

BARRIERS TO NEW NURSE PRACTITIONER JOB SATISFACTION

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Barriers to New Nurse Practitioner Job Satisfaction

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ABSTRACT

Novice Nurse Practitioners (NPs) face many challenges in the first few years of practice. A novice NP was defined as a NP who has practiced for two years or less. The focus of this practice improvement project was to investigate what novice NPs in North Dakota perceive as barriers to successful role transition, job satisfaction, and how organizational climate affects job satisfaction. A convenience sample of novice NPs (N=14) were recruited through three separate venues. The Misener NP Job Satisfaction Scale© (MNPJSS) and the Nurse Practitioner – Primary Care Organizational Climate Questionnaire (NP- PCOCQ) were chosen to measure the project objectives. Survey statistical analysis consisted of means and standard deviations due to a small sample size. The MNPJSS assesses intrinsic (emotional) and extrinsic (environment) NP job satisfaction (Misener & Cox, 2001) and the NP-PCOCQ evaluates organization climate in relation to NP job satisfaction (Poghosyan et al., 2013a).

The MNPJSS has six subscales, four extrinsic, and two intrinsic factors affecting job satisfaction. The extrinsic factors rated highest were related to fair evaluation, social contact at work, and immediate supervisor. The intrinsic factors were time spent in patient care, patient mix, and sense of accomplishment (Misener & Cox, 2001). The factors with the least satisfaction were related to bonuses and other compensation. Independence in practice, having a mentor, and feeling valued were organizational satisfiers. Lack of professional visibility and poor relations with administration were identified barriers.

Several studies have found that autonomous practice is one of the most important factors in NP job satisfaction (Choi & De Gagne, 2015; De Milt, Fitzpatrick, & McNulty, 2011; Faraz, 2016; Faris, Douglas, Maples, Berg, & Thrailkill, 2010; Misener & Cox, 2001). Nevertheless, laws limiting NP practice authority persist. There are 234,000 NPs in the U.S. and the number of

NP graduates increases exponentially each year, in 2015-2016 there were 23,000 NP graduates (AANP, 2018, January 22). The first step to ease transition to practice is to identify and limit barriers for NPs entering the workforce.

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DEDICATION

I dedicate this dissertation in honor of Hal, Landon, and Carter Weiser.

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CHAPTER ONE. INTRODUCTION

The United States (U.S.) healthcare system is going through dramatic transformation. Changes are occurring on many fronts creating stress on an already overloaded network of primary care providers (Chattopadhyay, Zangaro, & White, 2015). Chattopadhyay et al. (2015) predicted that the demand for primary care services would rise 81% over the ten-year period 2010-2020, based on population growth and the baby boomer increased longevity and illness chronicity. The Affordable Care Act (ACA) predicted expansion of insurance coverage to 32 million Americans (Institute of Medicine [IOM], 2011) at a time when physician resources in primary care are decreasing (Poghosyan, Liu, Shang, & D'Aunno, 2016). As of 2017, an additional 19.7 million Americans have health insurance than had coverage in 2014 (CDC, 2017). The IOM (2011) report recommended maximizing nursing knowledge, skill, leadership, and collective influence in remodeling and transforming the future of health care systems. Specifically, the IOM recommended removal of scope of practice barriers and focus on expanding the NP workforce.

The nursing organization's response has been robust and the numbers of NPs entering practice have surpassed predictions (Auerbach, 2012). NPs are entering primary care practice at rates higher than physicians or physician assistants (PAs). Currently, there are 234,000 licensed NPs in the U.S. and over 87% (204,000) are prepared in primary care (American Association of Nurse Practitioners [AANP], January 2018). However, despite forward movement in practice authority and an increase in the NP workforce since the initial IOM report, barriers and restrictions to NP practice persist. Constraint placed on NP independent practice has been shown to reduce NP job satisfaction according to Pasarón (2013).

The focus of this practice improvement project was to investigate what novice NPs perceive as barriers to successful role transition, job satisfaction, and organizational support. There were two surveys used in the project. The first survey, Misener NP Job Satisfaction Scale© (MNPJSS) consisted of a satisfaction scale specific to NP practice for assessing intrinsic and extrinsic barriers that affect NP job satisfaction (Misener & Cox, 2001). The purpose of the second survey, Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ), was to assess the NPs perception of as organizational barriers that lead to job satisfaction. Furthermore, two open ended questions, which asked for comments on job satisfaction and organizational climate were added to garner qualitative data. A presentation of the survey results to North Dakota State University (NDSU) Doctor of Nursing Practice (DNP) students and faculty is scheduled for late April 2018. The purpose of the Brown Bag meeting is not merely to share the survey results, the co-investigator's expectations are to create an open dialog and to brainstorm strategies to lessen obstacles to successful role transition for the DNP student.

Nurse Practitioners can ... “evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatment-including to prescribe medications” (Choi & De Gagne, 2015, pp. 170-171). State regulations govern practice in the state in which the NP is employed. Three levels of regulation and state laws pertaining to APRN practice authority exist in the U.S. *Restricted Practice* requires supervision, team management, or delegation by a physician, or other health provider; *Reduced Practice* reduces the ability of NPs to engage in at least one area of practice by requiring a collaborative agreement with another healthcare provider; and *Full Practice* allows NPs freedom to perform all responsibilities without physician supervision (AANP, n.d.b; Choi & De Gagne, 2015). The IOM (2011) implored states to eliminate advanced

practice registered nurse (APRN) practice restrictions and to uniformly allow APRNs to practice at the full extent of their education and training.

Pasarón (2013) reported that despite the American Medical Association's (AMA) statement in support of limiting NP autonomy, many physicians support increased scope of practice and found that NPs "improved patient care in the areas of quality, satisfaction, accessibility, patient/family compliance, and productivity" (p.2599). Surprisingly, DesRoches, Buerhaus, Dittus, and Donelan (2015) found primary care physicians would recommend a career as an NP (66%) over their own career (56%). Auerbach (2012) predicted the future NP workforce would grow by 130% to equal 198,000 practitioners by 2025. Using a forecast model, Auerbach (2012) calculated that by 2015 there would be 170,000 NPs. AANP data (2018, January) shows that the number of licensed NPs grew from 171,000 in 2013 to 234,000 in 2016. Approximately 36,000 more NPs were practicing in 2016 than Auerbach (2012) projected would be in the workforce in 2025.

The emphasis of NP training and practice is health promotion, disease prevention, and patient education (Harrington, 2011). The NP engages and empowers the individual or family to work collaboratively to develop a plan of care. Future goals of healthcare include patient centered models of care that focus on collaboration, prevention, and improved patient outcomes. NPs are well prepared to meet the challenges and demands in primary care; and are more likely to practice in underserved, remote, and rural areas (Bae, 2016; Faraz, 2016; Mason, Gardner, Hopkins-Outlaw, & O'Grady, 2016). North Dakota (ND) is a rural state with a shortage of primary care providers (ND Center for Nursing, 2016, April). The NP is ideally suited for a rural primary care setting and brings a holistic nursing perspective.

Researchers have examined approaches for successful role integration, professional development, and queried what role aspects were most satisfying, leading to overall job satisfaction among NPs. Intrinsic factors such as challenge in the job and practice autonomy provided the greatest job satisfaction among the NPs. In addition, job satisfaction was positively affected by percent of time spent in direct patient care, a sense of accomplishment, the ability to deliver quality care, and access to a supervisor or preceptor (Misener & Cox, 2001). The extrinsic factors that created the most dissatisfaction, included role on the healthcare team, monetary recognition, assertive influence, administrative support, and collegial relationships (Pasarón 2013).

Another barrier NPs confront is the disparity in reimbursement. Reimbursement for NP services is 15-25 percent less than physicians for the same care (Choi & De Gagne, 2015; Naylor & Kurtzman, 2010). Though reimbursement is less, patient outcomes were equal to, and in some instances, better than physicians (Naylor & Kurtzman, 2010; Stanik-Hutt et al., 2013). Fee for service or productivity, creates pressure to see more patients in less time; this leads to less face-to-face time with patients, a part of the role that NPs find most gratifying (Misener & Cox, 2001). Introduction of pay for performance reimbursement based on outcomes and patient satisfaction is an area for future inquiry. Well-designed studies are needed to give added support to the claim that NPs provide comprehensive, cost effective, quality care and that NP patient outcomes and patient satisfactions rival, or exceed, other medical providers.

The first year of practice can be particularly challenging for novice NPs. The time needed to feel comfortable and competent as an independent caregiver varies from individual to individual. The transition can be challenging, at best. The novice NP, unfamiliar with the new role, often lacks confidence, fears incompetence, and feels unprepared for practice in a complex

healthcare environment. Additionally, environmental barriers can impede role transition and job satisfaction for NPs. Healthcare organizations that recognize and remove barriers, as well as, support and cultivate the NP role, retain employees, and promote job satisfaction (Faraz, 2016; Hill & Sawatzky, 2011). The cost to the organization of training then replacing NPs extends beyond the financial losses incurred (De Milt et al., 2011). Patient satisfaction, quality, and safety also suffer from the loss (De Milt et al., 2011).

Significance of Proposed Project

NPs provide independent, high quality care, in multiple healthcare settings with patient outcomes equaling or exceeding physician colleagues (Stanik-Hutt et al., 2013). An anticipated shortage of 52,000 physicians by 2025 (Pettersen et al., 2012) will increase the need for primary care practitioners at a time when more people are entering the healthcare system, due to national policy change and an aging population. NPs can fulfill the growing need for providers in primary care. The number of NPs has more than doubled since 2004, from 106,000 to 234,000 (AANP, 2018, January). The AANP cites that more than 87% of NPs are prepared in primary care and three of four NPs currently practice in primary care.

The individual NP, the NP profession, the healthcare system, and the patient benefit when barriers to transition into advanced practice are reduced or eliminated. Faraz (2016) studied the challenges NPs face in the transition period that contribute to job satisfaction and NP's intent to leave. Common themes found in the literature related to role transition impediments included:

1. Physician lack of clarity about NP scope of practice, which contributes to role confusion (Poghosyan & Aiken, 2015).
2. The underutilization of NPs via a restrictive practice environment, further limits autonomy and complicates role transition (Poghosyan et al., 2013b).

3. A lack of organizational support or strategy to ease NP stress and anxiety experienced during the first year of practice, limits effective role transition (Hill & Sawatzky, 2011).

The focus of this practice improvement project was to identify intrinsic and extrinsic factors that influence job satisfaction in the first two years of practice. NP job satisfaction data was obtained using the MNPJSS, a 44-statement, 6-point Likert scale, job satisfaction survey formulated to assess elements specific to NP practice (Misener & Cox, 2001). There are six subscales that measure intrinsic and extrinsic factors. Higher statement means show satisfying elements of practice and lower means indicate dissatisfaction. NPs were also queried about the environmental climate that contributes to gratifying or distressing job environments. The Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ) contains 29 statements with a 4-point Likert scale and has four subscales individualized to NP practice (Poghosyan et al., 2013a). The statements with higher means indicate gratifying practice elements and low means show areas for improvement within an organization. The questionnaire assesses organizational climate with the aim to identify improvements that are beneficial to NP practice.

