

## Building a Collaborative Hematology/Oncology Advanced Nursing Practice: Part I

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A group of advanced practice nurses (APNs) in a comprehensive cancer center met personal and professional challenges by developing an intentional collaborative group practice. The group, comprised of nurse practitioners (NPs) and clinical nurse specialists (CNSs), practiced in a comprehensive cancer center with a long history of using APNs but no direct APN leadership or purposeful collaboration with other APNs. Amidst a rapidly expanding cancer center, the hematology/oncology NPs and CNSs faced challenges related to professional development, reporting structure, role, and accountability. This article is the first in a two-part series that describes the development of a collaborative APN group designed to address the challenges. Outcomes from the purposeful collaborative practice will be discussed in part II.

### Advanced Practice Nursing History and Challenges

Historically, the model for APN practice at the academic cancer center was based on seven NP and physician subspecialty teams in the outpatient setting. The teams were designated as hematology/oncology disease

management groups and practiced relatively independently of each other. Eight NPs functioned in the disease management groups, and one CNS practiced on the inpatient oncology unit in a traditional CNS role. In addition, two other NPs were members of the palliative care service and practiced regularly in the hematology/oncology setting. The individuals formed the core group that set out to form a new collaborative APN practice. Not unlike collaboration negotiations between individual physicians and APNs, the group had to identify and integrate multiple personal agendas and fuse them into mutually agreeable goals. The goals were developed in response to issues such as accountability, role identification, clinical practice, education, and academic productivity.

Role responsibilities for the NPs were quite diverse and encompassed functions typically performed by secretaries, staff nurses, CNSs, and physicians. NPs were accountable to the physicians with whom they worked, but their annual evaluations were completed by the department business manager, who had a master's in business administration and formerly practiced as a bachelor's-prepared RN. The CNS had a dif-

ferent reporting structure and was accountable to the department of nursing.

As the cancer center expanded, additional APNs were hired. Each was hired by the business manager or the physician with whom he or she would work within the disease management group. When new NPs were hired, they typically received a two-day orientation with an experienced member of the APN group. They subsequently were expected to be clinically independent, with further on-the-job training and socialization conducted primarily by the physician. In contrast, the CNS hired for the inpatient unit received a one-month orientation by a CNS mentor already working in the hospital system. The brief NP orientation and the evaluation process were perceived as inadequate by new and seasoned NPs.

Although interest in and opportunities for collaborative research and education abounded at the facility, no structure supported the pursuits. Individually, APNs were academically productive, as evidenced by professional publications, participation in research studies, and presentation of posters and abstracts. However, the accomplishments went largely unrecognized within the fragmented APN group and the larger medical community. Clinical research protocols involving NPs usually were written without their input. In addition, medical research articles to which APNs contributed often were

### Leadership & Professional Development

This feature provides a platform for oncology nurses to illustrate the many ways that leadership may be realized and professional practice may transform cancer care. Possible submissions include but are not limited to overviews of projects, accounts of the application of leadership principles or theories to practice, and interviews with nurse leaders. Descriptions of activities, projects, or action plans that are ongoing or completed are

welcome. Manuscripts should clearly link the content to the impact on cancer care. Manuscripts should be six to eight double-spaced pages, exclusive of references and tables, and accompanied by a cover letter requesting consideration for this feature. For more information, contact Associate Editor Paula Klemm, PhD, RN, OCN®, at [klemmpa@udel.edu](mailto:klemmpa@udel.edu) or Associate Editor Judith K. Payne, PhD, RN, AOCN®, at [payne031@mc.duke.edu](mailto:payne031@mc.duke.edu)

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published without acknowledgment of the APNs' contributions. Furthermore, novice APNs who sought assistance with research design or manuscript preparation found little support in the institution.

Group direction and leadership presented formidable challenges. The group elected certain APNs to be leaders and to rotate as facilitators of weekly APN meetings, which contributed to a lack of consistent leadership and direction. Although the meetings were designed to disseminate new information, provide networking opportunities, and solve long-term problems, they often focused on operational issues and daily problem solving. The group also lacked a reporting structure to provide consistent accountability for clinical and professional practice. When the group, as a whole, identified the challenges, it initiated a process by which they could be addressed.

