputs of the system, the environment is altered and the cycle begins again. The six throughputs of the NPD Practice Model are education, competency management, onboarding/orientation, collaborative partnerships, role development, and research/evidence-based practice/quality improvement. Together, these six throughputs represent the core of NPD
Orientation/Onboarding

Onboarding/orientation refers specifically to the education, competency verification and deliberate socialization of new employees during their first weeks in the organization. Onboarding/orientation is a common topic for NPD research and innovation, with the two terms often used interchangeably in the literature. Slate et al. reported on a robust longitudinal study to identify elements that contribute to successful orientation, particularly for new graduate nurses (2018). Rogers and Burke (2021) examined methods to promote learner centered orientation using a broad range of approaches. Other NPD practitioners have published on onboarding innovations ranging from use of immersive virtual reality (Zackoff et al., 2020) to escape rooms (Gates & Youngberg-Campos, 2020) to pandemic-driven virtual onboarding (Dale-Tam &
Thompson, 2021; Weiss et al., 2021). As a key component of the NPD Practice Model, onboarding/orientation is a very common subject of NPD research and publication.

Despite the widespread availability of literature on onboarding and orientation of nursing staff, there is surprisingly little literature devoted to onboarding/orientation in AC. In 2016, Allen published a study that highlighted the need for better orientation in AC. Three years later, Simpson and Lau reported there was still scant literature on AC nursing orientation (2019). With the increase in AC nursing, the lack of research available to support development of high quality orientation programs in AC settings represents a significant gap in the literature.

**Education**

Education refers to items like staff in-services, web-based training modules, tip sheets, and other stand-alone education provided to nurses or other clinical staff. Educational content development in NPD begins with identification of the practice gap and learning needs assessment (Pilcher, 2016). Once the gap between the desired state (knowledge, skills, or attitudes) and current state has been clearly identified, the NPD practitioner also needs to determine the source of the gap. Education is often requested for gaps that are caused by process problems or behavior issues rather than educational deficiencies (Grey, 2017). Careful assessment of the learning need is a critical precursor to NPD curriculum development. Once the NPD practitioner has verified that a learning need exists, curriculum is developed using defined learning objectives as a framework (Moore-Gibbs & Munn, 2020).
Batiste (2018) documented an increased need for AC staff education in recent years. She attributed this to increased patient acuity and patient volumes in AC settings. Likewise, Mills and Kanaskie (2019) reported a need for staff training secondary to recent growth in nursing roles in AC.

**Competency Management**

Like orientation/onboarding, competency management is a common subject within NPD literature. The term competency management refers to ongoing competency verification, including competencies required by regulatory agencies and accrediting bodies. Boyer et al. (2019) conducted a modified Delphi study to identify the necessary elements of a robust competency program. Others have studied common challenges related to competency management, such as evaluation of competency (Vanderzwan et al., 2020), tracking of competency completion (Hickerson et al., 2018), and differentiation between competency and education (Coughlin et al., 2021). The Donna Wright Model of competency evaluation (Wright, 2005; Wright, 2015) has become prominent within the NPD community in the last few years, valued for its learner-centered approach and its alignment with adult learning theory (Durkin, 2019; LaFlamme & Hyrkas, 2020).

As with onboarding/orientation, AC literature on competency management lags behind hospital-based literature. Batiste (2018) reported a growing need for development of competency management processes in AC due to the growth of nursing jobs in AC. In 2019, Simpson and Lau stated there was insufficient literature on ensuring nurse
competency in AC. There appears to be a need for more research on competency management in the AC setting.

**Collaborative Partnerships**

Collaborative partnerships in NPD include external partnerships such as academic-practice partnerships for the placement of pre-licensure students in clinical experiences and internal partnerships such as development of interprofessional continuing education, also known as IPCE (Harper and Maloney, 2016). Vnenchak et al. (2019) reported on a study evaluating the effects of an academic-practice partnership to provide a dedicated education unit for students. Holtschneider and Park have written about the value of collaboration to provide IPCE (2020). Emerging literature from AC documents increasing interest in academic practice partnerships to provide nursing students with clinical experiences in the AC setting (Fritz et al., 2020; Hooper-Arena et al., 2020).

**Role Development**

Role development most often refers to programs designed to help nurses grow into expanded responsibilities. In a groundbreaking study on the evolving nature of the NPD specialty, Warren and Harper (2017) found that role development has become one of the most important and time-consuming components of NPD work throughout the United States. They concluded this emphasis on role development as a core NPD activity was likely to continue, as NPD practitioners were increasingly called upon to help nurses navigate changing roles and practice settings. Currently, some of the most common types
of role development programs led by NPD practitioners are transition to practice programs (also known as nurse residencies) and preceptor training programs.

Transition to practice (TTP) programs have become popular since the publication of the Institute Of Medicine *Future of Nursing* report (Institute of Medicine, 2011), advocating for such programs to facilitate entry of nurses into new practice settings. While nurse residency programs traditionally were reserved for new graduate nurses, recent literature has documented a trend toward expanding residencies to practice transition for experienced nurses who are changing specialties (Warren & Harper, 2017), including entering AC (Fritz, 2017a; Moorer & Kirkley, 2019).

Preceptor training and support programs often include elements found in leadership development programs (giving feedback, conflict resolution) along with elements related to education, professionalism, teaching critical thinking (Kennedy, 2019; McKinney & Aguilar, 2020), and facilitating development of professional identity (Yee Mun & Crossman, 2015). In 2021, Harper et al. published the findings of a national preceptor practice analysis, which supported the validity of the Ulrich preceptor model (Ulrich, 2019) across multiple practice settings, including ambulatory care. Other recent literature has highlighted development of new preceptor training programs in AC (Fritz, 2020; Mills & Kanaskie, 2019).

**Research/EBP/QI**

The research/evidence-based practice/quality improvement throughput of the NPD Practice Model includes programs designed to increase nursing research outputs and facilitate use of evidence-based practice (EBP) and quality improvement (QI) in
clinical care (Harper & Maloney, 2016). Of the six throughputs of the NPD Practice Model, this may be the least well developed in the literature. In 2017, Harper et al. conducted a seminal study linking NPDP use of EBP to quality outcomes. This study identified a gap in NPDP competency related to effective use of EBP. In 2019, Harper and colleagues published a follow up report on actions taken by the Association for Nursing Professional Development to foster a spirit of inquiry among NPD practitioners (Harper et al., 2019).

Similarly, the journal of the American Academy of Ambulatory Care Nursing published a call for ambulatory care nurses to embrace a spirit of inquiry, highlighting the value of research and evidence-based practice in telehealth nursing (Koehne, 2018). Although the literature from AC nursing contains many reports of specific EBP and QI project implementations, there are few articles that broadly discuss the use of research, EBP, or QI in AC nursing. Only one article was found to address how NPDPs champion EBP use in AC (Fritz, 2017b). More research is needed to show how NPDPs in AC use research, EBP, and QI to improve patient outcomes.

**Significance to Nursing Practice**

Although recent literature indicates NPD practice is expanding in AC, both in numbers of NPD practitioners (Harper, Aucoin, & Warren, 2016) and in scope (Fritz, 2017a), the nuances of how NPD practitioners work in the AC practice setting remain unclear (Fritz, 2018). The lack of literature on NPD practice in AC makes this topic suitable for study using a descriptive phenomenological approach. The use of the NPD Practice Model in this study will allow results to be situated within the broader context of
the NPD specialty. This study is significant because it purports to explain the effects of the AC practice setting on the practice of NPD, which in turn affects the delivery of competent patient care in the AC setting.
Chapter 3: Methods

In this chapter, I discuss the process of recruitment, data collection, and analysis. I also explain the methods used to ensure the quality and rigor of the results. This study used descriptive phenomenology, drawing on the Husserlian tradition (Dowling, 2007) and employing Priest’s analytic method (2003) to generate a rich description of the essence of NPD practice in ambulatory care. The lived experience of NPD practitioners in the AC practice setting provided the lens through which the phenomenon was studied. The study used the NPD Practice Model as a framework to situate findings within the broader context of NPD practice. The six throughputs of the model are education, competency management, onboarding/orientation, collaborative partnerships, role development, and research/EBP/QI.

Setting/Sample

The setting for this study was ambulatory care organizations throughout the United States. Participants were drawn from the population of those who had experience in NPD in both acute and AC settings, as these NPDPs were expected to have the best ability to identify characteristics unique to the AC setting that influence NPD practice. It was also important to sample from as diverse a population as possible, in order to generate a rich and nuanced description (Willis et al., 2016). Settings from which participants were drawn included large and small organizations, academic and non-academic organizations, organizations offering both primary care and specialty care departments, urban and rural environments.
In this study, I used maximal variation sampling methods, with a goal of including representatives not only from varied work settings, but also from varied demographic groups. Potential participants were screened for diversity in ethnicity, gender, generation, educational preparation, certification status, longevity in the AC NPD role, and region within the United States. Although my goal was to maximize diversity, the respondents to my recruitment flyers were disproportionately white and female, and the final sample reflected that.

The sample size was ultimately determined by the number of participants required to reach data saturation, the point at which no new information was gained from new participants (Hamilton & Bowers, 2006). Data saturation is often reached in phenomenological studies with a sample size between 6 and 12 (Guest et al., 2006; Sim et al., 2018). In this study, data saturation was reached at 9 participants.

**Inclusion/Exclusion Criteria**

To be eligible for inclusion, participants had to be registered nurses who had worked at least one year at a minimum 0.5 FTE in outpatient NPD practice in the United States. Participants also had at least one year of prior experience practicing NPD in an acute care setting. Participants spoke English and consented to having their interviews recorded. NPD practitioners who did not speak English and who worked less than one year in acute and AC settings were excluded. Participants whose work was primarily in acute care but who also had ambulatory care responsibilities were excluded.

**Recruitment**
I conducted recruitment primarily via the Association for Nursing Professional Development (ANPD) and the American Academy of Ambulatory Care Nursing (AAACN). After obtaining permission from ANPD and AAACN leadership, I distributed study flyers by email to the membership of both organizations. I also emailed recruitment flyers to NPD practitioners who had previously expressed interest in this study during personal conversations. Recruitment flyers directed potential participants to an online survey where they were asked to answer a few demographic questions to determine study eligibility (see Appendix A for survey content). At the conclusion of the survey, potential participants were asked for their name, phone number, and email address so they could be contacted if they met inclusion criteria. From potential participants who completed the survey, I chose eligible participants for maximal variation in personal characteristics (race and ethnicity, gender, educational background, generation) and characteristics of the practice setting (size and structure of organization; specialties and roles supported; rural, suburban, urban, or mixed communities). Volunteers who did not meet eligibility criteria were notified by email that they were not needed for the study.

Data Collection

After verifying eligibility criteria, I scheduled each participant’s interview. Nine participants were interviewed for this study, using Zoom meeting technology (Archibald, et al., 2019). Interviews ranged in length from 26 minutes to 65 minutes. I conducted interviews from a private, quiet location. Several participants moved to private spaces shortly after logging in to the meetings. I obtained verbal consent for recording at the start of each interview. I conducted semi-structured interviews, using an interview guide with additional probing or clarifying questions as indicated during the interview (Bevan,
The interview guide for this study was derived from a pilot project completed in 2019 (see Appendix B).