Objectives

The objectives of the practice improvement project were to:

1. Identify barriers that affect the role transition and job satisfaction of the novice NP during the first two years of practice in a primary care setting.
2. Identify job satisfiers and dissatisfiers of the novice NP during the first two years of practice in a primary care setting.

3. Identify what novice NPs perceive as organizational barriers affecting role transition and job satisfaction.
4. Share the findings of the project with healthcare organizations, NP faculty, students in NP programs, and practicing NPs with the goal of working collaboratively toward reducing or eliminating barriers to ease transition.

CHAPTER TWO. LITERATURE REVIEW

A literature search was conducted on Cochrane Database of Systematic Reviews, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, PubMed, and PsycINFO with a period from 2011 to 2016. Keyword search included NPs, DNPs, NP job satisfaction, and barriers to job satisfaction. Only U.S. studies were included in the literature search, all foreign studies were excluded. Exclusion criteria included literature specific to Certified Nurse Midwife, Certified Registered Nurse Anesthetists, and Certified Nurse Specialists, as the focus of this projects was NPs working in primary care. Recent research about job satisfaction of novice NPs was difficult or impossible to find; therefore, older research articles were included in the literature review. Included in the literature were two articles, one from 2005 (Kacel, Miller, & Norris) pertaining to a Midwestern state about NPs with one-year of experience and another from 2007 (Hart & Macnee) describing perception of practice readiness of novice NPs.

A total of 1600 articles resulted with the search criteria. Article abstracts were reviewed for pertinence to the desired focus. Ongoing literature review of articles pertinent to the focus of inquiry was added as the project progressed. Most of the studies were descriptive cross-sectional surveys; others were literature reviews or descriptive-correlational surveys; and one a mixed quantitative and qualitative approach. The purpose of literature review was to identify elements of practice or work environments that support or impede job satisfaction for NPs. Specific surveys from original research were obtained for the needs assessment. The two surveys were the MNPJSS, a survey specific to measuring NP job satisfaction (Misener & Cox, 2001); and the NP-PCOCQ, an organizational climate survey (Poghosyan et al., 2013a).

The definition of a barrier to transition for the project was defined by issues that were problematic, caused stress, or were perceived as a lack of support and understanding by others of the NP role. Novice NPs experience challenge especially in the first few years of employment. Feelings of anxiety, stress, role ambiguity, and a lack of support are commonplace for NPs transitioning into their new role (Barnes, 2015b; Hill & Sawatzky, 2011). Several researchers examined barriers to NP job satisfaction and role transition. Topics included in the review of the literature are listed below.

1. Novice transition and intent to leave (Barnes, 2015a, 2015b; De Milt et al., 2011; Faraz, 2016; Fitzpatrick & Gripshover, 2016);
2. Orientation (Barnes, 2015a; Goldschmidt, Rust, Torowicz, & Kolb, 2011);
3. Mentoring (Harrington, 2011; Hill & Sawatzky, 2011; Zapatka, Conelius, Edwards, Meyer, & Brienza, 2014);
4. Collaboration and autonomy (Choi & De Gagne, 2015; DesRoches et al., 2015; Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011; Shea, 2015);
5. Independence and teamwork (Poghosyan, Boyd, & Knutson, 2014a);
6. NP job satisfaction -- between two states with differing statutory regulations (Ryan & Ebbert, 2013);
7. Quality of NP care (Stanik-Hutt et al., 2013);
8. Physician and organizational support (Barnes, 2015a, 2015b; Faraz, 2016; Pasarón, 2013).

Methods to promote success in NP practice found in the literature included individual and organizational conditions. Hain and Fleck (2014) discussed the impact of practice barriers to healthcare redesign as challenging and limiting NP contribution. Researcher consensus was that

there are multiple barriers to job satisfaction and commonalities universally exist. Many authors recommend further research to examine barriers to job satisfaction and encourage ways to improve job satisfaction across different settings.

The IOM (2011) recommends a change of vision for the nursing profession to respond to the increased need for primary care practitioners. The three crucial areas for change are practice, education, and leadership. The IOM recommended that (a) NPs practice to the full extent of education and training; (b) educational systems make improvements to promote seamless and higher levels of education; (c) NPs promote full collaboration with physicians and other health professionals in redesigning the future of healthcare; and (d) data collection and infrastructure be improved to create effective labor force planning; and policy change.

A growing need for primary care services and decreased physician workforce in primary care has created a demand for practitioners (Choi & De Gagne, 2016). There is a predicted deficit of 20,400 primary care physicians (DesRoches et al., 2015). By 2025, 52,000 additional primary care physicians will be needed in primary care (Pettersen et al., 2012; Poghosyan et al., 2016b). The IOM (2011) has invited nursing leadership to increase the number of APRNs as a solution to the demand for primary care providers. The IOM calls for expansion of the nurse workforce; doubling DNP graduates; collaboration with other healthcare professionals in redesigning care; instituting residency training; removing regulatory and institutional barriers to full scope of practice for NPs; and using insight and abilities to improve the quality and safety of care (National Academies, 2010). Attracting and keeping NPs in primary care is a priority for healthcare organizations (De Milt et al., 2011). Nursing research is extensive about the value NPs bring to healthcare. Outcomes for patients managed by NPs are equal to or exceed the outcomes for patients managed by physicians (Chattopadhyay et al., 2015; Stanik-Hutt et al.,

2013). For example, NP management of serum lipids equaled or exceeded physician lipid management (Stanik-Hutt et al., 2013). In chronic disease management and primary care NPs provide care comparable to physicians (Choi & De Gagne, 2016; IOM, 2011) at a cost savings (Stanik-Hutt et al., 2013).

Advanced practice registered nurses, specifically NPs, can fill the void of healthcare services, especially in primary care settings where access is limited, due in part, to the physician shortage (Barnes, 2015a). Research has shown that NPs, more often than physicians, provide care in rural and underserved areas and to vulnerable populations (Bae, 2016). Between the years 1995-2006, there was a 3% decrease in primary care residency programs and a steady decline of residents entering primary care and internal medicine programs. During the same period, primary care NP programs grew 61% (Naylor & Kurtzman, 2010).

Nurse Practitioner Definition

Nurse Practitioners are valuable healthcare providers who care for patients across the lifespan in primary care, acute care, specialty care, and long-term healthcare settings throughout rural and urban populations (AANP, n.d.c). NP care emphasizes health promotion, disease prevention, health education, and health counseling, creating a holistic approach to patient care. Attention to patient's physical health, mental health, and social issues allows the NP to individualize patient care (AANP, n.d.c). Taking time to listen, establishing a relationship, and collaborating with the patient are hallmarks of the nursing model of care. Health and wellness decisions are reciprocal between patient and NP (Poghosyan et al., 2013b). Healthcare reform calls for effective models of care that rely on providers who collaborate and communicate with the patient to improve health outcomes in society (Stanik-Hutt et al., 2013).

Nurse Practitioner Education

Colleges and universities are increasing enrollment in graduate nursing programs across the U.S. to educate NPs to meet the demand for primary care providers. Educational programs prepare NPs at the masters or doctoral level. The American Association of Colleges of Nursing (AACN) (2015) presented a White Paper in 2004 proposing that all APRN programs move to the Doctor of Nursing Practice as the terminal degree by 2015. Unlike the research focus of the Doctor of Philosophy (PhD) program, Doctor of Nursing Practice (DNP) programs prepare experts in clinical practice. Although many programs transitioned to the DNP, Master of Science (MS) programs still exist. The Commission on Colleges of Nursing Education (CCNE) (n.d.) began accrediting DNP programs in 2008. The goal to prepare all NPs at the DNP level by 2015 has not been accomplished. CCNE has accredited 259 DNP programs since 2008 (Nelson, 2015). In 2017, there were 303 programs admitting DNP students and another 124 programs were in development. All 50 states have at least one college or university offering a DNP program of study, nine states have more than ten DNP programs. The number of students enrolled in DNP programs increased by 3300 students and the number of graduates increased by 750 students in the 2015-2016 academic year. In addition to rigorous didactic curriculum, advanced clinical training is a major component in graduate programs. CCNE requires that DNP student complete a minimum of 1,000 clinical hours post Bachelor of Science in nursing (BSN).

Currently, there are three Universities in North Dakota that offer a DNP degree program. Requirements for admission to a DNP program are a BSN and a current RN license. The majority of DNP programs require one year or more of RN experience prior to admission (NDSU, 2018; UND, 2018; University of Mary, 2017). In August 2018, the University of North Dakota (UND) (2018) will transition from a 2-year master degree followed by a 2-year DNP

degree with an opt-out option after completion of the MS to a DNP only program. The UND DNP degree requires 92 credits over nine semesters and over 1,000 clinical practice hours (UND, 2018). The NDSU DNP program requires 86 credits and 1,020 clinical hours to meet graduation requirements (NDSU, 2018); and the same number of credits are awarded at the University of Mary (2017) but 1180 hours of clinical and leadership experience is required. A clinical practicum allows the student to learn “hands on” skills and gain experience in differential diagnosis, ordering diagnostic tests, and developing comprehensive treatment plans. The hours of experience under the guidance of a seasoned NP or physician role model allows real-time and valuable feedback while increasing the student NP’s comfort and competence in the clinic setting (Barnes, 2015b).

APRN licensure in ND requires graduation from an accredited educational program, as well as, certification by a recognized national certifying body (NDBON, 2018a). All states require registration and licensure with the State Board of Nursing (BON) to begin practice (AANP, n.d.a). NP certification renewal is required every five years by the two certifying organizations for Family Nurse Practitioners (FNPs), the American Academy of Nurse Practitioners Certifying Board (AANPCB) (2017) and the American Nurses Credentialing Center (ANCC) (2006). The requirements for recertification differs immensely between the two organizations, however, both require some combination of clinical hours and continuing education credits or the option of retesting.

Expert RN to Novice NP

Faraz (2016) found mixed results regarding the value of RN work experience prior to transitioning to the NP role. The new NP has added challenges and responsibilities of independent patient care and management that are different from prior RN experiences. Barnes

(2015a) suggested that the type of RN experience may have as much influence on successful role transition as the amount of RN experience. For example, RNs with inpatient experience may transition differently to NP outpatient care than RNs with prior outpatient experience. RN experience was found to neither support nor inhibit NP role transition. Further research is needed to identify if, or how, clinical experience with a variety of populations, practice settings, and the number of preceptor-supervised hours affect the transition from RN to NP (Barnes, 2015a).