## Theory of Group Development and Collaboration

**Group development:** Tuckman (1965) thoroughly described the development and behavior of small groups. The model, used by the institution's human resources specialists to facilitate group formation in the hematology/oncology setting, provided the framework that guided the APN group in the development of a collaborative practice. Tuckman initially identified four stages through which groups progress before reaching maximum effectiveness. Stage 1 is the "forming" stage, in which the behavior of individual members is driven by a desire to be accepted by the other members. Serious issues and expression of feelings are avoided while people focus on routines, details of organization (e.g., meetings), gathering impressions of other members, and group functioning. In stage 2, the "storming" stage, individuals begin to assert their views in minor confrontations that are addressed quickly and then glossed over. However, conflict often remains under the surface. Progression to stage 3, the "norming" stage, results in clear "rules of engagement" as group tasks or responsibilities are agreed upon. Resistance to internal or external pressure to change is a potential problem because members may fear that the group will dissolve. Stage 4 is known as the "performing" stage, whereby the group has become interdependent and flexible. Group identity, loyalty, and morale are high, and the group's energy is directed toward accomplishing goals because of the perceived comfort and security acquired by this stage. The model was refined in 1977 with the addition of a fifth stage (Tuckman & Jensen). Stage 5, "adjourning," describes a process of group completion and disengagement. For the purposes of this discussion, only the first four stages will be addressed directly.

**Collaboration:** Nursing literature on collaborative practice is limited and focuses

primarily on relationship issues between APNs and physicians (Marfell, 2002; Martin, O'Brien, Heyworth, & Meyer, 2005; Taylor-Seehafer, 1998) or aspects of clinical practice (Marfell) and research (Beavers, Gruber, & Johnson, 1990; Bergstrom et al., 1984; Brown, Tanis, Hollingsworth, & Brooten, 1984). Hanson and Spross (2005) defined the concept of collaboration as a "dynamic, interpersonal process in which two or more individuals make a commitment to each other to interact authentically and constructively to solve problems and to learn from each other to accomplish identified goals, purposes, or outcomes. The individuals recognize and articulate the shared values that make this commitment possible" (p. 344). Nugent and Lambert (1996) proposed a model of collaborative practice based on common purpose, professional contributions, collegiality, communication, and client-focused practice. The focus of the model was the physician/APN relationship. Overall, little consideration has been given to collaboration among APNs with the intent of fostering professional growth and advancing common goals.

## Group Needs-Assessment Process

Consistent with Tuckman's (1965) model at stage 1, APNs started preliminary discussions to articulate their needs as individual professionals, assess what members wished to accomplish as a group, and examine how the needs and goals fit the needs of the institution and the nursing profession. The group requested a facilitator from the human resources department to establish a qualified neutral presence to encourage feedback from all members. The action confirmed that members wanted to identify common goals and develop collaborative relationships with other APNs. Weekly one-hour meetings then focused on clarifying overall goals at the institutional, regional, and national levels.

The first step was to review the strategic plans of the cancer center and medical center. Identification of cancer center activities in which the APNs had little influence was an important focus. The group identified a consistent lack of input into decision making with regard to clinical trials, outpatient clinic function, educational initiatives, strategic planning, and APN practice. Members prioritized the roles that they believed were critical to practice (e.g., creation of core lectures, reimbursement and billing decisions, research protocol development) and determined the level of involvement they wanted to achieve. Other discussions included group goals for regional and national involvement (e.g., legislation and lobbying, public awareness of the APN role, prescriptive practice). Regional recognition would benefit the cancer center and highlight what the group had accomplished on the local level. National recognition would enhance regional and local credibility and spotlight the contributions of APNs at the cancer center. Involvement at

the regional and national levels was deemed critical to justify time devoted to academic pursuits (e.g., research projects, manuscript preparation, professional presentations).

## Process Steps to Successfully Address Identified Needs

To help plan the structure of the APN group and to ensure acceptance of its role, representatives from administration were asked to participate in the process. They included the director of nursing at the cancer center, the business manager, and the chief nurse executive at the medical center. The facilitator from the human resources department continued to assist in the group process by facilitating negotiations with administration to change leadership. This process step mirrored Tuckman's (1965) second stage of group development as APNs began to share conflicting ideas and worked through their differences to establish structural clarity for the group.

The next step consisted of a series of tasks designed to review advanced practice nursing at the facility and compare it with that of other similar institutions. The first task was to examine the structure and leadership of a group of certified nurse midwives who comprised the only cohesive and self-governing APN group in the institution. The director of the midwives, herself an APN, met with the group to discuss her role and provide insight into group collaborative practice. Two individuals in the work group investigated reporting structures for other APNs in the institution. In addition, two other members of the APN group developed an informal questionnaire to poll administrators of 25 comprehensive cancer centers regarding the number of APNs in each center, how APN groups functioned, and the nature of their reporting structures. The responses served as a benchmark that enabled the group to examine models of group process around the country. Of note was a lack of large, formally organized APN groups at the 10 cancer centers that responded to the survey.