**Data Management**

All interviews were recorded after I received verbal consent from the study participants. I transcribed each interview recording into an electronic file. I redacted all identifying information during transcription and assigned pseudonyms to participants to maintain anonymity. All recordings and transcriptions were kept on the secure University of Missouri Box repository, with access limited to members of the research team. A record of the demographic data provided by each participant was saved under the participant’s pseudonym, with the participant’s interview transcription. The list of participant pseudonyms was kept in a separate file from the study data. I compared the recordings with transcriptions to ensure accurate transcription.

**Data Analysis**

I analyzed the data using Priest’s method (2003), which draws on the descriptive phenomenology methods developed by Van Kaam, Colaizzi, Hycner, and Moustakas. Priest’s approach uses a streamlined, four-step method for data analysis (see Table 1). I previously used this approach in preliminary (unpublished) pilot work which included development of the interview guide.

I began the analysis with bracketing. Although Husserl’s original conception of bracketing called for suspension of all beliefs, modern nursing researchers typically describe bracketing as the suspension of all beliefs and preconceptions about the phenomenon of interest (Dowling & Cooney, 2012; Paley, 1997). To facilitate
bracketing, Priest’s method incorporates researcher experience with the phenomenon of interest into the initial description for future comparison with data from each participant (2003). I practiced NPD in a large multispecialty AC system from 2013-2020 and used that experience in developing the initial description of the phenomenon. This approach facilitated bracketing of my experience. After making assumptions, judgments, biases, and prior knowledge explicit, I was ready to compare new data from participants’ experiences with the original description and amend the description as needed. This approach is considered particularly useful when the principal investigator has experience with the phenomenon of interest (Johnston et al., 2017).

After generating the initial description, Priest’s method calls for an iterative process of incorporating data from each participant into the description of the phenomenon. Data collection ceases when additional interviews no longer contribute new insight into the phenomenon. This is data saturation (Guest et al., 2006). After transcribing each interview, I analyzed the interview data and updated the description to incorporate additional features and details about the experience of NPD practice in AC. Data saturation was achieved after nine interviews.

The final step of Priest’s method is member checking. Member checking with a subset of the sample is a common component of rigor and quality in descriptive phenomenology (Morse, 2015; Priest, 2003), as it enhances validity and trustworthiness (Morse, 2018). At the conclusion of their interviews, I asked participants if they were willing to review the results of the analysis. From those who consented to participate in member checking, I purposively selected Participants 1, 2, 4, and 8 for maximum variation of demographic characteristics and work settings (Teddlie & Yu, 2007) to
review the final description. I asked these participants to provide feedback on whether the
description accurately represented NPD practice in ambulatory care and how that practice
might differ from their acute care practice experience. Only two participants responded.
Both confirmed the results were an accurate reflection of their experience with NPD in
AC.
**Table 3.1**

*Priest’s Four Step Method of Data Analysis*

<table>
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<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>Step 1</td>
<td>Reflection and written description of phenomenon</td>
</tr>
<tr>
<td></td>
<td>Draw on knowledge and experience</td>
</tr>
<tr>
<td></td>
<td>Write an initial description of the phenomenon</td>
</tr>
<tr>
<td>Step 2</td>
<td>Repeated reading/listening to data from one participant.</td>
</tr>
<tr>
<td></td>
<td>Identify all relevant ideas</td>
</tr>
<tr>
<td></td>
<td>Consider all data equally valuable at first</td>
</tr>
<tr>
<td></td>
<td>Compare each statement to proposed description</td>
</tr>
<tr>
<td></td>
<td>Expand description as needed</td>
</tr>
<tr>
<td>Step 3</td>
<td>Repeat step two with data from each remaining participant.</td>
</tr>
<tr>
<td></td>
<td>Write a new description each time and expand as needed.</td>
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<tr>
<td>Step 4</td>
<td>Member checking</td>
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*Note: Steps are drawn from Priest, 2003*

Qualitative research methods should address issues of rigor and quality, including credibility, transferability, and confirmability (Peoples, 2021). To ensure the credibility of findings, I used prolonged engagement with the data and member checking. For prolonged engagement, I carefully viewed the recordings and compared them with the transcripts during the transcription phase. Then I immersed myself in the transcriptions, repeatedly reading and reflecting on the data throughout the analysis phase. For member checking, I sought feedback from participants to verify that my final description
accurately reflected their lived experience. Transferability refers to the degree to which findings may be useful to other members of the study population (Peoples, 2021). The experiences shared by study participants may be similar to experiences of other NPD practitioners who serve AC populations. I selected as diverse a sample as possible to increase transferability of the findings.

To ensure confirmability, I maintained an audit trail and reflexive journal in a research journal. The research journal contains a record of my conversation with the text (Morse, 2018). In my research journal, notes were recorded about issues that arose and how I handled them. Entries varied from notes about scheduling issues to the increased challenge of bracketing when a participant was a person I knew from previous professional collaborations. The process of keeping this journal promoted reflexivity, helping me think through issues as they arose and allowing me to confront my personal biases and preconceptions. Through these means, I believe I was able to protect the research findings from personal bias and focus on generating a description that showcases the essence of the participants’ lived experience with NPD practice in ambulatory care. The research journal for this study was maintained in a secure file with the data being analyzed.

**Challenges and Limitations**

One of the challenges of phenomenology is the difficulty in bracketing, which is an important component of rigor in this methodology because it allows the researcher to achieve a measure of distance and objectivity (England, 2016). This challenge was mitigated through purposeful reflection throughout the analytic process (Hamill &
Sinclair, 2010) as well as deliberate explication and bracketing of my prior experience (Johnston et al., 2017). In this study, my experience as an NPD practitioner in ambulatory care was incorporated into the initial description generated in step one. Subsequent data collection and analysis allowed for systematic examination and amplification of each point in the description.

Two related limitations were the fact that NPD practice in the AC setting is still evolving at a macro level across the country and the fact that individual organizational variables regularly change, influencing the day-to-day practice of NPD practitioners at the local, micro level. The nature of NPD practice in AC may change quickly as the American healthcare system continues to experience rapid structural changes. Likewise, organizational mergers and the adoption of new initiatives influence the work priorities of NPD practitioners. To address these limitations, the study focused on core elements foundational to NPD practice rather than specific details that are unique to an individual practice setting. The lived experiences of individual NPD practitioners provided insight into broader issues of practice within the AC setting.

A final challenge was the underrepresentation of men and minorities within the NPD community, and particularly within the AC NPD community. Recruitment strategies leveraged personal contacts with NPD practitioners who were involved in work to improve representation of men, minorities, and diverse practice settings within the NPD community. However, it was ultimately impossible to recruit participants with a full range of diverse perspectives. Although efforts were made to interview as diverse as possible a sample, readers should consider their own practice settings and populations
when transferring these findings to their practices. The general description of NPD practice in AC may provide helpful insights for NPD practitioners in the United States.

**Protection of Human Subjects**

The study proposal was approved by the Institutional Review Board of the University of Missouri. The study received an expedited review and was determined to present minimal risk to participants. All names of people, organizations, and locations were deidentified and participants were assigned pseudonyms, which were kept in a separate file from the data. Identifying information within the interview recordings was redacted during transcription. All recordings and transcriptions were kept on the secure University of Missouri Box repository, with access limited to members of the research team.
Chapter 4: Results

In chapter 4, I present the research findings. First, I describe the nine participants included in the study. Then I present the description of nursing professional development in the ambulatory care setting drawn from the participants’ interview data.

Participant Demographics

The sample contained nine NPD practitioners (NPDPs). These participants represented a range of geographic locations, years of experience in NPD in AC, generations, and practice environments. A full description of participant demographics is contained in Table 4.1.

I attempted to recruit participants from diverse regions of the country. However, no eligible participants from the Rocky Mountain region of the United States responded to requests for interviews. One participant from a Rocky Mountain state was interviewed but disclosed during the interview that she did not have the work experience recorded on her screening survey. Six people from the Pacific, Rocky Mountain, Southeast, and Northeast regions who initially screened as eligible did not respond to requests for interviews. The final sample is skewed toward the Midwest region (see Table 4.1).

The challenge of recruiting a diverse sample extended to educational preparation, gender, and race/ethnicity as well as geographic location. Although people with educational backgrounds ranging from Associate degree to Doctor of Nursing Practice responded to the screening survey, all participants who met eligibility criteria and responded to requests for interviews had a Master of Nursing Science degree. Most respondents to the screening survey identified as white. Of those who identified as Asian, Black, Hispanic, or Native American, none met the study’s eligibility criteria. Eight of
the nine participants identified as female and one as male. All participants were White, had a master’s degree, and most were female (89%).

**Findings**

The analysis yielded 19 codes, which I grouped into three themes. The codes and themes are presented in Table 4.2, which also maps the codes to the research questions. The themes are “features of the ambulatory care setting that affect NPD practice”, “same but different”, and “these are my people”. The theme “features of the AC setting that affect NPD practice” contains codes related to general characteristics of ambulatory care that influence the way in which NPD work is carried out. The theme “same but different” contains codes related to the throughputs of the NPD Practice Model, reflecting how the core responsibilities of NPD practice are enacted in the AC setting. Finally, the theme “these are my people” contains codes related to participant perspectives regarding their influence on and feelings about the AC practice environment.

**Features of the AC Setting That Affect NPD Practice**

The first theme, features of the AC setting that affect NPD practice, includes the codes focus on wellness rather than illness; many locations; complexity due to variety; regulation, accreditation, and clinical guidelines; mergers and growth; varying scope; and building trust with AC staff. Each of these codes describes a feature of the environment of ambulatory care that affects how NPD practitioners carry out their work.

**Focus on Wellness Rather than Illness**

When asked how their NPD practice changed in transitioning to AC from acute care, several participants highlighted a difference from illness focus in acute care to
prevention, wellness, chronic condition management and population health in AC.

Participant 8 said “The focus of the nurse is different. So, you know, I have to change my mindset.” Similarly, Participant 6 stated

Beyond just the actual sort of change in what I’m teaching, how I’m teaching also changes. And so, inpatient, when I teach, it’s very illness focused. And outpatient when I teach, it’s very wellness focused. And it’s very much to say, how do we optimize these people with chronic illness to live their best life? And it’s less about fixing a problem, and more about preventing a problem.

Participant 7 experienced this in reverse, transitioning at one point from the AC setting back to a hospital NPD position. She stated, “and I think that for me the transition was going from health promotion and prevention to not.” In addition to focusing on an individual patient’s health and wellness, some participants also described the AC setting as emphasizing community health, which informed the educational and professional development needs of clinical staff in AC. Participant 6 described it this way.

I think that that’s one of the things about AC that’s different. Is it’s, there’s a level of individual patient care that’s important…but there’s also a community level understanding of what’s going on that needs to inform our practice.

The emphasis on health promotion and illness prevention fundamentally alters the focus of the nurse and therefore also of the NPD practitioner who supports nursing in the AC setting. As a result of this change in focus, participants described a need for NPDPs in AC to emphasize more skills related to prevention and management of chronic conditions, and promotion of wellness within local communities.
Many Locations

Another element of the AC setting that influences the daily activities of NPDPs is the sprawling nature of many medical groups. Participants reported being responsible for professional development of staff in groups of clinics ranging from a single metropolitan area to five states. Most participants reported serving between 30 and 80 practices. AC NPDPs often navigate complex educational delivery issues caused by serving numerous locations across large areas. They must factor in travel time, time zone differences, and locations when planning on-site training and meetings. Participant 5 described setting aside three months each year to visit each of her organization’s 70 clinics in person: “on an annual basis, I meet with every clinic. Every clinic. Starting in August and then going clear through October, I set up meetings, I meet with every single one of the clinics.”