Nurse Practice Act

A nurse practice act (NPA) is a law enacted by the state legislature in each state with the intent of overseeing nursing practice to insure safety and to protect the citizens of the state (Russel, 2012). The NPA establishes a BON in each state that has the authority to develop administrative rules and regulations for nursing within the auspices of the NPA. After BON approval, public review, and legislative enactment, the rules and regulations provide full force and effect of law (Russel, 2012). Four categories of APRNs are governed by the ND NPA (ND Legislative Branch, n.d.). APRN classifications are certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners. APRN is defined as “a registered nurse who has submitted evidence of advanced knowledge, skills, and abilities in a defined area of nursing practice” (Chapter 54-05-03.1-02, n.d., p. 2), who holds a current license to practice as an APRN in ND, and functions within the board approved foci. APRNs must have graduated from an accredited graduate level APRN program and hold certification by a national certifying body in a specific APRN role and population foci. In ND, the scope of practice for APRNs is commensurate with nursing education and certification (ND Legislative Branch, n.d.). The NP scope of practice overlaps

with roles of other healthcare providers, is dynamic, and implies a continual response to evolving changes in healthcare patterns and systems.

To help clarify the legal scope of practice in ND, the North Dakota Board of Nursing (NDBON) (2016) Scope of Nursing Practice Decision-Making Framework poses 10 questions to help define the legal acts of nursing. The framework guidelines define actions that are either allowed or prohibited by the NPA. An affirmative response to questions indicates that the activity is within the legal scope of practice and prompts continuation in the decision-making process. A negative survey response indicates that the activity is not within the APRNs scope of practice and should therefore not be performed. ND BON frequently reviews and updates scope of practice assuring that APRNs are practicing within the definition set forth by the ND Century Code and NPA (NDBON, 2018a).

AANP (n.d.b) defines full scope of practice as “state practice and licensure law that provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing” (para 2). The IOM and National Council of State Boards of Nursing define full scope of practice similarly. Despite APRNs having full scope of practice in ND, some organizations unnecessarily impose physician oversight of NP practice, limiting full utilization of NP education and skill, as well as, reducing NP autonomy (Bauer, 2010).

North Dakota is one of 22 states and the District of Columbia that supports APRN full practice authority. Sixteen states have reduced practice authority that reduces at least one element of NP practice and limits the setting of one element of practice. The remaining 12 states

restrict NP practice and require supervision, delegation, or team management by physicians to engage in at least one element of NP practice (AANP, n.d.b).

In 2008, the National Council of State Boards of Nursing developed national standards for state licensing of APRNs. The document's framework (Licensure, Accreditation, Certification, and Education [LACE]), aligns licensing criteria for APRNs, accreditation of APRN education programs, certification of APRNs upon graduation, and educational standards for APRNs (Mason et al., 2016). Unfortunately, since each state BON interprets the LACE framework, standards differ from state to state. Fifty percent of the State boards of nursing do not comply with the LACE standards, which results in state legislatures not modernizing NPAs (Mason et al., 2016). Barriers to universal standardization of NP practice include variation in APRN scope of practice, limitations in reimbursement, and restrictions of prescriptive privileges (Mason et al., 2016). Hain & Fleck (2014) liken full scope of practice to independent or autonomous practice. However, the authors recognized that restrictions persist. Opposition to full practice authority for NPs by major medical associations and medical groups, such as the American Medical Association (AMA) are the principal threat to APRN autonomy.

The AMA, physicians, and healthcare organizations attempt to limit or control NP practice despite NPs having the training and education to practice independently (Faris et al., 2010; Hain & Fleck, 2014; Maylone et al., 2011; Shea, 2015). NP care has been compared to physician care in various aspects of patient outcomes, quality indicators, service utilization, and referral patterns; and no statistical difference exists. In fact, patients cared for by NPs received more health education, health counseling, and tobacco cessation interventions than patients cared for by physicians (Kurtzman & Barnow, 2017). Maintaining autonomy within the states that have full scope of practice and advocating for all remaining states without full scope of practice

is essential to expand the discipline of nursing. One way to advocate is by active involvement in state and federal legislative changes as recommended by the IOM (2011).

Areas of Practice

Nurse practitioner educational programs prepare NPs for a variety of primary, specialty and sub-specialty areas of practice. The AANP (n.d.c) lists the following specialty areas of practice: Acute Care, Adult Health, Family Health, Neonatal Health, Oncology, Pediatric/Child Health, Psychiatric/Mental Health, and Women's Health. Sub-Specialty practice includes Allergy & Immunology, Cardiovascular, Dermatology, Emergency, Endocrinology, Gastroenterology, Hematology & Oncology, Neurology, Occupational Health, Orthopedics, Pulmonology & Respiratory, Sports Medicine, and Urology. Chattopadhyay et al. (2015) conducted a large study in 2012 of 12,923 NPs finding that practice had expanded to the areas of hospice, home care, school/college health services, correctional facilities, federal clinics, and academic educational programs. Seventy-six percent of the NP workforce was educated in primary care and 48% of NPs worked in primary care settings in the U.S. (Chattopadhyay et al., 2015). NPs practicing in primary care is on the rise and according to the American Association of Nurse Practitioners (2018), in 2017, 234,000 NPs were licensed in the US, and of the licensees, 203,600 (87%) were prepared in primary care.

North Dakota Nurse Practitioner

Providing primary care in rural settings has additional challenges when compared to urban settings. There are disparities in health care access, chronic disease, mental health; and morbidity and mortality are higher. Mason et al. (2016) define rural counties as those outside the boundaries of 50,000 people or more. North Dakota is a rural state with only four counties considered Urban, given the definition above (United State Department of Agriculture,

Economic Research Service, 2007). The remaining 49 counties in ND are rural and present the healthcare disparities and challenges of rural environments.

ND is currently experiencing a shortage of primary care providers and most of the state is classified as a Primary Care Health Professional Shortage Area (ND Center for Nursing, 2016, April). There are 1,415 licensed APRNs in North Dakota, of which 954 are NPs, and 748 are certified as a FNP (NDBON, 2018b). In the *Future of Nursing Report*, the IOM (2011) recommended expansion of the NP workforce. Currently, only 20% of primary care workforce is comprised of NPs (Poghosyan & Aiken, 2015). Despite increases in the number of NPs entering primary care practice, the number of physicians in primary care continues to decline, resulting in a continued shortage of primary care providers, especially in the rural areas.

From 2014-2015, there were 722 job openings for NPs in ND with an average of 60 job openings per month (ND Center for Nursing (NDCFN), 2016, April). According to the NDCFN, NP students who complete their clinical hours in rural clinics increase the likelihood of the student returning to work in that location after graduation (ND Center for Nursing, 2016, April). The greatest shortage of primary care providers in ND is in Indian Health Services. Native Americans have poorer health outcomes, a shorter life expectancy, and a higher death rate in both preventable injuries and chronic diseases, higher infant and maternal mortality (Mason et al., 2016). Additionally, the deficit of American Indian providers working at Indian Health Services (IHS) clinics contributes to underutilization of clinic services (Mason et al., 2016).

Orientation

Healthcare agencies lack consistency in how new NPs are on-boarded to the organization and to the new role. Goldschmidt, et al., (2011) found that orientation is a critical component to the development, refinement, and clarity of the NP role. Barnes (2015a) reports that a formal

orientation plan promotes successful role integration for the NP. According to Pasarón (2013), a well-planned orientation is associated with a successful, effective collaborative practice. Furthermore, Parasón found that without orientation, collaboration was hindered, and NPs were underutilized. Poor collaboration had implications related to potential patient safety and continuity of care; most significant was miscommunication about patient care between practitioners (Pasarón, 2013).

Mentoring

Mentoring is a professional, nurturing relationship between experienced provider and novice NP. Mentoring can ease transition and help overcome barriers to practice (Hill & Sawatzky, 2011; Pasarón, 2013; Shea, 2015; Zapatka et al., 2014). A mentoring relationship can benefit the new NP in four areas of primary care practice: quality of care, productivity, job satisfaction, and longevity (Harrington, 2011, p.171). Shea (2015) found that mentors not only guide novice NPs with the skills necessary for patient care, but also model how to navigate the organizational barriers that hinder providing quality, holistic care. Mentoring eases stress and anxiety; promotes self-efficacy and role socialization; and creates sense of community within the organization for the NP (Hill & Sawatzky, 2011). Horner's (2017) study discovered all NPs with a mentor reported the relationship positively influenced job satisfaction.

Residency

Hart and Macnee (2007) found that 87% of NPs, with an average of 11 years of experience, indicated their willingness to participate in a post-graduate residency program or a supervised clinical training, had such a program been offered. Fifty-one percent of NPs in Hart and Macnee's study felt minimally prepared for practice after graduation, especially in ordering advanced diagnostics. NPs felt most prepared in core competencies, which are defined as

assessment, differential diagnosis, health teaching, acute/chronic illness management, and evidence based practice (Hart & Macnee, 2007). Residency programs may be the solution to improved NP preparedness.

Primary care physicians complete a three-year residency program before independent practice. The IOM (2015) recommended a residency experience for new RNs; however, APRN residency programs need to be tailored for “professionalization and the establishment of independence for an already experienced clinician” (p. 81). Improved confidence, competence, and strengthened role identity are a few the positive outcomes of NP residency programs. The structured environment of a residency program allows growth of skill and knowledge in a safe environment (Zapatka et al., 2014). There are currently 70 NP residency and fellowship programs throughout the U.S. Program characteristics vary immensely in length, specialty area, type of organization, and type of oversight. More in-depth study is necessary to understand the future role residency and fellowship programs can have for NP practice (Martsolf, Nguyen, Freund, & Poghosyan, 2017).

Most NPs do not have additional training following graduation unless the graduate NP is able to find a residency program (Zapatka et al., 2014). Residency programs allow the new graduate to ease into the role by providing an extended orientation of sorts. The transition from novice to experienced practitioner takes time and is most successful when barriers are minimized or overcome. There is a lack of literature related to NP transition, yet Faraz (2016) identifies three categories to successful transition: (a) individual characteristics of the NP, (b) role acquisition, and (c) job satisfaction.

A one-year residency program implemented by Flitner and Hart (2016) had graduate NPs journal feelings of the transition experience. The first quarter they documented feeling

jubilant, followed with feeling overwhelmed by complexity, fluctuating confidence, and exhaustion. In the last quarter, the NP journal reflected a sense of mastery of the NP role, feelings of well-being, and personal satisfaction. Residency programs in all practice settings are recommended with attention given to rural and critical access areas (IOM, 2015). The IOM (2015) recommends more attention be given to the successful transition of new NPs by development and implementation of residency programs in organizations after completion of advanced practice degree programs, or when transitioning into new clinical practice areas.