The third process step was to conduct a series of meetings specifically to work on group development. All meetings were moderated by the human resources facilitator, who stimulated dialogue, kept the discussion focused on the work, and summarized progress. After the "rules of engagement" were established, the third stage of Tuckman's (1965) model was realized as the group began to establish a sense of cohesiveness and mutual support. In short, the APNs and administrators worked together to establish a functioning group with common goals.

## Group Development Process Toward Collaborative Practice

**Mission and vision statements establish identity:** Early in the process, the group discussed ideas for the development of mission

and vision statements. Members agreed that personal (e.g., caring, ethics, courage, honesty, compassion, sensitivity) and professional (e.g., responsibility, thoroughness, productivity, integrity, commitment to good communication) values should be essential components of the mission statement. When the values were articulated, two members volunteered to write the following mission and vision statements, which, subsequently, were approved by the group.

- **Mission:** to provide comprehensive expert care to people affected by cancer while promoting wellness and self-care
- **Vision:** In two years, we will be locally, regionally, and nationally recognized APN role models, leaders, and indispensable contributors to the science and caring of people affected by cancer.

Because of the volume of work that was required, a retreat was needed to provide time to summarize where the group was, where it was going, and where it wanted to be. Four hours were set aside to develop and formalize current and future expectations of group members and to develop a timeline to enable the group to meet its goals.

**Development of group goals to achieve unity:** Group goals had to be clear and measurable to provide useful indicators of success. In addition, the group recognized that a number of internal and external variables in the work environment influenced goal formation. Therefore, the group evaluated its collective strengths and weaknesses to guide the development of the vision into clear and measurable goals (see Figure 1). Interestingly, several of the strengths were listed in the literature as justification for the APN role (Nevidjon & Knudson, 2005). Next, external influences identified as opportunities and threats were explored to determine whether they would affect the growth of the group (see Figure 2). Finally, the group decided that goals should be consistent with and further those of the cancer center and the institution. Establishment of goals based on group and institutional aims centered around four themes, which formed the basis for the stated goals: (a) recognition, (b) role models and leaders, (c) contributors to science, and (d) contributors to caring. Identification of key audience members (e.g., physicians at the institution, the local general public, a national audience) assisted the group in planning concrete ways to meet each goal. In addition, a specific plan was developed to provide group accountability for goal achievement over a two-year period.

While the group developed measures to achieve stated goals, it examined APN contributions individually and as part of the group. The group realized that individuals might pursue different levels of professional involvement in research, education, or scholarly work and that they would be respected. The members sought to foster a collaborative environment that was mutually supportive

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#### **Strengths: Values**

- Integrity
- Attention to detail
- Ethical
- Compassion
- Integrity
- Indispensable

#### **Strengths: Functions**

- Interpersonal skills
- Communication skills
- Compassion and empathy
- Experience
- Expertise
- Accessibility
- Productivity
- Critical mass of advanced practice nurses (enough to have influence within the department)
- Collective knowledge and experience

#### **Weaknesses: Values**

- Overcommitted
- Varying experiences and interests
- Gender issues
- Lack of professional esteem
- Lack of unified voice
- Public perception
- Physician perception
- Reactionary

#### **Weaknesses: Functions**

- Lack of political experience
- Competing priorities
- Lack of role clarification
- Lack of clear accountability
- Reporting structure
- Professional development structure
- Limited time
- Lack of unified peer support
- Differences in knowledge and education

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### **Figure 1. Group Strengths and Weaknesses**

and noncompetitive and in which all achievements toward personal and professional growth were celebrated. Members were frank about what they could contribute to ensure that clinical responsibilities were fulfilled in a manner that was fair to all involved. Each APN was responsible for assessing how his or her individual projects or plans fit with the group's goals to facilitate successful group outcomes.

**Leadership to spearhead recognition:** The next step in the group process arose from questions raised by the process itself: "Would the current leadership structure facilitate successful accomplishment of our mission, vision, and goals?" If not, then "how could we change it to be consistent with our group process?" Given those questions, the group decided that it needed a representative who would advocate effectively for the APNs in the cancer center. In addition, representation was needed at

meetings in which decisions were made that affected the APNs' future (e.g., strategic planning, education, research, fiscal and financial budget planning, policy and procedures, patient care). Communication and feedback mechanisms were necessary within the cancer center to disseminate knowledge and provide a process for APN feedback to be heard. Institutionally, the group sought a liaison with the office of professional nursing practice to facilitate involvement within the larger institution.

In addition, advocacy was necessary on an academic level. Negotiations with APN colleagues for clinical cross-coverage allowed APNs to work on academic pursuits without interruptions. However, no mechanism was in place to ensure that the time was, in fact, uninterrupted. This made accepting academic commitments (e.g., speak, teach, attend continuing education events) difficult because APNs did not know whether they would be granted the time to fulfill commitments.