Moreover, AC NPDPs further describe relying on technology as a means of accommodating geographic constraints when planning educational offerings. For example, Participant 6 described using weekly virtual meetings to provide support and community for isolated nurses in more than 40 communities he supports.

For those nurses who have felt really left out, I’ve been able to sort of bring them into the fold. And say, you know, I know you work by yourself in [LOCATION], like underneath a mountain, but you have internet. And so, why don’t you join our weekly case conference where we’re gonna talk about different topics, we’re gonna present cases, and you’re gonna be able to participate.

Some participants indicated having multiple locations for training necessitated adaptations in some of the models used to support professional development in the acute
care setting. For example, Participant 1 said “I cannot lead the type of nurse residency program that I was leading inpatient that I’m able to lead with this AC system with our, with our geographic region.” For another example, orientation models that involve frequent face to face check-ins by the NPDP are not practical in large AC systems. Participant 4 said “Acute care, I had more direct contact with the staff. More day to day, um, observation of ‘This is what they need’…it was more personable. Um, in AC, it’s just such a wide area.” Participant 4 also talked about adjusting her schedule to make time to stop in at various clinics on her way home to check on new staff and students.

The number and locations of clinics within the NPDP’s scope of responsibility significantly affected the way NPD practice was enacted in AC. These features made in-person contact much more time-consuming in AC than in acute care, which resulted in reduced frequency of in-person contact between NPDPs and clinic staff and modified approaches to programs like nurse residency or orientation. NPDPs used technology to mitigate the challenges imposed by the distances between clinics and facilitate connections with AC staff in remote locations.

**Complexity Due to Diversity**

A third feature of AC NPD practice is the diversity of medical specialties and job roles supported by NPD practitioners in the outpatient setting, often with little or no experience in the specialties served. Participant 2 remarked “it’s just the diversity of locations, diversity, like I said, specialties of what is being offered in those locations is a big part of that change.” Participant 4 stated “We have a medical office pavilion here on the main campus that probably has everything…whatever it has is what I cover.” Similar
statements were made by six of the nine participants. For example, Participant 9

described supporting 26 primary care clinics as well as specialty clinics in cardiology,
pulmonology, headache and neuro, vascular, obstetrics and gynecology, allergy, ENT,
and endocrinology.

Participant comments highlighted the need to be aware of emerging guidelines
and best practices for the various specialties they support. Participant 1 provided an
example of this.

You know ACOG [American College of Obstetricians and Gynecologists] has
released…PAP [Papanicolaou smear] guidelines. There are some new PAP
guidelines that recently came out about, you know, based on this result or this
age, it used to be you had to follow this plan, now you can do that. So just like
okay, point person you know we are seeing, you know, these are the guidelines
that are coming out…What do we need to have in place to roll this out to our
teams, to update, you know, our follow up plans? To update our internal
algorithms for tracking those and then getting the information out to staff in ways
that they can take that in to impact and update their practice.

To further complicate the NPDP’s work, some participants reported not having
access to medical libraries or other resources needed to remain abreast of new and
changing evidence. Highlighting this, Participant 1 stated

But as well as external resources…you know, your inpatient hospital system
might be affiliated with a school. And so you have access to a lot of, like EBSCO
or CINAHL [journal databases] or journals or different things, and we don’t really have any of that.

As a result of limited access to resources, AC NPDPs report reliance on materials from professional organizations to support their practice both in the NPD specialty and in the varied clinical specialties they support. Participant 3 said “If you have multiple areas…you have to really stay on top of your game, so don’t stop reading and join your professional organization.” Similarly, Participant 8 said “if we’re having a problem we, we throw that out there either on AAACN [American Academy of Ambulatory Care Nursing] or on Magnet to try and, you know, get some outside things”. In reference to resources specifically for NPD practice, Participant 1 also reported relying on a professional organization, but she noted a lack of resources specifically addressing issues related to NPD practice in the AC setting.

So, connecting, you know, with ANPD [Association for Nursing Professional Development] has also been something that I’ve been able to do. But as we have discussed and a lot of those external resources or research data are often pretty geared towards inpatient NPD work …. There’s still just not the volume of research or information or stories out there for how to navigate it when you are just generally looking at different settings and circumstances than you are in inpatient.

In addition to working with many specialties, AC NPDPs often provide professional development services for staff in non-nursing and sometimes even non-clinical roles, such as front desk staff. One participant also reported supporting onboarding, competency management, and continuing education needs for provider roles.
Participant 1 said “the front desk, your registration team, it's medical assistants, LPNs (licensed practical nurses), the registered nurses, and then it’s our nurse practitioners, PAs (physician assistants), certified nurse midwives, and then I specifically also then work with physicians.”

Each role may have its own professional development and continuing education needs, requiring support for maintenance of credentials and competency. For example, speaking about medical assistants, Participant 9 said “and they’ve also asked for continuing education, so I’ve been talking to several people about trying to bring that into our organization. Likewise, Participant 5 stated,

What I was delivering to them in the educational frame had to change a little bit. It wasn’t just geared toward RN staff. I now have a whole radius of people that share a lot of tasks. And we, you know, I need to make sure that education is fitting for them as well.

Participants noted complexity due to the diversity of specialties served and roles supported. They described challenges in ensuring nurses and other staff kept their practices up to date with current evidence. They also described a need to provide continuing education in ways that fit a variety of clinic staff.

**Regulation, Accreditation, and Clinical Guidelines**

The influence of regulatory and accrediting bodies on NPD practice can be quite different in AC settings, particularly within clinics not physically attached to hospitals. These clinics are not required to adhere to The Joint Commission’s (formerly known as The Joint Commission for Accreditation of Healthcare Organizations, or JCAHO)
standards. Participant 7 noted “the education in the hospitals was more of…infection control. JCAHO standards.” By contrast, best practices and guidelines from state agencies, specialty-specific accrediting bodies, and other professional organizations may factor heavily in the education, competency, and professional development needs of AC staff. For example, Participant 3 said “We had competencies that were designed based on ONS [Oncology Nursing Society], which is our nursing organization, based on their recommendations.” NPDPs in AC must become familiar with an array of accrediting or regulatory bodies and best practice guidelines not typically relevant in the acute care setting.

**Mergers and Growth**

The majority of participants spoke about their roles in bringing in new practices or supporting staff through organizational expansions or mergers. Participant 4 said “This past year we onboarded seven different locations. So, I was in charge, or assisted with those.” Later she clarified these new medical practices resulted in approximately 100 new staff for her to onboard to her organization. The frequent mergers and additions of clinics increased the workload of participants, who reported being responsible for rapidly onboarding large numbers of staff.

While increasing workload, such expansions also resulted in growth of job opportunities for NPDPs in ambulatory care. Several participants spoke of new positions being created for ambulatory NPDPs in their organizations within the last few years. Participant 1 said “I have expanded my department by 3.5 FTEs”, while Participant 7 was
hired explicitly to “create and develop a nursing program” for a group of clinics that is experiencing rapid growth and hiring of nurses and other clinical personnel.

These are key elements of the AC setting that affect NPD practice in the AC space. From the focus on prevention and wellness, to the number of clinics, specialties, and clinical roles supported, to the differences in regulatory oversight practices, the nature of the AC setting shapes NPD practice. Some of the differences in how NPD practitioners work and how they build relationships with staff will be explored next.

**Varying Scope**

Some participants explained their AC organizations were small when compared with hospital systems, and the relative paucity of resources resulted in a need for the NPD department to engage in a wider scope of activities than in acute care. Participant 1 elaborated, saying her organization had a “much smaller resource pool to draw from. Thinking in, you know, the solely ambulatory organization. It was a definite shock for me the first time I came on.” Later in our interview, this participant said she would advise potential new NPDPs in AC to come in knowing they will end up being involved in many areas, “come in knowing that and being prepared for, being able to dig in and be involved in so many different things because it's a pretty big scope and there aren't a ton of people doing it.” Examples shared by participants ranged from leading workgroups and rolling out new clinical programs to bringing new clinics into a system.

In one case, a national lack of resources for a particular clinical specialty resulted in grant funding for a study participant to travel throughout the country and train nurses at other organizations to begin offering this clinical specialty. Participant 6 stated
We have a grant through the federal government to say “you guys are the experts in this [NAME]. And so, if there are health centers or communities throughout the country that want to learn how, we just, we’ll pay for you to go there and teach them. It’s like a subcontract.

While most participants described their scope as greater in AC than it had been in acute care, one participant had the opposite experience. Participant 4 said her position was new within her organization when she started. She described limitations on her role in the following quote.

Initially, it was the lack of what they knew that I could do. Um, and somewhat that is still. I think it’s getting better. Because I’m getting more requests to assist...Initially it was, “You’re strictly onboarding these new people. Or assisting with their transfers.” Um, and still today, that’s pretty much what some practices want me just to do. Is just onboard and collect paperwork and move on. Now though, there are some managers that will actually reach out and say, “We have a concern with this and could you maybe come and do some education?”

Participants noted varying scope for their roles, with most reporting expanded duties for NPDPs in AC. Some participants speculated that their enlarged scope stemmed from an overall low number of staff resources in their organizations. One participant reported a restricted scope for her role in AC.

**Building Trust with AC Staff**

When the AC NPD role is new in an organization, trust from AC nursing staff is not a given, especially when the NPDP comes from a hospital background. Participants
indicated that lack of understanding the ambulatory work environment can be a barrier to building relationships and trust. Participant 7 said it is important to understand the work the staff are doing, “because it will be thrown back going ‘Really? And how often have you done this?’” Participant 6 said

I think that that really makes somebody an effective ambulatory educator, is you need to be in the same boat as the nurses you are working with. Otherwise, what happens is you become too removed. And you actually don’t know what it’s like on the ground.

Although an NPDP may not come with an AC background, a willingness to learn about ambulatory nursing practice and to respect the work of clinic staff helped some participants establish the necessary rapport and collaborative relationship with learners. In describing her experience learning about the fast pace and intensity of work in clinic settings, Participant 5 stated “That was very shocking to me. I did a double take on ‘Wow! You’re kidding me!’ I developed a huge appreciation for the clinic staff…I didn’t realize that before, in the ambulatory world. Before I was exposed to it.” Now, this participant says “I love them, they seem to love me. They say they do. They tell me to never go anywhere, cause they like me as their educator.”

Participants 5 and 6 both said they encourage staff to call them at any time for questions or support. After describing a phone call in which he helped staff work through a complicated patient situation, Participant 6 said “I think that that’s a really key, important thing. Not just the regular in-house education but also the like, in real time, are you available to folks”. Participant 9 also discussed the importance of being available to
meet the varied needs of staff, from providing education or finding resources to simply
taking the time to be there for an employee who needs a listening ear.

In this section, the different ways in which the AC setting requires NPD practitioners to work were described. In the following paragraphs, influences of the ambulatory setting on NPD responsibilities will be described as they relate to the throughputs of the NPD Practice Model.

Same, But Different

Participant responses often reflected a theme of “same, but different”. Participant statements showed NPD practitioners in AC fulfilled the six main responsibilities delineated in the NPD Practice Model, but they approached these responsibilities in different ways than in the acute setting. Participant 2 highlighted this when she said,

I still find myself doing orientation, you know, from both settings, I was involved in orientation, and competency assessment. So some of those pieces of the job remained, but you know how they’re conducted in a small setting versus big, in a one-location setting versus multiple locations, is different.