Role Transition

The transition from novice to experienced practitioner takes time and is most successful when barriers are minimized or overcome. There is a lack of literature relating to NP transition. Faraz (2016) identified three categories to successful transition as (a) individual characteristics of the NP, (b) role acquisition, and (c) job satisfaction. Barnes (2015b) defined the concept of role transition as the period of change between two stable states of professional identity, experience, and confidence. Role transition has no tool to measure degrees of success. Instead NP transition is viewed through four characteristics: (a) absorption of the role, (b) shift from provider of care to prescriber of care, (c) straddling two identities, and (4) mixed emotions (Barnes, 2015b). Specific activities and behaviors are necessary to reach successful transition.

To fully embrace the new role, the NP must disengage from the previous RN role (Barnes, 2015b; Smith & Parker, 2015). Quality clinical experience during graduate school and a well-structured orientation after graduation are invaluable for new NP transition (Barnes, 2015b). Constructive feedback from preceptors, faculty, and mentors leads to increased job competency, role clarity, and a sense of mastery (Barnes, 2015b).

The experienced RN in the new role of NP faces a sharp learning curve upon entry into rigorous independent NP practice (Goldschmidt et al., 2011; Hill & Sawatzky, 2011). The new NP performs duties at a slower pace initially and internalizes the complexities of the new workflow, which decreases self-confidence. Additionally, the reality of poor workflow and processes of the facility may be at fault for causing undue stress for the new NP (Hill & Sawatzky, 2011). Harrington (2011) reports despite adequate education in health promotion, disease prevention, and medical management of patients in primary care, work can be overwhelming for the novice NP. Support from other NPs, physicians, and ancillary personnel can aid transition. The high novelty of the NP role, or opportunity to learn new skills and knowledge, is both exciting and daunting (Barnes, 2015b). Mixed emotions are part of transition and with support, role models, and feedback; the struggle with self-doubt, inadequacy, and feeling like an imposter change to feelings of mastery, confidence, and professional identity (Barnes, 2015b). Faraz (2016) asserts perceived competence becomes self-confidence over time and is imperative to autonomous decision-making, a valued facet of NP practice. Successful transition is fundamental to job satisfaction that leads to retention (Barnes, 2015a; De Milt et al., 2011; Faraz, 2016; Hill & Sawatzky, 2011; Horner, 2017; Poghosyan et al., 2013a), improved patient outcomes (Choi & DeGangne, 2015; Poghosyan et al., 2014a; Ryan & Ebbert, 2013; Stanik-Hutt et al., 2013), and cost savings (Stanik-Hutt et al., 2013).

Role confusion is a barrier to transition for novice NPs that cause inequality in access to organizational resources. Differing state and organizational definitions of NP role create confusion in developing professional identity for the NP (Poghosyan & Liu, 2016). Likewise, there is confusion of NP practice for other health professionals, healthcare administrators, the public, and third-party payers (Ryan & Ebbert, 2013).

Job Satisfaction

Job satisfaction is positively associated with NP retention (Barnes, 2015a). When NPs enjoy their job, they remain in the place of employment. NPs that are satisfied with their work provide higher quality healthcare (Barnes, 2015b; Faris et al., 2010; Pasarón, 2013). The most significant predictor of job satisfaction among NPs is autonomy (Chattopadhyay et al., 2015; Choi & De Gagne, 2015; De Milt, Fitzpatrick, & McNulty, 2011; Faraz, 2016; Faris et al., 2010; Horner, 2017; Misener & Cox, 2001; Pasarón, 2013; Poghosyan et al., 2014a). Autonomy empowers NPs to control aspects of their practice (Choi & De Gagne, 2015; De Milt et al., 2011; Faraz, 2016; Hain & Fleck, 2014; Maylone et al., 2011; Pasarón, 2013; Shea, 2015). However, the restrictions placed on NP practice by physicians and healthcare organizations, diminishes NP autonomy and therefore, career satisfaction.

Misener and Cox (2001) developed a highly reliable and valid tool to measure job satisfaction specific to NPs. They found intrinsic and extrinsic factors affect job satisfaction and concluded the intrinsic factors (job performance and ability to meet the challenge of the job) provided the most satisfaction and extrinsic factors (work environment and work conditions) led to the highest levels of dissatisfaction. The intrinsic satisfiers identified were the percent of time in direct patient care challenge in work, sense of accomplishment, ability to deliver quality care, and access to preceptors. The extrinsic dissatisfiers were related to compensation (salary and bonuses), involvement in research, and conflict resolution methods. The survey continues to reveal near identical results with repeated use (Horner, 2017).

Poghosyan et al. (2013a) developed a reliable and valid measurement of organizational climate and barriers specific to NPs. Poghosyan and Aiken (2015) found positive job experiences, such as, when NPs are used to full scope of practice; feel their role is understood by

others within the organization; and feel valued by the organization; are factors that contribute to job satisfaction. Further studies highlight the importance of improving practice environments to promote job satisfaction, NP visibility within organizations, and improving NP – Administration relations (Poghosyan, Boyd, & Clarke, 2016a; Poghosyan et al., 2014a, 2016b).

NPs are of financial value to organizations as the salary for NPs is much lower than physicians, and yet NPs perform many of the same functions as physicians. Third-party reimbursement for preventative and wellness performance will override payment for volume of care provided in the future (Blue Shield Blue Cross of ND, 2015). NPs provide primary care services such as, patient counseling, education on health promotion, and disease prevention. Focus on prevention and education can potentially lower disease rates and hospitalization (Chattopadhyay et al., 2015). NP care incorporates prevention and a holistic approach to patient care preparing them to adapt to new reimbursement plans based on patient outcomes.

In the U.S., the turnover rate of NPs is twice that of physicians (Barnes, 2015a; Fitzpatrick & Gripshover, 2016). The factors associated with intent to leave a job include, decreased job satisfaction, delayed role transition, and lack of autonomy (Faraz, 2016). External stressors affect job dissatisfaction and include busy patient load, navigating unfamiliar electronic charting, stress of coding correctly, and making proper referrals. The barriers to job satisfaction and intent to leave a job were (a) limited autonomy (Faris et al., 2010; Hain & Fleck, 2014; Poghosyan et al., 2013b), (b) lack of administrative support (Faris et al., 2010; Poghosyan & Aiken, 2015; Poghosyan et al., 2016b; Shea, 2015), and (c) lack of understanding of NP role (Faraz, 2016; Hain & Fleck, 2014 Poghosyan & Aiken, 2015).

When organizations promote full utilization of NP skill, support collegial relationships with physicians and administration, and value the NP's role within the healthcare organization,

positive outcomes are realized for the NP and the patient (Bauer, 2010; Pasarón, 2013; Poghosyan et al., 2016a). Likewise, Poghosyan et al. (2016a), found practice environments that fail to provide resources to enhance NP performance result in poor patient and practitioner outcomes. The social support in personal and organizational levels is necessary for adjusting from novice to expert NP. Faraz (2016) found job satisfaction is beneficial to (a) personal development; (b) developing positive coping techniques to stress; (c) having a sense of meaning; (d) being motivated; (e) feeling empowered; (f) job commitment; and (g) intent to stay in a job.

Measuring NP Job Satisfaction

The Misener NP Job Satisfaction Scale © was developed specifically to measure NP job satisfaction. The Misener scale had high validity and reliability (Misener & Cox, 2001).

Identifying barriers to transition and job satisfaction for the new NP in the first year of practice is important to foster rapid adaptation to the new work environment, improve job satisfaction, and improve retention. There are many satisfiers and dissatisfiers in practice. Creating environments that foster the aspects that most positively affect NP practice will promote quality, efficiency, and cost-effective care for patients (Bauer, 2010; Pasarón, 2013; Poghosyan et al., 2016a).

Theoretical Framework

Meleis' Transition Theory directed this project and provided an excellent framework for examining the transition of novice NPs to experienced NPs. The theory describes change as an external event and transition as an internal process. Transition properties include time span, process, disconnectedness, awareness, and milestones or turning points (Smith & Parker, 2015). The transition process has a beginning that is well defined and is marked by triggers that cause change. The transition outcome is marked by a healthy and successful response to transition. There are three change triggers relevant to NPs: situational, developmental, and organizational.

The transition experience begins with the anticipation of change. Situational change is the transition from the role of a NP student to a practicing NP. Barnes (2015b) relates this attribute of change as a ... “shift from being a provider of care to a prescriber of care” (p. 140). The developmental trigger is when the NP begins practice and makes the novice to expert transition.

Meleis described patterned responses to transition as process and outcome (Smith & Parker, 2015). The response to change is influenced by personal values and meaning of the change for the individual. The transition process transpires along a predictable trajectory. Initially, an individual is immersed in the erratic change process, thereafter, the individual becomes progressively more comfortable in the new position; and ultimately the individual has a perception of confidence and contentment in the role. The goals or expected outcome of transition includes mastery, fluid integrative identity, resourcefulness, healthy interactions, and perceived well-being (Smith & Parker, 2015). When an individual experiences a forward progression through the transition process, achieves positive outcomes, and feels confident, successful transition is achieved.

Meleis’ theory can be applied from a personal level to a community level transition and each transition is a unique, multidimensional, and complex experience. In applying the concept of interventions to affect outcomes, transition can be influenced positively or negatively (Poronsky, 2013). Successful or unsuccessful transition depends on environments that are predicted to either foster or hinder the transition (Barnes, 2015a). “A successful transition is characterized by a subjective sense of well-being; increased confidence and competence; mastery of skills; and autonomous practice. An unsuccessful transition is characterized by negative emotions, a lack of confidence increased turnover, and limited support” (Barnes, 2015a, p. 179).

Successful transition is dependent on minimal barriers or overcoming barriers that lead to career satisfaction.

Many of Meleis' theory assumptions speak to the difficulty of transition when encountering barriers to job satisfaction for the novice NP. The developmental and situational transition have periods of confusion between the end point of one event and the mastery of a new role or competence (Smith & Parker, 2015), and mirrors the ups and downs of becoming competent as a new member of the healthcare team. Awareness of the experiences that have meaning for the NP defines the experience of change. As familiarity in a job replaces unfamiliarity, new meaning is assigned to the NP role and awareness of the successful transition leads to independence and confidence. Internal and external processes are assimilated for positive transition to overcome barriers to job satisfaction.

Iowa Model

Determining that a change is necessary to improve practice can be seen as an opportunity. Assessing barriers to NPs transitioning to a new job is necessary to learn what the barriers to transition are. Implementing change to ease the difficulties of the first year can benefit the NP and the organization. Job satisfaction leads to intent to stay in a job, better patient care, and cost containment for institutions. A guiding framework for planning and implementing a practice change helps in developing actions of change and making decisions to continue with the change or modify course with the change. The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Healthcare (University of Iowa Hospitals and Clinics, 2015) gives guidance in making changes in clinical or administrative practices (see Figure 1). The first step of identifying triggering issues or opportunities from either existing data or new knowledge highlights opportunity for improvement. Problem-focused triggers arise from NPs questioning

current practice and envisioning an opportunity for improvement. Knowledge-focused triggers are typically from disseminated scientific findings and are more likely a top-down approach that requires additional planning for implementation (Melnyk & Fineout-Overholt, 2015).