To promote freedom of discussion with respect to group leadership, the APNs asked the administrators to refrain from attending meetings at which group leadership was discussed. This was initially met with some resistance but was accepted with support from the human resources facilitator. Strong agreement emerged for an APN to lead the group as opposed to an administrator with a master's degree in business administration or a physician. This was deemed critical for several reasons. The APN role is complex and requires interaction with many other providers on different levels. APNs are accountable in some instances to medicine and to others in nursing. In the authors' institution, accountability belongs specifically to neither one, and is therefore unique. The group felt strongly that it should be led by one of its own members but was willing to look outside the group if a viable internal candidate did not emerge.

The group had to determine what leadership responsibilities the group wanted to own. This was an important step to ensure the level of leadership necessary to foster group goals. Key tasks for the APN leader were identified: Track group accomplishments, push for professional growth, develop faculty appointments, advocate for academic time, and mentor members. In addition, the individual would address APN complaints, manage performance evaluations, and be responsible for hiring and firing. He or she would develop a peer-review process as a part of annual evaluations and be responsible for scheduling and coverage issues. The group decided that the APN leader would have a clinical patient load as well. Finally, the individual would seek to ensure accurate and appropriate use of relative value units with respect to APN practice in the cancer center. Because the issue was complex, a second four-hour retreat was planned to finalize the process and plan for implementation.

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### Opportunities

- Improve satisfaction of advanced practice nurses (APNs).
- Create new structure for APN group collaboration at the institution.
- Receptivity of physicians to group growth
- Growth of the cancer center
- Administrative interest in an APN leader within the cancer center
- Change in research funding toward patient-centered projects
- Growing evidence base for APN quality care
- Potential revenue impact

### Threats

- Changes in group structure with subsequent difficulty in reaching consensus
- No APN presence in higher levels of cancer center administration
- Perceived competition by physicians
- Physician and APN power dynamics
- Inability to compete for research dollars with bigger institutions
- Lack of APN organization and autonomy
- Volatile reimbursement environment

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## Figure 2. Opportunities for and Threats to Group Development

### Final Phase of the Group Process: Plan for Implementation

Three steps in the final phase of the group development process remained to be addressed. The first was to solidify group goals to support the mission, which were finalized during another short APN retreat. Members worked on a personal “goal grid.” Individual goals then were categorized as part of larger group goals and set out on a quarterly timeline. The second step was to determine the APN leadership structure and create a plan for implementation. To achieve the representation necessary to achieve the goals, the group sought a director-level position. The position was negotiated among a senior APN (at the time a representative of the group, who later was elected to the leadership position), the business manager, and the physician who was the hematology/oncology section chief. The facilitator from human resources was invaluable during the negotiation. The new position was approved by the section chief, after the group explained its goals and the rationale for APN leadership. The APN director position was to be formally accountable to the section chief, with an informal link

to the director of nursing. The third step consisted of a group meeting to finalize job requirements and behavioral expectations for the APN leader position, establish the selection process, and outline the steps for reorganization of the group after the interim leadership. An APN subcommittee developed a job description for a director-level position modified for the APN role. The position description and minimum requirements were submitted to the group for review, comment, and final approval.

Finally, the group discussed how it wanted to be involved in the selection process for the new director. Were formal interviews required; if so, who would be involved? Could the group reach consensus on who it would recommend to the section chief? Should the section chief interview the candidate independently and make a unilateral decision? The group decided that candidates would be interviewed formally by members of the APN group who volunteered for the task. Group consensus was reached on a candidate, and a recommendation was sent to the section chief, who made a final decision.

### Conclusion

The process described in this article led to the current model of collaborative APN practice at the cancer center. The group reached what Tuckman and Jensen (1977) described as the fourth stage of “performing.” The process produced a collaborative group that has demonstrated remarkable academic achievement while delivering expert patient care consistent with the APNs’ mission and vision. APNs meet weekly to discuss a broad range of issues (e.g., benefits, retreat planning, research ideas, problem solving, networking, hiring, professional development) that affect the entire group. The current model also includes three months of formalized orientation that is tailored toward the needs of APNs who are new to the group. The group is strengthened by collaborative relationships, ongoing communication, and a yearly APN retreat to facilitate professional development through didactic seminars and team-building exercises. Seasoned APNs mentor newer members. Time to pursue academic interests is granted based on a system that awards points to those who are academically productive. The annual review process incorporates input from peers and the APN director. Perhaps most importantly, the group has a leader who understands the unique issues faced by oncology APNs and advocates for the group. The process of group

development led to a successful model for advanced practice nursing in oncology at the academic medical center. The outcomes of personal and professional achievement, along with local, regional, and national recognition, will be described in detail in part II.

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