For the most part, participants said the core responsibilities of NPD were the same in AC as in acute care. However, participants highlighted numerous differences in how those responsibilities were carried out in AC. Because my probing questions and the participants’ responses focused primarily on these differences, the results presented in this section mostly describe the differences. Codes in this theme include education, orientation and onboarding, competency management, role development, collaborative partnerships, research/evidence-based practice/quality improvement.
**Education**

Participants reported a need to adapt and innovate educational delivery approaches when switching from acute to AC settings. When asked about her transition to AC, Participant 5 stated “I definitely had to change my thought process. And I had to become very creative in developing the kind of education that would reach my clinic people. Their needs were different.” Specifically, participants noted challenges related to three areas: size and staffing of clinics, attitudes of staff toward education, and specific educational needs of clinic staff.

**Size and Staffing of Clinics.** Although most participants reported supporting staff in 30 to 80 clinics, the number of staff in any one clinic was often far smaller than the number of staff on a typical hospital unit. This resulted in small class sizes which presented challenges to delivery and sustainability of educational programs. Clinic staff often found it difficult to attend classes when there were few other staff in the clinic and no coverage was available. Participant 1 noted that some of her clinics had as few as four people. Likewise, Participant 5 observed “one of the first things I realized is you don’t have the amount of staff that you have in the ambulatory world, to be able to pull half their staff into an in situ classroom.” Participant 1 said

At the end of the day, I get five people, you know, five people in attendance, which probably proportionately to what I was experiencing inpatient is proportional to what I'm experiencing outpatient, but when it truly is, like, five people, I don't really know if we can sustain a program like this.
Participant 3 also noted challenges related to staffing, saying “Asking them to step out of a clinic is like they, even the providers, they act like the place will fall apart if the nurse isn’t there.”

Several participants described adjusting training schedules to accommodate clinic needs. For example, Participant 1 stated her organization offered clinic hours outside standard business hours in response to the needs of the communities they served. As a result, the NPDPs adjusted their training schedules to accommodate the varying hours of their clinics. Participant 5 spoke of rotating learners through training one at a time, on site, to minimize disruption to patient care. Thus, staffing and travel time were important considerations in planning educational opportunities for AC staff.

Participants reported that low numbers of staff participating in training made it difficult to advocate for professional development programming, even though they represented a high proportion of clinic staff. When discussing her desire to offer certification prep classes for staff, participant 5 said “The need is there; the quantity is not.” In large systems, participants reported continuing education programs were weighted heavily toward inpatient education needs. Participant 7 observed “funding for education is provided well for in inpatient and education is just, um, kind of assumed in ambulatory care”.

Some participants also noted less support for interprofessional continuing education (IPCE) in AC than in inpatient settings within the same system. IPCE occurs when members of multiple health professions engage in shared continuing education programs. Regarding IPCE, Participant 2 noted,
We mostly don’t do a lot with providers and staff education. That might occur when we run mock codes and things like that, but collaborative education mostly would involve our RN and MA staff, so I feel like there’s room for growth with that.

Participants stated educational planning and delivery was different in AC because of the size and staffing of their clinics. Participants adapted educational delivery models to serve small numbers of staff at numerous locations. They also adapted education to meet the needs of staff roles other than nursing.

**Attitudes of Staff Toward Education.** Participants reported a wide variety of attitudes toward education from the staff they supported. Participant 5 said,

I have found that working with the ambulatory clinic staff, they are so, they’re like sponges. They want this education. They, they don’t have opportunities to go to the classes, so they’re really, they want it. They, they love any kind of education that we have for them.

By contrast, another participant shared challenges when clinic staff felt they did not need education. While variable attitudes toward education may not be unique to AC, some participants spoke of encountering a greater degree of difficulty in getting ambulatory nurses to want to come to training than they had experienced when working in acute care. Participant 6 stated

To me the most surprising challenge is that there are definitely nurses who, who I, who I think don’t belong there [in AC], and they, they’re relegated there. And so
you're teaching this crowd that really is ambivalent to learning. Which is much, much harder.

Participant 7 also noted ambivalence toward education, but her perspective was that this attitude was enculturated in organizational structure rather than coming directly from nurses. The following quote is from her response to a question about what surprised her in the transition from practicing NPD in inpatient settings to the outpatient setting.

When I came back into, out of the hospital the last time, I think that was one of my stark realizations of going “huh”. Just the prioritization of education and support, and ongoing education. Because in the hospital, there is that yearly check. It’s just built in. Whereas in ambulatory care, depending on what facility you work in and how it’s built into the policies and procedures, it may not be there to have that structure.

Participants noted varying attitudes toward education from staff in AC. They posited several potential reasons for these attitudes. Participants believed staff attitudes toward education were influenced by both the individual nurse’s fit in AC and organizational culture.

**Specific Educational Needs of Clinic Staff.** The core skills and knowledge of nursing are needed in AC as well as acute care, but the way they are applied may be different and additional skills are needed to practice in AC. In addition, the relative priority of skills (e.g. central line care, urinary catheterization, intravenous therapy) may be quite different. The most frequently mentioned skill throughout all interviews was blood pressure measurement technique. In the AC setting, blood pressure technique,
intramuscular injection site landmarking, and electrocardiograph lead placement are common skills requiring NPD support during orientation, reflecting the ambulatory focus on activities of prevention and chronic care management. Two skills common to AC but not acute care are ear lavage and telephone triage. Participant 9 described using an innovative “telephone triage escape box” to teach this skill.

In both acute and AC settings, mock codes and emergency response were frequently reported as topics for education. Participants said the way emergencies are handled varies according to the capacity of the clinic. Different clinics have different levels of code response and the NPDP needs to help each clinic prepare for potential emergencies according to its capacity to respond. This adds further complexity to NPD practice in AC. Participant 8 alluded to this when describing her system’s approach to code education.

The code lesson is going to go both ways. We’ve got one part that’s the code cart, which is acute focus; but then we’ve got the go bags and the emergency supplies for the ambulatory. So those are really two separate lessons. They just have the same heading.

Another aspect of emergency response in AC involves the focus on chronic care and prevention in addition to medical management of the presenting emergency. An example is highlighted in this case example shared by Participant 6 which underscores both the acuity and holistic approach needed in this setting.

And so patient presented, escalating, having recently used methamphetamines. How do you de-escalate the patient, assess for acute HIV risk, recommend
prevention, recommend contingency management and treatment for their crystal meth while also assessing the overdose risk from contamination with things like fentanyl?"

Most participants also highlighted the importance of teaching professional communication, especially when addressing sensitive or stigmatized topics. Some participants mentioned communication as an area that may require additional individualized education, coaching, and role modeling. The emphasis on communication skills reflects the nature of nursing practice in AC, which participants noted may be conducted entirely via telephone. Two study participants worked closely with specialties associated with high levels of stigmatization. Both participants specifically mentioned coaching employees on how to communicate with their patients on difficult topics. Participant 6 stated “I also tend to add a lot of stigma training into what I do.”

Participants identified some clinical skills as relevant for both acute and AC settings. Some of these skills were identified as higher priority in AC, such as BP measurement technique and communication. Other skills requiring education were identified as unique to AC, such as telephone triage. Participants also identified areas in which the education staff needed on a topic was different in AC than acute care, such as emergency response.

**Orientation & Onboarding**

Participants all reported orientation and onboarding were integral to their roles, with one participant stating she completed 370 orientation plans in 2020. Participants indicated specific skills requiring training or competency verification varied considerably.
depending on the new employee’s role and the specialty into which the new employee was hired. Participant 9 described inpatient orientation as primarily skill-based, and outpatient orientation as a blend of skills and learning about the ambulatory nursing environment.

Most participants indicated orientation in their settings typically included all clinical roles (nurses, medical assistants, various technologists). Some participants were also responsible for orientation of nonclinical staff. Participant 2 said “our morning is structured for all employees. Then in the afternoon our schedulers would go off to scheduling orientation and we would focus more on the clinical aspects.”

Most participants described orientation as a blend of on-site training at a centralized location with continued learning at the employee’s clinic location. The centralized portion often included skills checkoffs, training in customer service, and simulation. Simulation topics most often described by participants were rooming patients and practicing challenging conversations. Participant 1 described this in the following quote.

It's still this kind of simulated environment for them to practice things that might be sometimes challenging to ask someone the first time about. You know, “Who do you have sex with, and where?” and you know, all sorts of questions that might not be intuitive and so…getting to practice that kind of in a safer environment first.

Participant 9’s description of orientation skills was representative of the sample:
We also have some skills that we teach as well. We teach about metered dose inhalers, um sterile instruments, the blood pressures. Um, we do a sim - an emergency response sim – um, so that they can utilize their emergency bag that they have in their clinics, so we know how to respond to an emergency if it happens in their area. Um, so we do that in their orientation, and um, let’s see, oh and we just added a new one. Staple removal and suture removal…And then we do some soft skills as well. We talk about teamwork, like I said, we talk about, um, professionalism.

Although most participants stated their ambulatory clinics had orientation lengths around two weeks, they often noted specialty departments needed longer. Participant 3 said “Our infusion center – they might just get two weeks. And it’s not enough.” Some participants said their organizations avoided hiring new graduate nurses and assumed experienced nurses would not require much orientation to a new practice setting. Participant 3 stated “Um, I’ve heard that said. ‘They already know how to do this, they’re just doing it in our environment.’ And it’s frustrating, because it’s totally different.” Participant 6 noted it could be difficult to change encultured expectations held by nurses who transitioned from inpatient settings. “It gets easier when you have nurses who’ve sort of done this type of work before. But I, in the beginning, for nurses who have been inpatient for a long time, it is like pulling teeth.” Participant 7 recently redesigned her organization’s approach from having no formal onboarding process to providing a full month with a standardized schedule of onboarding activities. Participant 9’s organization was an outlier, offering six weeks of orientation and welcoming new graduate nurses into AC.
A challenge noted by some participants was the lack of qualified preceptors. Although this concern may be expressed by acute care NPDPs as well, the challenge of finding good preceptors is exacerbated in AC by the typically small number of staff in any one location. Participant 3 said “In our [SPECIALTY NAME] department, there’s only two nurses. There’s only, there’s very few options for who can precept someone.”

Participants noted several features of onboarding/orientation that were unique to AC. The first was the increased workload faced with frequent additions of new clinics being brought into organizations. The second was the blend of roles included in orientation, with some roles not typically found in acute care (e.g. medical assistant). A third feature was the consistent reports by participants of inadequate orientation lengths coupled with unrealistic expectations that experienced nurses would not need much orientation to the AC setting. The final feature identified by participants was the small number of potential preceptors available at many clinic settings.

**Competency Management**

Approaches to competency management varied widely. While a few participants described robust competency management programs, several said their organizations had only recently begun systematically addressing competency management and competencies were still under development. Participant 9 said “We’re not quite there yet. This is a new program that we’re building, um, but the ambulatory world hasn’t really done a lot of competencies.” Participant 6, speaking of a specific clinical specialty, noted

There are not a lot of [SPECIALTY] competencies. We actually just wrote a paper...because there aren’t any really...because [REDACTED] is a specialty that
many people are not paying attention to for a long time. And so, like, we wrote the competencies.

Similarly, Participant 7, speaking of a primary care setting, stated

The other thing that we implemented were competencies. Because they didn’t have that and when I came on board they were like ‘Oh, the nurses aren’t doing their jobs.’ And I’m like ‘Well, how do you know?’ and so we developed competencies.

Programs for competency management may follow similar structures as in acute care, but with different specific competencies or different ways of achieving the same competency. In talking about creating a competency related to quality, Participant 3 said “The outpatient needs are different, but they, the staff doesn’t really seem to understand that they’re also the same. Quality is quality. Are you giving good quality outpatient care?” The Donna Wright competency model was named by three participants, all of whom represented ambulatory care within larger hospital systems that had adopted this model systemwide.