Determining priority of change for the organization is the next step in the model. The evidence-based process may lead to change in practice but other forces affecting the organization may take priority. For example, accrediting agency requirements or regulation may drive a change and assign high priority to an evidence-based change. Organizational priorities related to barriers to NP job satisfaction are correlated with institutional and market forces, such as changing reimbursement. The first goal of organizations is cost effectiveness while providing care; the second organizational goal is to receive reimbursement based on quality patient outcomes and not the volume of patients (Blue Shield Blue Cross, 2015). Knowledge that NPs have equal patient outcomes, and in some instances better patient outcomes than physicians (Stanik-Hutt et al., 2013) aligns with the two goals of organizations described above.

Healthcare delivery is analyzed to produce best practices, maximize utilization, and contain costs. Healthcare administrators, leaders, and organizations evaluate practice processes to improve efficiency and develop improved patient outcomes. In the Iowa model, teams of stakeholders are formed for the purpose of implementing change, improving quality, and reducing risk within the organization. The Iowa Model outlines the steps to develop and pilot practice change. If changes are appropriate for adoption by the organization, the next step is to implement the recommended changes, and to monitor quality improvement throughout the change process. Hardwiring the change within the organization will sustain the action. The dissemination of results involves informing and educating others of the success of the evidence-based practice change. Feedback loops along the model allow reassessment and adjustment to

stay on goal. Figure 1 graphically depicts the decision tree of the Iowa Model for evidence-based practice.

The Iowa Model is a framework for evidence-based practice improvement was useful for identifying an opportunity for change and reviewing literature that supports the change. Fostering transition to practice and job satisfaction is a priority in the current healthcare environment. Informing DNP students and faculty is an initial step to design and implement a practice change. The next possible step is to involve NP organizations and employers in conversations of the best way to apply and execute the change.

This chapter analyzed and synthesized current literature related to NP job satisfaction, role transition, methods to support NP practice, and definitions germane to NPs. Additionally, education, licensure, state nurse practice laws, and other areas pertaining to NP practice were explored. An evidence-based model is utilized to explain implementation and dissemination of findings. The theoretical framework presented describes the concept of transition and processes that lead to healthy outcomes when applied to NP transition in a new job. The next chapter discussed project design in measuring job satisfaction of novice NPs.

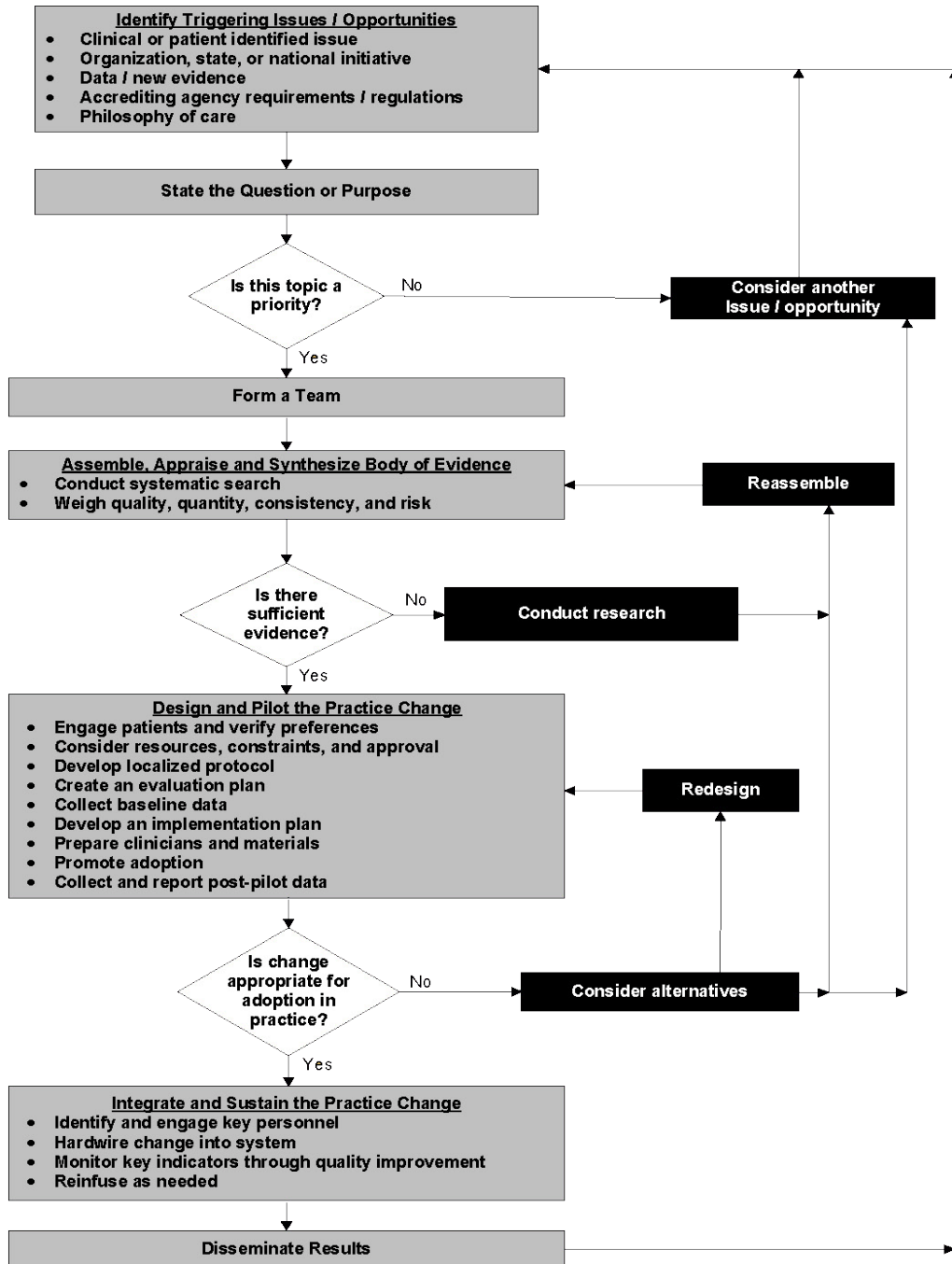


Figure 1. The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Healthcare. Used/Reprinted with permission from the University of Iowa Hospitals and Clinics; Copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at (319)384-9098.

CHAPTER THREE. PROJECT DESIGN

Objectives

The purpose of the practice improvement project was to discover the barriers to transition, therefore, job satisfaction of novice NPs the first two years of practice. The goal of the project was to explore the influence of organizational environment, NP job satisfiers, and dissatisfiers, and to stimulate discussion about NP transition to practice. Project goals were to determine solutions to lessen or alleviate barriers and ease the transition from novice NP to experienced NP. The purpose was to involve stakeholders and implement change in NP practice, education, and organizational support of NPs new to practice.

The objectives of the project were to:

1. Identify barriers that affect role transition and job satisfaction of the novice NP during the first two years of practice in a primary care setting.
2. Identify job satisfiers and dissatisfiers of the novice NP during the first two years of practice in a primary care setting.
3. Identify what novice NPs perceive as organizational barriers affecting role transition and job satisfaction.
4. Share the findings of the project with healthcare organizations, NP faculty, students in NP and DNP programs, and practicing NPs with the goal of working collaboratively toward reducing or eliminating barriers to ease transition to practice.

Project Design

The project survey consisted of a cover letter (see Appendix A), demographic information created by the co-investigator (see Appendix B), the Misener Nurse Practitioner Job

Satisfaction Scale © (Misener & Cox, 2001), the Nurse Practitioner Primary Care Organizational Climate Questionnaire (Poghosyan, Nannini, Finkelstein, Mason, & Shaffer, 2013a) (see Appendices C and D), and two statements encouraging comments about job satisfaction and organizational climate (see Appendix E). The aforementioned surveys have been used in prior research with confirmed reliability and validity. The intent of the surveys was to discover barriers to job satisfaction experienced during the first two years of practice. The first two years of NP practice can be stressful that without proper support can lead to increased turnover. Survey results interpreted by the co-investigator confirmed topics that ought to be addressed by NPs, NP students, NP faculty, and administrators to improve job satisfaction and leads to retention of valuable primary care NPs.

Sample Population

Data was gathered by convenience sample of NPs attending the North Dakota Nurse Practitioner Association (NDNPA) Annual Pharmacology Conferences in September 2016 and 2017. Novice NPs working in primary care for one to two years, or less (defined by graduating in May of 2015), were invited to voluntarily participate in the surveys. An announcement about the DNP project was made at the conference and display table was available in the hall. NPs who had graduated within the past two years from an NP program and worked in a primary care setting were invited to participate in the survey. Participation criteria included (1) graduated in May of 2015 or later; (2) employed as a primary care provider; and (3) gave informed consent to participate.

At the September 2016 conference, participants meeting inclusion criteria were given the option to complete a paper or online survey. Two laptop computers with the survey preloaded were available for survey completion on location. Seven NPs completed the paper surveys. In

order to increase participation rate at the 2017 conference, NPs who graduated after May 2015 were asked to complete the survey, which extended the time since graduation to two years. In 2017, in addition to paper survey packets, a URL link to the survey was available if potential participants preferred to complete the survey at another time. Permission was granted by the NDNPA board to make the URL link accessible on the NDNPA Facebook page for three weeks prior to the 2017 conference date and four days after the conference. Conference attendees were made aware of the URL link available on the NDNPA Facebook page. The survey was removed from the association Facebook page on Oct. 3, 2017.

At the September 2016 and 2017 Annual NDNPA Pharmacology Conference survey packets were available for conference attendees who met inclusion criteria and were willing to complete the survey on paper or electronically. Participants could elect to enter a drawing for gift cards in \$50.00 and \$20.00 amounts respectively, in each of the survey years. Survey packets included a cover letter explaining participation and informed consent, a sealable 8 inches by 11.5-inch manila envelope, ten demographic questions developed by the co-investigator, and two questionnaires – the MNPJSS, and the NP-PCOCQ.

Participants were asked to put the completed survey in the manila envelope, seal the envelope, and place the envelope in the designated, secure box. In 2016, six paper surveys were returned in the envelopes provided however, in 2017, all surveys were completed online, and no paper surveys were returned. Post conference, surveys were transported to the primary investigator's office on the NDSU campus in Fargo, ND and placed in a locked drawer. Survey responses were transcribed by the investigator onto Qualtrics software program, which allowed the investigator to collate and analyze the survey responses on a password-secured Qualtrics

website (www.qualtrics.com, Provo, UT). Surveys were destroyed upon completion of the project.

An amended IRB form was submitted and approved by NDSU IRB to extend inclusion criteria to allow participation up to two years post-graduation. The amendment also included placing a link to the survey on social media (NDNPA Facebook page). Eight participants completed surveys in 2017. One survey was removed from the data because the participant did not meet inclusion criteria. A combined total of 14 surveys (that met inclusion criteria) were received in 2016 and 2017.

Survey Instruments

The survey packet contained a co-investigator developed survey with ten demographic questions. Also included in the packet was the introductory Misener and Cox MNPJSS survey. The MNPJSS survey consists of 44-statements pertaining to NP job satisfaction. The survey utilizes a 6-point Likert scale (6-Very Satisfied, 5-Satisfied, 4-Minimally Satisfied, 1-Very Dissatisfied). The MNPJSS survey measures job satisfaction on the premise that both intrinsic and extrinsic components are dynamic and relative to the NP based on that employee's expectation, values, environment, and personal characteristics. The operational definition of satisfaction or dissatisfaction is therefore, individual; however, commonalities and trends are noted across studies utilizing the MNPJSS (Bush & Lowery, 2016; Horner, 2017; De Milt, Fitzpatrick, & McNulty, 2011; Pasarón, 2013). Statements are factored into six subscales of job satisfaction:

1. Intrapractice/Partnership/Collegiality
2. Challenge/Autonomy
3. Professional, Social, and Community Interaction

4. Professional Growth
5. Time
6. Benefits

Intrinsic factors are from the performance of the job and the nature of the work. MNPJSS survey statement subscales two and four measure intrinsic factors. Extrinsic factors arise from the work environment. Statements in subscales one, three, five, and six relate to the extrinsic factors of job satisfaction or dissatisfaction; and subscales two and four relate to intrinsic factors (Misener & Cox, 2001).

The MNPJSS has proven reliability and validity with an overall Cronbach's alpha of .96, and subscale reliability of .94, .89, .84, .86, .83, and .79 respectively (Misener & Cox, 2001, pp. 96-97). Bush and Lowery (2016) used the MNPJSS to survey job satisfaction of NPs with three years of NP practice post-graduation. In 2016, Faraz surveyed novice NPs with 3-12 months experience using the MNPJSS. This project may be the first to use the MNPJSS to survey NPs with 1-2 years of experience and the first to survey ND NPs.

The survey NP-PCOCQ was developed by Poghosyan et al. (2013a) to measure organizational climate in primary care, specific to NP job satisfaction. Measurement of organizational climate is divided into four domains:

1. NP Professional Visibility
2. NP - Administrative Relations
3. NP - Physician Relations
4. Independent Practice and Support

Subscale reliability is confirmed by Cronbach's alpha of .87, .95, .90, and .98, respectively (Poghosyan, 2013a). The NP-PCOCQ survey contains 29 statements using a 4-

point Likert scale (4-Strongly Agree, 3-Agree, 1-Strongly Disagree). The survey was developed to evaluate organizational climate and to identify what factors that NPs perceive to be problem areas within the organization. If the problems are known, the organization can plan and implement interventions designated to improve the climate. Interventions such as policy change to promote favorable work environments create a supportive, positive organization that attracts and retains NPs (Poghosyan et al., 2013a). Positive work environments lead to increased productivity, decreased absenteeism, and decreased turnover (Poghosyan et al., 2013a). The presumption is that a positive organizational climate creates constructive work environments for NPs. The NP-PCOCQ results can be compared across organization in the U.S. to implement changes that lead to uniformity of work environments.

Institutional Review Board Approval

NDSU IRB approval as an exempt study was obtained prior to initiation (Appendix F). Because of the low participation rate in the initial survey, an amended IRB, Protocol Amendment Request Form, in which additional survey collection dates and platforms was submitted and approved on August 16, 2017. Amended IRB approval was obtained prior to offering the survey at the 2017 conference and prior to placing the invitation on the NDNPA Facebook page (Appendix G). Each survey packet or online survey had a cover letter that invited voluntary participation and informed participants that completion of the survey implied consent. The potential risks and benefits were described in the invitation letter.

Timeline

The timeline for the development and implementation of the project was as follows:

- June 2016 – September 2016 – Literature review and synthesis
- September 2016 – Proposal development, approval of committee

- September 2016 – IRB approval
- September 29-30, 2016 – obtain novice NP participants at the Eighth Annual NDNPA Pharmacy Conference, Fargo, ND
- October-December 2016 – Compile assessment results
- September 28-29, 2017- obtain novice NP participants at the Ninth Annual NDNPA Pharmacy Conference, Bismarck, ND
- March 2018 – submit dissertation to committee
- April 2018 -Present results to NPs enrolled in the DNP program and faculty at NDSU
- April 2018 – Defend dissertation.
- April 2018 – Submit dissertation to nursing program chair and graduate school

The timeline was adjusted to accommodate the additional survey offered at the NDNPA Pharmacology in September 2017. The data results were compiled in November 2017-February 2018 and submitted in March 2018. Final defense was completed in April 2018. Results were presented to DNP faculty and students enrolled in the graduate program at NDSU.

Resources and Costs

The resources used for the project consisted of personnel, time, approval of measurement instruments (see Appendices H and I), organizational approval of Iowa model to guide project (Appendix J), and costs. The costs for printed surveys and envelopes were minimal and absorbed by the co-investigator. A drawing for two Target gift cards for \$50.00 and \$20.00, respectively, for 2016 and 2017 survey participants were paid for by the co-investigator. In order to provide the participants with convenience access to the electronic survey, two laptop

computers were borrowed from the NDSU Information Technology Center and were available at the co-investigator's conference exhibit table, solely for participant use.

The Technology Coordinator, of the Group Decision Center located in the Family Life Center at NDSU, met with the co-investigator on three separate occasions to discuss survey development. The demographic information, project surveys, and voluntary drawing for Target gift cards were transcribed onto the Qualtrics software program by the Technology Coordinator. Amendments to the project cover letter and demographic form in 2017 were entered by the Technology Coordinator. An assigned graduate assistant from the NDSU Statistics Department provided consultation and assistance with statistical analysis. A meeting to discuss aims of the project directed statistical analysis. The co-investigator and statistician assistant met on three occasions and corresponded by email to discern statistical information. Statistician provided expert advice and thorough explanation of statistical information and significance.

NDNPA donated display table space at both Pharmacology Conferences, enabling the co-investigator to distribute survey packets and place the laptops if participants preferred to complete the electronic survey. A sign, placed on the table, had a description of the project and an invitation for participation. The co-investigator recruited conference NPs in attendance through networking, an announcement prior to an educational session, and offering mints as incentive to stop at the display table. The coinvestigators received approval from the NDNPA Board of Directors to post the project description, participation invitation, and URL to access the electronic survey on the organization's Facebook page, at no cost

CHAPTER FOUR. EVALUATION

Evaluation Methods

The overall goal of the project was to evaluate job satisfaction and organizational climate of NPs in the first two years of practice. The target population was NPs practicing in North Dakota that had graduated from a NP program after 2015. How new NPs perceive the positive influences and the barriers to successful transition from RN to NP can guide development of strategies to mitigate barriers and support transition. Job satisfaction leads to NP retention, as well as, better patient outcomes and patient satisfaction.

Objectives

Objective One

The first project objective was to identify barriers that affect role transition, therefore, subsequent job satisfaction for NPs the first two years of practice. Two survey instruments were used to measure job satisfaction and organizational climate as aspects of transition. The first survey, the MNPJSS, consists of 44 statements that are divided into six subscales of intrinsic and extrinsic factors. Cronbach's alpha ranges from .79 to .94 in the MNPJSS subscales. Internal consistency of a scale or survey refers to the interrelatedness of items or tests in a group measuring the same concept (McClave & Sincich, 2013). The internal consistency reflects the reliability of the scale to measure what the scale was created to measure. Cronbach alpha is the statistical test most commonly used to estimate scale reliability and values range from 0-1. The closer the value is to one, the higher the internal consistency and scale reliability. Coefficients > .80 correspond with good to very good reliability. Although, greater than .80 is desired, values greater than .70 indicate acceptable scale reliability (McClave & Sincich, 2013). The second survey, the NP-PCOCQ, measures organizational climate that affects NP satisfaction in four

subscales. The subscale reliability ranges from .87 to .95 Cronbach's alpha and in the project the subscales ranged from .75 to .92 (Poghosyan et al., 2013a). Qualitative responses added clarification of specific factors in practice that novice NPs experience as barriers to transition and job satisfaction.

In the concept analysis of NP role transition, Barnes (2015b), identifies personal and environmental antecedents of transition that mirror intrinsic and extrinsic factors of the MNPJSS and factors of organizational support in the NP-PCOCQ. Personal antecedents are "graduate education, experience, active engagement in the new role, and desire for feedback" and environmental antecedents are "novelty of the job, support, and formal orientation" (Barnes, 2015b, p. 141-142). Further summary of successful transition characteristics are subjective sense of well-being, increased confidence and competence, mastery of skills, and autonomous practice (Barnes, 2015a). Survey statements pertaining to antecedents and characteristics of transition were analyzed. The antecedents and characteristics of transition with lowest means indicated barriers to transition.

Meleis' Transition Theory (Barnes, 2015a; Smith & Parker, 2015) was useful to guide the evaluation of transition from novice to expert NP. Two of the four situations that trigger transition experiences that pertain to novice NPs are situational transition from graduate NP to confident practitioner. A second is organizational transition that the new NP can affect toward his or her benefit, by discussing with employers those aspects important to the NP, such as having a mentor; limiting patient load until comfortable; and being involved in decisions that affect reward and compensation. The process of engagement depends upon actions and interventions; knowing one's position within the organization; and level of confidence in handling demands of the new role. At the personal level, this may be manifested in knowing

who support persons are for guidance and advice. At the organizational level feeling valued as a team member can lead to ownership and feeling vested. The outcome patterns described by Meleis (Smith & Parker, 2015) occur at the end of the transition process and include role mastery; fluid and integrative identity during uncertainty; and interaction and connections in new relationship. Career satisfaction is the goal of promoting transition that leads to a solid foundation of confident and competent practice for the NP (Barnes, 2015b).

Objective Two

The second objective was to determine job satisfiers and dissatisfiers of the novice NP during the first two years of practice in a primary care setting. The same two survey instruments were used to measure job satisfiers and dissatisfiers, as well as organizational climate. The MNPJSS has 44 statements divided into six factors of intrinsic and extrinsic satisfiers. Misener and Cox (2001) based development of their survey on multiple conceptual theories of extrinsic and intrinsic factors that are dynamic and relative to an NP; and both components can lead to job satisfaction or dissatisfaction. They found job satisfaction is most correlated with intrinsic factors of: percentage of time spent in direct patient care, challenge in work, sense of accomplishment, ability to deliver quality care, and access to preceptors. Extrinsic factors most correlate with dissatisfaction were: monetary bonuses that are available in addition to your salary, opportunity to receive compensation for services performed outside of your normal duties, reward distribution, involvement in research, and process used in conflict resolution (Misener & Cox, 2001, p. 97). Statements with highly rated mean scores represented factors that promote job satisfaction. Lowest statement means signified a restriction to NP job satisfaction.