As in acute care, participants indicated regulatory and accreditation standards helped drive competency selection and leadership support was critical to their competency programs’ success. Participant 8 stated “So clinical education kind of develops those general competencies so we can kind of meet those accreditation standards.” Participant 9 said her organization’s ambulatory clinic directors had been “very supportive in all of our decision-makings for the competencies. So they’re, um,
they will also push it towards their managers and their supervisors as well…so that we can hopefully roll it out smoothly.”

Competency management in AC shared many features with competency management in acute care, but was less consistently well-developed. Most participants were building or had recently built competency management programs for their clinics. Participants whose clinics were part of a larger hospital system tended to use the same competency models as their hospitals.

**Role Development**

As in acute care, role development in the AC setting takes many forms, from residency programs to clinical ladders to simply helping individual staff members find resources for professional growth. Although a few participants reported having robust role development programs, most indicated role development opportunities were either nonexistent or very limited for ambulatory staff, compared to the array of role development opportunities offered in acute care. Some participants also indicated the concept of role development in AC was somewhat ambiguous, as confirmed by Participant 1, “Role development, it can be a little amorphous. This one I feel like is not necessarily as clear cut.”

Participants who supported clearly defined role development programs reported handling clinical or academic advancement programs (including supporting registered nurses to become providers and unlicensed assistive personnel to become medical assistants) and certification programs. Participant 6 stated that 7 of the 10 nurses at his main location were in training to become nurse practitioners. He explained, “When we
empower nurses to be resilient, when we empower them to be autonomous, they go ‘well I could be a provider’. So it’s, I actually consider it a good problem to have.” Other participants discussed their work in supporting staff from nonclinical areas to grow into clinical staff roles. Participant 8 shared

If you are not working in health care at all, but you want to become a CMA [certified medical assistant], we have a 12-week program that you can, you can take that program and it’s a combination of classroom and clinical time. And it prepares you to work as a CMA and to take the exam so you can become certified. Um, and we, we do have a lot of staff that will transfer out of maybe the customer service, or maybe environmental services.

In organizations where role development opportunities were limited or nonexistent, participants tended to describe their role in two ways: advocacy for increased resources and connecting staff with opportunities as they became available. Participant 5 described advocacy for more resources and organizational support for role development.

I’ve actually reached out to the, um, director, who is the ambulatory nursing director…So that’s something that will actually be hopefully opening up for us more in the next year or two. So that we can help develop some of those in those careers. Cause we do have so many clinics and so many staff that I know would really benefit from that.

Those who spoke of role development in terms of connecting staff with opportunities emphasized the importance of building relationships with staff in each department so they
could connect engaged staff with internal opportunities for growth and development. For example, Participant 1 shared “So some of its just, like, highlighting work groups and committees or specifically connecting people when they are reaching out on those things.”

Role development was also often interconnected with competency management, as AC settings often use site “champions” or “validators” from each clinic to partner with educators. Staff in these roles function as education partners to ensure staff receive required education and competency validation. The role of “champion” or “validator” is seen as both an opportunity for role growth and leadership among clinical staff and a means of coping with geographic constraints that preclude the educator from being on site regularly. This is highlighted in the following quote from Participant 2.

The one thing we will do is encourage, like when we have a, maybe a change in procedure, or a piece of equipment, we will ask for a champion from the building. And so, we have our glucometer champions and our ECG, or we use the GE machines, we want a champion for that where they will come in, we’ll give them training, get them so they feel very comfortable with the piece of equipment and then they can turn around and train.

Several participants indicated role development opportunities for leadership roles like charge nurse or clinic manager were not readily available. When asked, Participant 3 stated, “I hate to say this, but it’s, it seems a lot like putting warm bodies in a position. Not giving them tools they need.” Participant 9 suggested the small number of nurses in any one clinic contributed to diminished opportunities for staff to develop in leadership roles. “We do have a charge nurse’s class. Um, in the ambulatory it’s, some of the clinics
are large enough to have a charge nurse, whereas other clinics, they’re very small, and may only have two nurses.”

Participants from larger healthcare systems sometimes noted that leadership development opportunities based in a hospital were open to ambulatory staff, but the AC NPDPs role was limited to helping staff gain access to those resources. Others stated their hospitals had such programs, but these were not available to ambulatory staff. For example, Participant 8 shared “We do have a mentor program, but that’s more inpatient. It hasn’t really moved into ambulatory yet, so we don’t really do much with the mentor there.” Participant 7 highlighted the need for resources to promote role development, saying “have us pay for that so that they can be successful”.

The most robust role development opportunities were described by participants who also spoke of being connected to Magnet hospitals. These organizations tended to include ambulatory nurses in residency and clinical pathway programs. Many organizations represented by participants, including the Magnet organizations, also offered certification reimbursement. Among organizations with more robust resources, such as ambulatory care nurse residency programs, participants tended to describe these as very recent developments. Participant 9 stated “We have set up the residency program which is new. That was one thing that I helped to set up.” Elsewhere, she indicated this had been completed within the previous year.

Participant engagement in role development varied greatly. As with competency management, all participants valued role development but not all had fully implemented the role development programs they felt their staff needed. Participant functions in role
development varied from advocating for resources to building and running robust programs such as nurse residencies and certification preparation classes.

**Collaborative Partnerships**

Participants identified a need to establish collaborative partnerships with both internal and external stakeholders. AC NPDPs often need to coordinate with many clinic managers and leaders from the varied clinics they support. Participant 1 shared an early experience of learning to collaborate effectively with leaders in ambulatory care.

I remember coming to ambulatory care and I was rolling something out and someone asked me, “Well, have you talked to our Chief Medical Officer about that yet?” I was like, “Absolutely not. Why would I ever do that?” I worked inpatient for years in this, and I never spoke with our medical director. Like those are different worlds. And it’s like, “Well, no, you have to talk to our medical director about that before this rolls out.” I have recurring one on ones with our chief medical officer.

Another participant, representing a large integrated delivery network where all staff attended the same system orientation, spoke about partnering with inpatient NPD colleagues to ensure the system orientation program included examples and case scenarios representative of both ambulatory and acute care settings.

AC NPDPs often collaborate with leaders from various departments to address specific education needs. Participant 4 shared “I typically haven’t had the request for uh, pediatric mock codes. So, when I got that request and Peds is not my specialty. So I brought in our respiratory therapist, STI – staff development instructor – and the inpatient
pediatric instructor.” Participant 8 summed up the essence of internal collaborative partnerships this way.

I think, really, our department is one of those that really kind of facilitates the collaboration across the board, right? I mean depending on what’s going on, we get in touch with the CE [Continuing Education], get in touch with the continuing education group or you know, accreditation or policies, or you know, various departments and you know, try and bring as many ideas together when we’re trying to put things together.

In AC, NPDPs also manage numerous external collaborative partnerships. A common type of collaboration is partnership with local colleges and training programs to provide educational opportunities for students, especially medical assistant students. For example, at the time of interview, Participant 7 was working with a local program to provide apprenticeship opportunities for medical assistant students, with a particular focus on increasing diversity in her local healthcare workforce. Participants also reported serving as advisory board members or partnering in other ways with local colleges and training programs. While NPDPs in AC may participate in arranging clinical rotations, these are often structured differently than in acute care. Student populations may be heavily weighted toward medical assistants rather than nurses, usually with an intent to hire successful medical assistant graduates. Participant 8 said “We have several community colleges in the area that have their medical assistant students. Um, and we support their clinicals, you know, hope that they’re a good fit and we can keep them.”

Unlike medical assistant students, nursing students are not always welcomed in the AC setting. Participant 3 said
I attempted to get some students over in the outpatient setting, but they would not allow it. Um, even, you know, students that wanted, were interested in [SPECIALTY DEPARTMENT]. Um, they wouldn’t allow them in the [DEPARTMENT] area, they wouldn’t allow them to come and shadow or anything.

Participant 4 also answered “No. We don’t. We don’t get nursing students in the clinics.” By contrast, a few participants successfully advocated for welcoming RN students into the AC setting. Participant 7 stated she wanted to bring students in to “expose students to the fact that AC exists.” She also indicated it was important for the academic partner and practice setting to experience mutual benefits from their collaboration.

NPDPs commonly partner with vendors to provide education for staff on using new equipment. When partnering with outside vendors to provide education in AC, the NPDP may need to engage in considerably more coordination than in an acute care setting, due to the number of locations affected. Participant 5 alluded to this when she said “I provided them with not only a map of the entire organization…and I also provided them with a list of every single preceptor, with their contact information.”

AC NPDPs manage many internal and external collaborative partnerships. Internally, they partner with medical directors, clinic leaders, and other stakeholders to provide education for AC staff. Externally, AC NPDPs often partner with colleges and training programs to provide students with clinical experiences and with vendors to provide training related to new equipment.

Research, Evidence-Based Practice, and Quality Improvement
This code contains three parts: research, EBP, and QI. Most participants indicated research and EBP were not priorities in their setting. Participant 3 said there was “Not a whole lot of push for nurses to do that. Um, so, it’s kind of lackluster.” while Participant 4 said “Um, not much now that I think about it.” When asked further about EBP and research she stated “That’s not a thing. Not to my knowledge. It’s never been mentioned.” Participant 8 stated “I’m not aware of any research right now...I find that most people are focused on inpatient.”

Several participants spoke of a desire to promote more research and evidence-based practice but noted barriers. Participant 5 said “It’s something that I have been thinking about, but it’s really, it’s very difficult to implement in ambulatory area.” She hypothesized that document sharing technology may help facilitate cross-site work on research, EBP, and QI initiatives. Participant 7 suggested encouraging staff to join their professional organizations to remain abreast of current evidence related to their specialty areas. She also provided staff with tutorials on using research databases to find credible evidence.

Participants described having leading roles in translation of evidence from new research or best practice guidelines into clinical practice. Participant 9 stated “We’ll follow evidence-based practice in all that we do. Um, if we see something that is really important and we feel that everyone in ambulatory should be aware of it, then we bring it to our ambulatory shared governance group.” She also described drawing on the experience of new employees to learn about evidence-based practices from other organizations. Participants 3 and 8 both talked about supporting graduate students in completing EBP projects for master’s or doctoral nursing programs.
A challenge that may contribute to the relative lack of emphasis on research and EBP may be the mix of staff roles common in most clinics. When the team consisted of a mixed group of MAs, LPNs, RNs, and other clinicians, participants found it difficult to appropriately involve everyone. Participant 7 described it this way.

Depending on their schooling, they may not have necessarily been exposed to research and so, how to figure out that balance where they’re all supported, but not talked down to, not talked up to, and so try to figure out what each individual’s needs are. And what they’re comfortable with.

By contrast, QI initiatives often fall within the purview of AC NPDPs. All but one of the participants spoke clearly of their roles in supporting QI in AC, with responses ranging from general statements about the goals of QI to naming specific quality measures being tracked and describing interventions of the NPDP in addressing those measures. Participant 7 said

My primary goal for quality is positive patient outcomes. First and foremost. And so, are what we’re doing, is it best practice?...I think the part that’s really important for quality is making sure that you do constant evaluation and modification of the plan if needed.

Taking this approach to using data to improve quality even further, Participant 6 described using public data to inform interventions at both an individual and a community level.

So if we see there’s a bunch of new overdoses, um, in [NAME], which is one of our neighborhoods, I reach out to that community health center and say “Hey, do
you know there were 20 new overdoses in your city last month? What is going on and how can I help?”

He went on to describe ways this conversation could lead either to reeducation of an individual team member or to implementation of a community wide initiative, depending on what his investigation revealed. Other participants spoke of collaborating with QI departments to support quality initiatives and follow up on changes in quality metrics. This variability in NPD involvement in quality monitoring and response reflects the scope and variety of roles an NPDP may fill in the AC setting.

Although the NPD Practice Model presents the trifecta of research, evidence-based practice, and quality improvement as a single category of NPD responsibility, participants described their involvement with these topics differently. Participants reported little or no involvement in research and evidence-based practice work in the clinic setting. By contrast, participants reported having extensive involvement in quality improvement initiatives in AC.

**These Are My People**

In the previous sections, characteristics of the practice setting and commensurate changes in NPD practice were identified. This section contains participants’ descriptions of their influence on ambulatory nursing practice and their feelings about being in the AC practice setting. Codes in this theme are representation matters, NPD practitioner as advocate, isolation/invisibility, influence, parallels, and joy and meaning.

**Representation Matters**
Participants felt it was important for them to represent AC on system or hospital councils. Participant 5 stated “I’ve learned to speak out. ‘Wait, hey, put me in that meeting because ambulatory needs represented in that some way.’” Likewise, Participant 6 said “I think that my role really and truly is in promoting nurses in this field that has so often been dominated by other professions. And to say, ‘Actually, nurses are the people who are best positioned to help here.’” Participant 4 stated “Even, you know, to come to a practice manager meeting, I think would be beneficial. Participants reported assuming responsibility for representing ambulatory care within the larger healthcare system.

**NPD Practitioner as Advocate**

Participants indicated advocacy and strong communication skills were critically important for demonstrating the value of NPD in AC and obtaining needed resources for NPD work. Participant 1 said “You really have to become an advocate and vocal about the work and about the role”. Participant 7 similarly described advocating for leader support to create a new role development initiative in her organization. She stated, “one of the things I’ve learned in my career is that if you ask, you are usually more surprised by the positive rewards.” Participant 9 advocated successfully for having new graduate nurses in the clinics and built a residency to support new graduate nurses in the AC setting. Most participants indicated advocacy for their specialty and practice setting was important to their work.

**Isolation/invisibility**

Participants who supported AC within larger healthcare systems indicated they sometimes felt isolated or unseen within the larger system. Participant 5 said “I really feel
that there’s a lot of other educators out there would have no idea how intricate
ambulatory is and how important education is for them. I mean, it was an eye-opener to
me.” Participant 6 cautioned “outpatient is just as intense [as inpatient], or more if you’re
doing it the right way.” Participant 5 said “I think a lot of times with us, we are very
individual and sometimes we’re kind of like the redhead stepchild, we’re forgotten
about until the last minute.” Participant 7 stated “Hospital nursing is not the only
nursing.” And Participant 4 noted “It is sort of a loner because you feel like you’re a little
on the outside.” She continued, “It would be nice to have, to be in the loop of things.
Sometimes I feel like I’m outside the loop.”

Participants said comparatively fewer system resources were allocated to
supporting their work in the ambulatory setting than in their acute care experience.
Participant 7 described it this way. “Funding for education is provided well for in
inpatient and education is just kind of assumed in AC.” She went on to describe a variety
of role development programs available to hospital employees that were nonexistent in
her AC context.

Participants emphasized the need for new AC NPDPs to receive mentoring and
experience community in NPD. Participant 7 advised “Join your professional
organization. Reach out, buy the books”. Having NPD colleagues or mentors even from
the inpatient setting was found to help mitigate the sense of isolation. Participant 4 said
“It helps that I’m in a department with other NPDs, and we’re all in one main, central
area. So that helps.” Participant 8 added that her organization had recently initiated a
program to foster community and collaboration among educators serving similar
populations.
A sense of isolation and invisibility was pervasive in participant comments. Participants reported feeling lonely in their roles, and some felt unsupported by their system leadership. Most participants stated they would advise others to find ways to connect with fellow NPDPs, for mentoring and community.

**Influence**

NPDPs in AC believed the importance of NPD work in AC was increasing. Participant 5 said “Honestly, looking at it, the need for educator support is very important in the ambulatory world. Probably more so than ever because a lot of things are rapidly changing in the ambulatory world.” This is consistent with statements by participants about new AC NPDP jobs being recently created in their organizations, new clinics being brought into their systems, and new competency and role development programs being created within the last few years. Participant 8 said “I feel like I have a lot of influence on ambulatory practice here. When I moved into this role, I designed our transition to practice program.” She also stated,

> For better or for worse, I find that I’m kind of the resource for scope of practice. MA, CMA, LPN, and RN in the ambulatory side. Um, so I’m fielding a lot of scope of practice questions on a routine basis. So in that role also, in that respect also, I have a lot of influence over how things happen.

Participants identified their roles as highly influential in the AC setting, largely due to rapid changes in the US healthcare system.

**Parallels**
Many participant comments demonstrated parallels between AC nursing and AC NPDP practice. Throughout their interviews, participants shifted often between describing their work and describing in similar terms the work of the staff they served. For example, in one breath, Participant 8 spoke both of shifting her mindset as the educator and of ambulatory nurses needing to “be able to switch your brain back and forth” because of the nature of their work in the clinics, seeing patients in person while also providing telehealth nursing services. The same parallelism was evident in comments about staff feeling invisible or marginalized within the healthcare system, similar to the isolation and invisibility of AC NPDPs described in the previous section. For example, Participant 3 described the perspective of the staff she served, saying “there’s a mindset of ‘nobody kind of knows what we do. Nobody understands it.’” The parallels between how NPD practitioners in AC describe their own work and how they describe the work of the staff they serve indicate a sense of investment in and identification with ambulatory care nursing.

Joy and Meaning

Despite the challenges, AC NPDPs reported benefits related to their practice setting. Some participants described feeling excited about seeing the influence of their work on clinical practice and patient outcomes and feeling this influence was greater than what they experienced when working in the inpatient arena. Participant 7 stated emphatically “Oh, yeah, I’m making a difference!” Participant 6 referred to the excitement of seeing the impact AC NPDPs have “not just on the patient level, but on a community level, to really change healthcare outcomes and promote wellness on a community level.” Participants valued the ability to support employees in developing
professional role growth. In talking about competency management, Participant 5 noted “They appreciate everything we do for them.”

Other sources of professional satisfaction were noted. Participant 2 said “It’s also been kind of fun because you get to, you know, be right there with them and help them alleviate their fears”. Additionally, participants noted benefits related to clinics typically being closed on holidays, weekends, and nights. Participant 3 stated “Never forget that not working holidays and weekends and having to do dressing changes and clean up…bowel movements, is pretty nice.”.

A strong personal interest in the practice setting and alignment with the organizational mission also contributed to NPDPs’ sense of meaning in their work. Participant 6, in talking about the patient populations served by his specialty, said “Those are my people.” A similar sense of identification was evident in many participant statements, even from those like Participant 5 who did not have a background in ambulatory care nursing prior to taking on her current role. She said “I have had the opportunity to leave ambulatory and go to different areas within our department. I’m like, “No. No, I’m sticking with ambulatory.” Participant 6 said “There is a dedication to something beyond yourself that I think is really important to have, to drive initiatives within ambulatory nursing education.” Participant 7 said “A lot of my career has been in AC one way or another.” and “I have to say my own bias is I’m not a, not a fan of hospitals” before going on to explain her appreciation for the AC focus on prevention and health promotion.

Most participants reported finding joy and meaning in their work and indicated they intended to stay in AC. Participants valued both their ability to influence practice
and the perceived perks of the ambulatory care environment. Several reported strong personal alignment with the mission and values of the clinics they supported. All these factors were referenced by participants as contributing to the joy and meaning they derived from being AC NPDPs.

**Summary**

This chapter has presented the findings of the research study. The findings included 19 codes in three overarching themes: features of the AC setting that affect NPD practice, same but different, and these are my people. In the next chapter, these findings will be discussed as they relate to the study aims and research questions.
Table 4.1

Participant Demographics

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\(^a\) Some percentages do not add up to 100 due to rounding.
### Table 4.2

**Findings Related to Research Questions**

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Chapter 5: Discussion

In chapter five, I discuss the findings and their implications for nursing professional development in the AC setting. I show how the findings answer the four research questions and how they extend the knowledge of the NPD specialty, using the six throughputs of the NPD Practice Model (Harper & Maloney, 2016) as a framework to situate the study within the broader context of the NPD specialty. These throughputs are education, orientation/onboarding, competency management, collaborative partnerships, role development, and a combined throughput of research, evidence-based practice (EBP), and quality improvement (QI). I conclude the chapter with implications for the practice of NPD in AC.

In their 2017 NPD role delineation study, Warren and Harper noted an expansion of NPD roles in non-acute care settings and advocated for more professional development for NPD practitioners transitioning into settings with new roles and responsibilities. Overall, findings from this study corroborated Warren and Harper’s findings related to the growth of NPD roles in the AC setting. This study adds to what is known about NPD practice by describing specific features of the AC setting that influence the ways the NPD specialty is practiced therein. These results may be used to inform creation of the professional development opportunities Warren and Harper recommended.

Response to the Research Questions

Findings from aim one describe AC NPD practice in the context of the broader NPD specialty, answering the questions “How is NPD practiced in AC?”, “How does NPD practice in AC fit within the broader NPD specialty?”, and “How do NPD
practitioners perceive their role’s influence on the practice of AC staff?” Findings from aim two identify areas in which NPD practice in AC diverges from NPD practice in acute care if such areas exist, answering the question “How do NPD practitioners who have worked in both acute and AC describe the differences in practice between settings?”

**RQ 1: How is NPD practiced in AC?**

Findings from each theme addressed the first research question, but theme one contributed the most to understanding how NPD is practiced in AC, as it showed how NPD practice adapted to fit the features of the AC setting. Theme one will be discussed more fully in the next section. Theme two showed how NPD practice in AC largely centered around the same six core activities (throughputs of the NPD Practice Model) as in acute care, but with different nuances according to the needs of AC staff. Theme three showed that, in contrast to NPD practice in acute care, NPD practice in AC involved increased advocacy for the professional development needs of staff, particularly in organizations where ambulatory care clinics are a component of a larger hospital system. Ultimately, all three themes contributed to answering the question, “How is NPD practiced in AC?”.

**RQ2: How Does NPD Practice in AC Fit Within the Broader Context of NPD?**

Findings from this study clearly showed NPD practice in AC is still, at its core, NPD practice. Although the practice setting varied, the work remained essentially similar between AC and acute care. This was most clearly evidenced in the participant comments
that made up the codes of theme two, “same, but different”, which will be discussed further in this chapter.

**RQ3: How Do NPD Practitioners Perceive Their Role’s Influence on the Practice of AC Staff?**

Findings from theme three, “these are my people”, most strongly addressed this question of how NPDPs perceive their role’s influence on the practice of AC staff. In this theme, participants talked directly about their influence on AC practice. Some felt they had a greater capacity to influence nursing practice in AC than in acute care. Most participants spoke of the importance of their role in representing ambulatory care and raising the visibility of ambulatory care within the broader healthcare system. Participant comments related to these issues will be discussed later in the chapter, within theme three.

**RQ4: How do NPD Practitioners Who Have Worked in Both Settings Describe the Differences?**

The findings related to research question four were inseparably linked to every theme and nearly every code. Some of the most strongly expressed differences shared by participants were related to resource allocation, the relative prioritization of NPD Practice Model throughputs, and the various features of the AC setting that affect NPD practice. All of these will be discussed later in this chapter.