A second survey, the NP-PCOCQ has 29 statements categorized in four subscales that assesses organizational climate. Positive, supportive work environments increase productivity;

can reduce absenteeism and turnover; reduce costs for organizations; and most importantly, confirm impact to NP job satisfaction and maximize productivity (Poghosyan et al., 2013a). Use of the survey over time may help determine positive or negative impact of policy changes within an organization. Subscales with the lowest rated mean scores indicate disagreement with the statements and represent barriers to organizational satisfaction.

Objective Three

The third objective was to identify organizational barriers affecting NP role transition and therefore, job satisfaction. Objective three was evaluated using the NP-PCCOQ survey. Detecting the statements with the lowest means within each subscale was recognized as barriers for new NPs in an organization.

One assumption of Meleis' Transition Theory is that preventative and therapeutic actions can influence outcomes. Interventions can serve to facilitate healthy process and outcome responses (Smith & Parker, 2015). Identifying barriers during the transition period of novice NPs can lead to actions that prevent the negative impact on transition, ease transition, and increase job satisfaction. Researcher review of survey outcomes can identify challenges on a personal and organizational level specific to novice NPs. The middle-range theory can apply to situational transition novice NPs experience in a new job and within the organization. Appropriate actions at either level can influence positive outcomes at a personal or organizational level and lead to improved job satisfaction; faster acclimation to work environment; and improved outcomes for NPs and organizations.

Objective Four

The fourth objective was to share the findings of the project with healthcare organizations, NP faculty, students in DNP programs, and practicing NPs with the goal of

working collaboratively toward reducing or eliminating barriers to ease transition to practice.

The co-investigator will share the study results during a Brown Bag luncheon for NDSU students, faculty, and practicing NPs. Dissemination to students and faculty in both locations of NDSU's Graduate DNP program will be via Polycom. Discussion should be informal and the co-investigator hopes to spark conversation during a PowerPoint presentation of survey results of novice NPs in ND.

Increasing awareness of identified satisfiers, dissatisfiers, and barriers NPs encounter in a new job is part of this project's dissemination. Discussion will be aimed at requesting audience feedback of perceived interventions to ease transition. Discussing positive interventions that can be implemented during the interview process or in organizations to cultivate support for NPs will ease transition. Students may find the results of this study important as they consider employment opportunities. NPs have inherent strengths and weaknesses and job satisfiers can be individual. Based upon individual traits, NPs can write their own job description that produces a satisfying career.

Faculty may incorporate ideas and findings into didactic curriculum for future students. DNP graduates that are knowledgeable about barriers to job satisfaction and the organizational climates that are most conducive to successful transition can wisely select employment opportunities. Additionally, DNP students can prepare a strategy and interventions that may foster adaptation to the work environment specific to their own strengths and weaknesses. As the novice NP transitions to expert NP, leadership skills, and evidence-based practice can be the cornerstone to practice change and improvement.

Framework

The Iowa Model Revised (University of Iowa Hospitals and Clinics, 2015, June) provided a framework for planning the project's initial steps in implementing change in the workplace. The first step is to identify a trigger issue, or an opportunity to improve practice. The opportunity is found based on regulations, initiatives, new evidence, clinical/patient issues, or a philosophy of care. Recent evidence of NP turnover rates and intention to leave a potentially satisfying career triggered the project to gather new evidence. The purpose was to determine NP job satisfiers, dissatisfiers, and barriers to transition and job satisfaction. The national healthcare provider shortage is the stimulus to prioritize the project's appraisal and syntheses of the body of evidence to decide future action. Designing a pilot change could be the next step in implementing the project. Involving stakeholders to consider all aspects in designing a practice change is necessary to ensure successful completion of any project. The feedback loops of the model permit adaptation and redirection to achieve the outcome of successful intervention, change, and adoption of the planned change.

CHAPTER FIVE. RESULTS

Presentation of Findings

A description of demographics of respondents, data analysis of the MNPJSS and NP-PCOCQ surveys, and evaluation of the responses to two statements of job satisfaction and organizational climate are presented in chapter five. The aggregate data was converted from Qualtrics to an Excel format. The investigator consulted with a statistician at NDSU's Information Technology Statistical Department to discuss statistical analysis and information sought from the data. The statistician used SPSS Statistical Software to analyze the results of the MNPJSS and the NP-PCOCQ. The co-investigator analyzed the demographic data and the qualitative data. One respondent that did not meet inclusion criteria was omitted from the data.

The MNPJSS was designed to measure NP job satisfaction in six areas of practice. There are 44 statements categorized into six subscales. The survey is scored on a 6-point Likert scale (6 – Very Satisfied, 5 – Satisfied, 4 – Minimally Satisfied, 1 – Very Dissatisfied). The six subscales factors are grouped into intrinsic and extrinsic factors of job satisfaction. The subscales have a Cronbach's alpha range from .79 to .94 (Misener & Cox, 2001). The first NP-specific survey instrument designed to measure organizational climate in primary care was the NP-PCOCQ. There are 29 statements in four subscales, measured on a 4-point Likert scale (4 – Strongly Agree, 3 – Agree, 1 – Strongly Disagree). The four subscales measure relationships in the organization, independent NP practice, and role clarity. The Cronbach's alpha ranges from .75 to .84 (Poghosyan et al., 2013a).

Demographics

The demographic questions that required a written response were not completed on two surveys. Demographic characteristics of sample participants are represented in Table 1. The

demographic data was based on 14 respondents (N=14), except for age which was based on n=12, due to two participants not filling in their age. The age of participants ranged from 27 to 39, with a mean age of 30.7 years old. Thirteen of the participants were female, and one was a male. Twelve participants identified themselves as Caucasian, one Asian, and one Hispanic. Eleven respondents received a degree in ND, one each from Kentucky, Indiana, and Alabama. Half (n=7) completed a master's program, and half completed a DNP degree. Nine indicated that the DNP program from which they graduated was Hybrid, meaning that a portion of the instruction was online and a portion included face-to-face traditional classroom structure. All participants were currently employed in ND. Nine of the NPs were not employed by the same organization they worked for as an RN.

Table 1

Characteristics of Nurse Practitioner Demographics

| Characteristic | n |
|---|----|
| Gender | |
| Female | 13 |
| Male | 1 |
| Race | |
| Caucasian | 12 |
| Asian | 1 |
| Hispanic | 1 |
| State of Education | |
| North Dakota | 11 |
| Alabama | 1 |
| Indiana | 1 |
| Kentucky | 1 |
| NP Program Degree | |
| Masters | 7 |
| DNP | 7 |
| Program Setting | |
| Online | 4 |
| Hybrid (partially online) | 9 |
| On Campus | 1 |
| State Practicing in | |
| North Dakota | 14 |
| Clinical Area of Practice | |
| Primary Care (Family Practice) | 7 |
| Interventional Radiology | 2 |
| Acute Care | 1 |
| Endocrinology | 1 |
| Gastroenterology | 1 |
| Psychology | 1 |
| Pulmonology | 1 |
| Graduated after 2015 | |
| Yes | 14 |
| No | 0 |
| Working in the same institution as when employed as RN | |
| No | 9 |
| Yes | 5 |

Misener NP Job Satisfaction Survey (MNPJSS)

The MNPJSS is a 44-item survey. The survey uses a 6-point Likert scale and response options are 6- Very Satisfied, 5- Satisfied, 4- Minimally Satisfied, 3- Minimally Dissatisfied, 2- Dissatisfied, and 1- Very Dissatisfied. The MNPJSS 44-item scale has a maximum score of 264. Three participants that did not respond to all 44 statements were not included in calculating the total survey means. The MNPJSS total score mean of the 11 participants answering all statements was 214, with a SD of 10.75, and a total statement mean of 4.86 on the 6-point Likert scale. The total statement mean fell within the Satisfied (5) to Minimally Satisfied (4) range.

In Table 2, the statement responses have been reordered highest to lowest means for each of the six subscales of job satisfaction. The Cronbach's alpha ranged from .56 to .92 in the subscales. In the Intrapractice Partnership/Collegiality subscale, respondents were most satisfied with the statement *evaluation process and policies* (5.86). They were least satisfied with *monetary bonuses in addition to regular salary* (3.36) and *opportunities to receive compensation for services performed out of normal duties* (3.62). *Monetary bonus* had the lowest mean in the entire survey. Within the Challenge/Autonomy subscale, respondents were most satisfied with the *time spent in patient care* (5.38) and least satisfied with *opportunity to expand skill level/procedures within scope of practice* (4.71). Response means in Professional, Social, and Community Interaction ranged from 5.21 to 4.64. Having *time for social contact at work* was the top satisfier and *not interacting with other disciplines was a dissatisfier*. Professional Growth response means were 4.31 to 4.71 (Minimally Satisfied) showing a barrier in all statements of the subscale. The factor of Time showed satisfaction in *time to see patients* (5.29) and showed least satisfaction with *scheduling practices* (4.71). The last factor, Benefits, had only three statements and *vacation/leave policy* had the highest mean (5.00).