**Features of the AC setting that affect NPD practice**
AC nursing focuses heavily on prevention, wellness, management of chronic conditions, and population health (Fritz, 2017a; Jessie & Swan, 2017) which differs from the illness focus in acute care (Mason, 2016). Findings from this study confirm the focus on wellness and prevention and how that shift substantively influences the work of NPDPs in AC, from the skills that are taught in orientation (e.g. telephone triage instead of telemetry monitoring) to the goals chosen for QI projects (e.g. increasing blood pressure rechecks for hypertensive patients instead of reducing catheter-associated urinary tract infections). NPDPs who transition from acute care to AC need to understand the nature of AC nursing and how AC fits within the overall health care system.

While using similar technology to their hospital-based counterparts, ambulatory NPDPs may rely more heavily on technology as a means of accommodating geographic constraints when planning educational offerings. Some participants talked about conducting virtual training to reach participants in remote locations and help reduce their sense of isolation. Previous literature has acknowledged the value of technology in reaching remote patients (Baldwin-Medsker et al., 2020; Sudhakara et al., 2019); this study suggests similar benefits may apply in reaching remote healthcare staff with professional development opportunities.

In the NPD Practice Model, environmental scanning is a crucial element of the NPDP inputs (Harper & Maloney, 2016). Environmental scanning is described by Rheingans (2016) as “the important step of continuously scanning the interprofessional practice and learning environment for opportunities or threats, both within and external to the organization, which may signal a potential professional practice gap” (p. 278). Several participants alluded to having numerous specialties to support. The higher
number of specialties supported by many AC NPDPs may make environmental scanning more challenging than in the acute care setting. This challenge was reflected in participant comments about needing access to resources like journal databases or specialty organization memberships to find current, relevant evidence.

Most participants reported that their organizations had recently brought in new clinics, reflecting the national trend toward merging small AC clinics into larger networks (Physicians Advocacy Institute, 2019). The growth of such networks appears to be generating increased need for NPDPs in AC, to help support onboarding and orienting of new staff into the culture and standard work of the larger networks and to facilitate quality improvement. This finding is consistent with findings by Warren and Harper (2017) about both growth of NPD jobs in non-acute care settings and the prioritization of QI work in NPD practice.

Warren and Harper’s 2017 study also predicted an expansion in NPD roles beyond the traditional focus on onboarding and education. Warren and Harper found that NPDPs were increasingly tasked with facilitating practice transitions of nurses to new settings such as AC, and with leading QI and process improvement work. This aligns with findings in the current study in which the two participants from small, exclusively ambulatory organizations both spoke about having job responsibilities they did not have in acute care, including more leadership and program management. Participant 1’s comments indicated her belief that the relative paucity of personnel resources was the reason for NPDPs being tasked with additional program and project management responsibilities in her setting. NPDPs entering small AC settings should anticipate being
asked to engage in work beyond the scope of what they encountered in acute care, including more program and project management.

Participant 7 represented an unexpected population not previously found in the literature. Three people who completed the eligibility screening survey for this study were in hybrid managerial/NPD roles, with job titles related to management rather than professional development. Only one of them, Participant 7, had enough NPD experience to meet eligibility criteria for this study. Participant 7 is therefore representative of a population of nurses in small AC organizations where professional development and management roles are wrapped up in one person. Warren and Harper (2017) noted an increasing need for transformational leadership skills among NPD practitioners and a shifting of NPD work toward outpatient settings, but their article did not anticipate this melding of NPD and management roles. The findings suggest efforts to support NPDPs in AC should be shared with nurses in AC management roles as well as those with NPD-related job titles.

In descriptive phenomenology, unusual and contrasting experiences are accorded careful consideration (Priest, 2003). Participant 4’s experience with NPD scope was just such a contrast. While most participants experienced an expanded scope of responsibilities in AC, Participant 4 had a narrowed scope, almost completely limited to onboarding and orientation. Participant 4 believed the reason for her limited scope was lack of understanding by organizational leadership about how best to use her skills. This suggests AC organizations employing NPDPs may need to explore how they use the NPD role and whether there are opportunities to optimize the role to allow NPDPs to practice to the full extent of their scope and training.
Same, but Different

Findings from this study showed strong alignment with four of the six throughputs of the NPD Practice Model (Harper & Maloney, 2016); education, orientation/onboarding, competency management, and collaborative partnerships. However, role development, research, and EBP seemed to be prioritized significantly lower in AC than in acute care. These priorities appeared to be largely determined by organizational expectations rather than by participants, with nearly all participants stating they wanted to do more work in role development, research, and EBP.

Resource Allocation

One feature woven consistently throughout the narratives was a general lack of resources allocated for NPD in the AC setting. Only two participants worked for solely ambulatory organizations. The rest were embedded within larger hospital systems. The narratives of those seven reflected a consistent bias in resource allocation toward acute care settings. Some participants posited that the comparatively low number of nursing staff in the clinic setting may be a reason for the lack of resources: “the need is there, the quantity is not” (Participant 5).

A growing proportion of healthcare is being delivered in the AC space (Abrams et al., 2019). As the U.S. healthcare system shifts from privileging volume-based to value-based care models (Kissam et al., 2019), it may also be necessary to adopt a value-based mindset to resource allocation for professional development. Instead of focusing on the number of nurses served by an educational program or a role development opportunity, leaders should focus on the patient populations that ultimately benefit from a nurse’s
professional development. Such a shift in mindset might achieve a more equitable distribution of resources between acute and non-acute care settings.

**Education**

Batiste (2018) documented an increased need for AC staff education in recent years, due to increased patient acuity and patient volumes in AC settings. Likewise, Mills and Kanaskie (2019) reported a need for staff training secondary to recent growth in nursing roles in AC. Given the need for more education in AC, one of the more curious findings of this research was the variability in how participants said their nurses felt about participating in educational activities. While some said nurses were excited about the opportunity to receive ambulatory-specific education, others noted ambivalence or even resistance to participation in educational activities. Commenting on this range of responses, Participant 6 posited that some learners came to AC by choice because they were passionate about caring for patients in their specialty. However, he observed other nurses were “relegated” to AC as a pre-retirement option, on the spurious assumption that clinic nursing is easier than hospital work and therefore clinics make good places for aging nurses to wind down their careers. It was his opinion that these nurses were more likely to be uninterested in educational opportunities.

Participant 6’s perception reflects a pervasive sense of isolation commonly felt by AC nurses (Allen, 2016) and described by participants, believing that “nobody kind of knows what we do” (Participant 3). He believed that because clinic nursing was not well understood, nurses were sent to the clinics who did not belong in this setting, and who were less likely to engage in professional development opportunities. Although no
literature has been found that directly addresses this hypothesis, the idea may be supported by Participant 5’s comments about assuming clinic nursing was easier or slower than hospital nursing until she experienced the clinics for herself.

There may be other explanations for AC nurses’ ambivalence toward participating in educational opportunities. For example, Participants 3 and 5 both alluded to the challenge of taking even one person out of staffing to attend training when a clinic only has 1-2 nurses on site. Very lean staffing may be a factor in how nurses feel about taking time to attend training. Batiste (2018) described creating a model within her organization for having NPDPs travel frequently to provide education on site, which allowed education needs to be met with minimal disruption to clinic operations. Similar approaches were employed by some study participants. NPDPs in AC should consider planning staff education models around frequent travel and very small class sizes rather than attempting to replicate centralized training models commonly used in acute care.

**Competency Management**

Although competency management was consistently acknowledged as an important part of the NPDP’s work, it was surprising that many organizations had only recently begun efforts in this area. Some were still developing a competency management process and others had recently developed theirs. Comments about competency management having been nonexistent until recently came from participants representing both primary care and specialty settings. The lack of robust competency management programs in AC is consistent with Simpson and Lau’s (2019) finding that there is insufficient literature on ensuring nurse competency in AC. Batiste (2018) implies the
recent emphasis on developing competency management processes reflects a growth of both nursing jobs and, subsequently, NPDP jobs in AC.

**Role Development**

Like competency management, role development in the AC setting seemed to be in a period of rapid growth. This finding is consistent with the work of Fritz (2017a) and Moorer and Kirkley (2019) related to the fledgling development of transition to practice programs in AC, and Mills and Kanaskie (2019) on preceptor development in AC. Responses to questions about role development were highly variable, ranging from a simple “It’s pretty bad.” (Participant 3) to a comprehensive menu of role development opportunities offered by the organizations where Participants 8 and 9 worked, including transition to practice programs. However, even in the cases of Participants 8 and 9, many of these opportunities had been created very recently. These findings are promising, suggesting that some healthcare systems have recognized the value of investing in their AC staff and are implementing role development programs accordingly.

**Collaborative Partnerships**

A major difference between acute and AC NPD was seen in the de-emphasis on working with schools to host nursing students. While most participants expressed a desire to have nursing students in the AC setting, not all were successful in advocating for nursing student placements. Participants who hosted nursing students expressed a strong belief in the value of introducing students to AC at the pre-licensure phase as a means of increasing the visibility of AC nursing. This finding is consistent with emerging literature.
from AC (Fritz et al., 2020; Hooper-Arana et al., 2020) on the importance of providing nursing students with AC clinical rotations.

**Research/Evidence-Based Practice/Quality Improvement**

The findings indicate a surprisingly low emphasis on nursing research and EBP in the practice of NPDPs in AC. Since the Institute of Medicine (now known as the National Academy of Medicine) called for 90% of clinical decisions to be evidence-based by 2020 (Institute of Medicine, 2009), EBP has enjoyed a place of prominence in nursing literature. EBP is also one of the core responsibilities of NPD practitioners depicted in the NPD Practice Model (Harper & Maloney, 2016). Given these facts, the number of participants who described EBP as a desired future state, or as something done only by graduate students as part of their degree requirements was unexpected. In contrast to research and EBP, quality improvement was described by participants as an important part of their work. This aligns with the findings of Warren and Harper (2017), who noted an increasing emphasis on quality improvement work within NPD practice.

**These are my People**

Research question three asked how NPD practitioners perceive their role’s influence on the practice of AC staff. Most participants clearly articulated their influence and exhibited a sense of accomplishment and pride in the impact they had on staff development and subsequent patient care. Most also evinced a sense of identification with AC nurses, even if they had no experience in direct care nursing in the AC setting. These findings are discussed primarily within theme three, “these are my people”.

**Representation and Advocacy**
The scope and standards of practice for NPD (Harper & Maloney, 2016) identifies advocacy for the NPD specialty as a standard of practice. While the participants’ narratives reflected advocacy for greater visibility and support for the NPD role within their organizations, they also reflected advocacy for greater visibility and support for AC nursing overall, going well beyond the standard of practice common to all NPDPs. Whether advocating for a place at the decision-making table, for a greater share of organizational resources for staff development, or simply for more visibility within the organization, NPD practitioners saw themselves as representing and promoting AC nursing as a whole, not just the NPD specialty.

Isolation

The literature shows that peer support is important for successful transition into the NPDP role (Fritz, 2018). This finding was affirmed by the findings, as several participants described community with other NPD practitioners as valuable in combating feelings of isolation in their roles. Some participants who did not have NPDP colleagues in their organizations emphasized the value they found in joining professional organizations as a means of finding peer support. This suggests that although some AC organizations may be unable to hire more than one NPDP, it is both possible and important for all NPDPs to find peer support.

Influence

Participant narratives showed a significant capacity for NPDPs to influence nursing practice in AC. From providing guidance on scope of practice to ensuring nurses are aware of new best practice guidelines, participants changed the way patient care was
delivered in their organizations. Some participants indicated they felt they had greater capacity to effect change in the AC setting than they had experienced in acute care, and they found this rewarding. Prior literature hints at the influence of NPDP roles on nursing practice in AC (Batiste, 2018), but this topic has not been explored in detail.

**Parallels**

The parallels between how AC NPDPs describe their own work and how they describe the work of the staff they serve indicate a sense of investment in and identification with AC nursing. This parallel has not been noted in previous literature in the same way. Others have written about the tendency of NPDPs to maintain their identities in their previous clinical specialties (Harper et al., 2016) but no literature has been found documenting cases in which NPDPs came to identify with new clinical specialties they supported. This phenomenon may warrant further investigation.

**Joy and Meaning**

Nearly all the participants spoke about their work with pride and some shared stories about specific elements of their work that brought them a sense of joy or meaning. These stories ranged from seeing their influence on the professional growth of staff to simply enjoying the AC environment. Regardless of the reasons cited, most participants were clear that they valued the opportunity to work in AC.

**Contributions to the NPD Practice Model**

The findings suggest that in settings where the NPD role is new (which is often the case in AC), the throughputs of the NPD Practice Model (Harper & Maloney, 2016)
may be adopted in a somewhat predictable and linear fashion. Orientation and onboarding, education, and quality improvement were critical components of every participant’s work and seemed to be the first priorities for the NPD department. Collaborative partnerships were also common to all participants, although to varying degrees. Creation of competency and role development programs followed, and these were described as very recent additions by several study participants. Research and EBP were largely regarded as next steps toward a desired future state. Understanding the typical evolution of new NPD departments may be useful to others who, like Participant 7, have been tasked with building an NPD program from scratch.

**Strengths and Limitations**

The purpose of a descriptive phenomenology is to reify the essence of a phenomenon, using the lived experiences of those who have personal knowledge of the phenomenon of interest. According to Matua and Van Der Wal (2015), descriptive phenomenology is a desirable approach when an experience is not already well understood, while interpretive phenomenology is useful in helping people understand an experience within its context. Descriptive phenomenology gives shape to a phenomenon; interpretive phenomenology helps make sense of the phenomenon. Descriptive phenomenology was chosen for this study because the phenomenon of NPD practice in AC has not been previously described in the literature. Prior literature on NPD practice has tended to either ignore NPD practice in AC or assume that NPD practice is essentially the same in all settings. This study was conducted to make the features of NPD practice in AC explicit, showing where they converge and where they diverge from NPD practice in acute care. While descriptive phenomenology excels in providing rich
descriptions of phenomena, the methodology is limited to simply showing the phenomenon as it currently exists. Future work will need to explore how to improve NPD practice in AC.

There were some limitations to this study. The first was the difficulty of recruiting an ethnically, educationally, and geographically diverse sample. Current demographic information on NPDPs is unavailable, but a national nursing workforce survey conducted in 2017 showed 80.5% of registered nurses in the US were White. Another 5.5% were Black/African American, 6.6% were Asian, 2.1% were two or more races, and the remaining categories had less than 1% each (Smiley et al., 2018). Given these statistics, the sample should ideally have included at least one non-White participant.

By contrast, the gender breakdown of the sample was relatively consistent with the overall population of registered nurses (93.4% female) reported in the same survey (Smiley et al., 2018). The fact that all participants had master’s degrees was somewhat surprising. A national survey of hospital-based NPD practitioners published in 2016 found only 59% of NPD practitioners had a master’s degree (Harper et al., 2016). The findings may not adequately reflect the experiences of non-white NPDPs in AC, those working in underrepresented parts of the country, or those with a different level of educational attainment.

Another limitation was recruitment through professional organizations. Although several participants strongly recommended involvement in professional organizations as an aid to NPD practice in AC, that finding may have been biased by the fact participants were recruited primarily through professional organizations. Engagement in professional organizations may not be common to the experience of all, or even most, NPDPs in AC.
Recommendations for future research

The description of NPD practice in AC suggests opportunities for future research. The first is the existence of hybrid manager/NPD roles in AC. The prevalence of this phenomenon is unknown and further study is warranted. Moreover, as noted by Batiste (2018), management and NPD are two different jobs. Nurses serving in dual roles may benefit from additional training to ensure they have the skills to fulfil both roles.

Transition to practice as an NPDP in AC may also require further investigation. Existing literature focuses on transition to practice in NPD more broadly, and almost exclusively in inpatient settings (Fritz, 2018). Future research should examine transition to the NPD role within the context of varied practice settings.

These findings also raise the question of how to meet the need for professional development opportunities when the number of staff is small. In the current system, a small staff may not seem to justify the cost of professional development. Future research should evaluate the impact of NPD work in terms of patient outcomes and population health rather than, or in addition to, number of staff served. Adjusting the lens through which outcomes are viewed may result in support for more staff development even when staff numbers are low. Finally, although the features of the NPD Practice Model were largely reflected in the descriptions of participants, further research could help identify areas in which the model may not completely represent NPD practice in ambulatory and other non-hospital settings.

Implications
This study is important because it addresses a substantial gap in the literature regarding NPD practice in AC. The findings indicate that NPDPs in AC are integral to the delivery of high quality patient care and to the professional growth of the staff they serve. NPDPs raise awareness for AC within larger health systems. They advocate for, and often succeed in securing, the resources and recognition AC staff need. The variability in scope reported by participants suggests some NPDPs in AC may need to become more assertive in explaining what they bring to the team and how they can be used most effectively.

Several participants said they would advise new NPDPs in AC to seek community with other NPDPs. Organizations may need to be more intentional about supporting NPDPs in AC to find peers and reduce isolation in their roles, particularly when the organization is small and has only one NPDP in AC. The findings suggest the number of NPDPs in AC is growing, which may make it easier for NPDPs to find others who share their practice setting.

NPDPs transitioning to AC may require additional orientation time to develop contextual knowledge. Organizations hiring AC NPDPs from an acute care background should develop orientation plans that include time in each specialty department. This time could aid NPDPs both in understanding the AC context and in performing an accurate learning needs assessment for AC departments.

Conclusion

NPD practice in AC is a growing field in the US. Despite the growth of NPD in this setting, what we know is limited as most literature on NPD practice comes from
acute care settings. Current evidence about NPD practice in AC settings suggests organizations are working to build NPD departments and incorporate elements of practice that are mostly consistent with the NPD Practice Model. This study adds to our knowledge by establishing a clear depiction of the current state of NPD practice in AC and delineating features of the AC setting that influence NPD practice. Future study is needed to further understand how best to meet the professional development needs of staff within the AC context.
Appendix A

Screening Survey for Potential Participants

Potential participants who respond to the recruitment flyer will be asked the following screening questions to determine eligibility for the study.

1. Are you a registered nurse? (Respondents who answer no will be taken to a “thank you, but you are not eligible” screen.)
2. Are you employed at least half time (0.5 FTE) in nursing professional development in an ambulatory care setting? (Respondents who answer no will be taken to a “thank you, but you are not eligible” screen.)
3. How long have you worked in an ambulatory care setting?
4. Have you worked in nursing professional development in an acute care (hospital) setting? (Respondents who answer no will be taken to a “thank you, but you are not eligible” screen.)
5. How long did you work in nursing professional development in an acute care setting?
6. In what state is your primary place of employment?
7. What type of organization do you work for? Please select all that apply.
   a. Academic
   b. Non-profit
   c. For profit
   d. Rural
   e. Urban
   f. Suburban
   g. Multi-site
   h. Large system
   i. Local community-based organization
   j. Other (please describe)
8. What is your highest degree earned?
   a. What is your highest nursing degree, if different?
9. Are you certified in Nursing Professional Development?
10. What is your gender?
    a. Female
    b. Male
    c. Other
    d. Prefer not to say
11. What is your race or ethnicity?
    a. Asian
    b. Black
    c. Hispanic/Latino
    d. Mixed
    e. White
    f. Other
12. With which generation do you most closely identify?
    a. Silent Generation/Veteran (Born before 1964)
    b. Baby Boomer (Born between 1946 and 1964)
    c. Generation X (Born between 1965 and 1980)
d. Millenial (Born between 1981 and 1994)
e. Gen Z (Born between 1995 and 2015)

13. Please enter your name, phone number, and preferred email address and a member of the research team will contact you.
Appendix B
Semi-Structured Interview Guide for NPD Phenomenology

1. Please describe your experience practicing as an NPD in ambulatory care.
   Possible probing questions derived from pilot study include
   a. Please describe a typical day at work.
   b. How many sites do you support? How does that support differ by site?
   c. How many specialties do you support?

2. When you moved to ambulatory care, how would you say your practice changed from your work as an NPD in acute care?
   a. Please share some examples from your acute care experience to help me understand these differences?

3. Please tell me about something unexpected you have encountered in ambulatory care.
   a. What did you first notice?

There are 6 specific areas of NPD work I would like to ask you about. I am looking for your understanding of these 6 areas and examples of what these are like in your setting.
(Probing questions include asking for examples, such as “Tell me about a time when you were asked to provide in-service education”.)

4. We will start with education. What does that look like in your practice?
5. What does it mean to support orientation and onboarding in your practice?
6. What does role development look like in your practice setting?
7. Please talk about your experience with competency management in ambulatory care?
8. How do you facilitate collaborative partnerships in your setting?
9. Now for the last one – research, evidence-based practice, and quality improvement.
   What does that look like in your practice?

Thank you. I have a few additional questions.

10. What advice would you give to someone who expressed interest in becoming an NPD in ambulatory care?
11. Please describe the essence or meaning of NPD practice in ambulatory care.
12. Please describe your influence on ambulatory nursing practice.
    a. Please share some examples from your experience.

13. Is there anything I have not asked about that you would like to share?
14. “If needed, are you willing to be contacted near the end of my study to read my results and give feedback on whether my final description accurately represents your experience with NPD practice in ambulatory care?”
References


Nurses for Enhanced Roles in Primary Care, Atlanta, Georgia, June 2016: Josiah Macy Jr. Foundation.


Elizabeth Fritz is a program manager in system clinical education at SSM Health. Her work supports the professional development of nurses and other clinical staff at about 20 hospitals and hundreds of clinic locations in four states. In this role, Elizabeth plans, implements, and evaluates programs related to role development, competency, and interprofessional continuing education.

Elizabeth began her nursing career at Baptist Hospital in Pensacola, Florida, where she worked on a large medical floor. She quickly became a preceptor and charge nurse. In these roles, she discovered her greatest professional joy lay in supporting the development of students and new nurses on her floor. After three years, she had an opportunity to move to Wisconsin to begin teaching nursing.

In 2007, Elizabeth became an instructor at Maranatha Baptist University and started her dual-track MSN through the University of South Alabama, training for the roles of adult clinical nurse specialist and nurse educator. During her education practicum, Elizabeth was introduced to the role of the nursing professional development (NPD) practitioner.

After teaching at Maranatha for six years, Elizabeth transitioned to an NPD role, working for Dean Clinic (now SSM Health Dean Medical Group). In that role, Elizabeth discovered the world of ambulatory care nursing. She also discovered the lack of literature available to guide NPD practitioners in practicing their specialty in the ambulatory care environment. This prompted her quest to learn to conduct valid and reliable research and help fill the gap in NPD literature in ambulatory care.
In 2020, Elizabeth transitioned to her current role, where she oversees NPD programs at a system level. In this role, she is already conducting research related to NPD practice.