Table 2

MNPJSS Mean Values by Factor for the 44 items in descending order

| Factor 1: Intrapractice Partnership/Collegiality | Mean | SD | N |
|---|------|------|----|
| Cronbach's alpha = .56 | | | |
| Extrinsic | | | |
| Evaluation process and policy | 5.86 | 0.66 | 14 |
| Your immediate supervisor | 5.29 | 0.73 | 14 |
| Amount of consideration given to your personal needs | 5.00 | 0.68 | 14 |
| Freedom to question decisions and practices | 4.93 | 0.62 | 14 |
| Opportunity to develop and implement ideas | 4.93 | 0.62 | 14 |
| Consideration given to your opinion and suggestions for change in the work setting or office practice | 4.79 | 0.58 | 14 |
| Respect for your opinion | 4.79 | 0.58 | 14 |
| Amount of administrative support | 4.71 | 0.47 | 14 |
| Process used in conflict resolution | 4.71 | 0.47 | 14 |
| Recognition for your work from superiors | 4.64 | 0.84 | 14 |
| Input into organizational policy | 4.57 | 0.51 | 14 |
| Reward distribution | 4.57 | 0.65 | 14 |
| Opportunity to receive compensation for services performed outside of your normal duties | 3.62 | 1.33 | 13 |
| Monetary bonuses that are available in addition to your salary | 3.36 | 1.28 | 14 |
| Factor 2: Challenge/Autonomy | | | |
| Cronbach's alpha = .82 | | | |
| Intrinsic | | | |
| Percentage of time spent in direct patient care | 5.38 | 0.51 | 13 |
| Patient mix | 5.29 | 0.61 | 14 |
| Sense of accomplishment | 5.21 | 0.58 | 14 |
| Ability to deliver quality care | 5.21 | 0.70 | 14 |
| Level of autonomy | 5.21 | 0.58 | 14 |
| Sense of value for what you do | 5.07 | 0.73 | 14 |
| Challenge in work | 5.00 | 1.04 | 14 |
| Flexibility in practice protocols | 4.93 | 0.47 | 14 |
| Expanding skill level/procedures within your scope of practice | 4.86 | 0.53 | 14 |
| Opportunities to expand your scope of practice and time to seek advance education | 4.71 | 0.47 | 14 |

Table 2. *MNPJSS Mean Values by Factor for the 44 items in descending order* (continued)

| Factor 3: Professional, Social, and Community Interaction | | | |
|---|------|------|----|
| Cronbach's alpha = .70 | | | |
| Extrinsic | | | |
| Social contact at work | 5.21 | 0.70 | 14 |
| Status in the community | 5.00 | 0.39 | 14 |
| Interaction with other NPs including faculty | 4.86 | 0.36 | 14 |
| Recognition for your work from peers | 4.71 | 0.73 | 14 |
| Acceptance and attitudes of physicians outside of your practice (such as specialist you refer patients to) | 4.71 | 0.73 | 14 |
| Quality of assistive personnel | 4.64 | 0.74 | 14 |
| Social contact with your colleagues after work | 4.64 | 1.08 | 14 |
| Professional interaction with other disciplines | 4.64 | 0.77 | 14 |
| Factor 4: Professional Growth | | | |
| Cronbach's alpha = .68 | | | |
| Intrinsic | | | |
| Opportunity to expand your scope of practice | 4.71 | 0.61 | 14 |
| Support for continuing education (time and \$\$) * | 4.64 | 1.15 | 14 |
| Opportunity for professional growth | 4.64 | 0.50 | 14 |
| Time off to serve on professional committees | 4.64 | 0.63 | 14 |
| Amount of involvement in research | 4.31 | 0.75 | 14 |
| Factor 5: Time | | | |
| Cronbach's alpha = .76 | | | |
| Extrinsic | | | |
| Time allocation for seeing patient(s) | 5.29 | 0.61 | 14 |
| Time allotted for answering messages | 5.21 | 0.43 | 14 |
| Time allotted for review of lab and other test results | 5.21 | 0.43 | 14 |
| Patient scheduling policies and practices | 4.71 | 0.61 | 14 |
| Factor 6: Benefits | | | |
| Cronbach's alpha = .92 | | | |
| Extrinsic | | | |
| Vacation/Leave policy | 5.00 | 1.11 | 14 |
| Benefit package | 4.93 | 1.07 | 14 |
| Retirement plan | 4.93 | 1.00 | 14 |

Note: * Omitted from Cronbach's alpha calculation

Satisfiers

Respondent mean scores on sixteen statements were ≥ 5 (satisfied) (see Table 3). Factor 1: Intrapractice Partnership/Collegiality (Extrinsic) and Factor 2: Challenge/Autonomy (Intrinsic), had statements with the highest means of 5.86 and 5.38, respectively. In Factor 1: Intrapractice Partnership/Collegiality, three of 14 statements had a mean range of 5.00 to 5.86 (Satisfied). In Factor 2: Challenge/Autonomy, seven of ten statements in the subscale averaged 5.0 to 5.38 (Satisfied). The highest rated statement in Factor 4: Professional Growth *opportunity to expand your scope of practice* was repeated later in the survey with the addition of – *time to seek advanced education*, in Factor 2: Challenge/Autonomy, which was the lowest rated mean in that subscale. Respondent education levels were equal between master's degree and DNP degree.

Factors 1, 3, 5, and 6 are considered extrinsic. In Factor 1: Intrapractice Partnership/Collegiality, the statements with the highest mean scores included the statements *personal needs being considered*, *supervisor satisfaction*, and *contentment with evaluation process and policy*. Factor 3: Professional, Social, and Community Interaction, the highest rated statements were *social contact at work* and *status in the community*. In Factor 5: Time; three of four statements fell within the satisfied range with the means ranging from 4.71 to 5.29. In Factor 6: Benefits, Vacation/Leave policy was the highest rated satisfaction statement, however, two of the statements *benefit package* and *retirement* fell in the higher end of Minimally Satisfied with a mean of 4.93.

Table 3

Summary of MNPJSS Satisfiers

| Highest-scoring items – Descending order | Factor | Intrinsic - Extrinsic | M | SD |
|---|--------|-----------------------|------|------|
| Evaluation process and policy | 1 | Extrinsic | 5.86 | 0.66 |
| Percent of time spent in direct patient care | 2 | Intrinsic | 5.38 | 0.51 |
| Your immediate supervisor | 1 | Extrinsic | 5.29 | 0.73 |
| Patient mix | 2 | Intrinsic | 5.29 | 0.61 |
| Time allotted for seeing patient(s) | 5 | Intrinsic | 5.29 | 0.61 |
| Sense of accomplishment | 2 | Intrinsic | 5.21 | 0.58 |
| Ability to deliver quality care | 2 | Intrinsic | 5.21 | 0.70 |
| Level of autonomy | 2 | Intrinsic | 5.21 | 0.58 |
| Social contact at work | 3 | Extrinsic | 5.21 | 0.70 |
| Time allotted for answering messages | 5 | Extrinsic | 5.21 | 0.43 |
| Time allotted for review of lab & other tests | 5 | Extrinsic | 5.21 | 0.43 |
| Sense of value for what you do | 2 | Intrinsic | 5.07 | 0.73 |
| Amount of consideration given to personal needs | 1 | Extrinsic | 5.00 | 0.68 |
| Challenge in work | 2 | Intrinsic | 5.00 | 1.04 |
| Status in community | 3 | Extrinsic | 5.00 | 0.39 |
| Vacation/Leave policy | 6 | Extrinsic | 5.00 | 1.11 |

Dissatisfiers

Respondent mean scores on 19 items were ≤ 4.57 (Minimally Satisfied) (See Table 4).

Response means of ≤ 4.57 (Minimally Satisfied) were in all subscales except for Factor 6:

Benefits where means were higher at 4.93 to 5.0 (Minimally Satisfied to Satisfied). Four of five lowest means were from the extrinsic factor, Factor 1: Intrapractice Partnership/Collegiality.

The statements with the lowest means were *opportunity to receive compensation for services performed outside of your normal duties* (3.36), *monetary bonuses that are available in addition to your salary* (3.62), *reward distribution* (4.57), and *input into organizational policy* (4.57). The other dissatisfier from Factor 4: Professional Growth, an intrinsic value, was *the amount of involvement in research* (4.31). Misener and Cox (2001) had the same dissatisfiers except in this

study the dissatisfier *input into organizational policy replaced process used in conflict resolution*.

Table 4

Summary of MNPJSS Dissatisfiers

| Lowest-scoring items – Ascending order | Factor | Intrinsic - Extrinsic | M | SD |
|--|--------|-----------------------|------|------|
| Monetary Bonuses available in addition to salary | 1 | Extrinsic | 3.36 | 1.28 |
| Opportunity to receive compensation for services performed outside of normal duties | 1 | Extrinsic | 3.62 | 1.33 |
| Amount of involvement in research | 4 | Intrinsic | 4.31 | 0.75 |
| Input into organization policy | 1 | Extrinsic | 4.57 | 0.51 |
| Reward distribution | 1 | Extrinsic | 4.57 | 0.65 |
| Recognition for your work from supervisors | 1 | Extrinsic | 4.64 | 0.84 |
| Quality of assistive personnel | 3 | Extrinsic | 4.64 | 0.74 |
| Social contact with colleagues after work | 3 | Extrinsic | 4.64 | 1.08 |
| Professional interaction with other disciplines | 3 | Extrinsic | 4.64 | 0.77 |
| Support for continuing education (time and \$\$) * | 4 | Intrinsic | 4.64 | 1.15 |
| Opportunity for professional growth | 4 | Intrinsic | 4.64 | 0.50 |
| Time off to serve on professional committees | 4 | Intrinsic | 4.64 | 0.63 |
| Amount of administrative support | 1 | Extrinsic | 4.71 | 0.47 |
| Process used in conflict resolution | 1 | Extrinsic | 4.71 | 0.47 |
| Opportunities to expand scope of practice and time to seek advance education | 2 | Intrinsic | 4.71 | 0.47 |
| Recognition for your work from peers | 3 | Extrinsic | 4.71 | 0.73 |
| Acceptance and attitudes of physicians outside of your practice (such as specialists you refer pts to) | 3 | Extrinsic | 4.71 | 0.73 |
| Opportunity to expand your scope of practice | 4 | Intrinsic | 4.71 | 0.61 |
| Patient scheduling policies and practices | 5 | Extrinsic | 4.71 | 0.61 |

Note: * Omitted from Cronbach’s alpha calculation

Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ)

The NP-PCOCQ is a 29-item questionnaire to measure NP perception of organizational climate in primary care. The survey statements are grouped into four subscales (Factors), Professional Visibility; NP – Administrative Relations; NP – Physician relations; and Independent Practice and Support. Cronbach’s alpha of the subscales in the study was .81, .92,

.75, and .84 respectively. Survey statements are rated on a 4-point Likert scale of 4- Strongly Agree, 3- Agree, 2- Disagree, and 1- Strongly Disagree.

Agreement

Means of the NP-PCOCQ are in descending order of agreement within the four factors (see Table 4). The factors with the highest level of agreement were in the NP – Physician Relations subscale which had means of 2.57 to 3.50. Independent Practice and Support had a mean range of 2.88 to 3.46. NP – Physician Relations had seven statements and five of the statement were rated ≥ 3 (Agree). The statement with the highest mean was, *in my practice setting, I have colleagues who I can ask for help*. In the subscale, Independent Practice and Support, seven of nine statements rated ≥ 3 (Agree). The highest rated statement was *I do not have to discuss every patient care detail with a physician*. NP – Administration Relations, a lower scoring subscale, had only two of nine statements rated as ≥ 3 (Agree). They were, *I feel valued by my organization*, and *administration is open to NP ideas to improve patient care*.

Disagreement

NP-PCOCQ statements are in descending order with lower means at the top of the factors. The lower means correspond to areas that NPs perceive as less than optimal organizational climates (see Table 5). All statement means in Factor 1: Professional Visibility, were ≤ 3.00 (Agree) and statement means ranged from 2.71 to 2.93 (Disagree). The next area of disagreement was NP – Administration Relations with seven of ten means rated less than 3 (Agree). Statement means ranged from 2.71 to 2.93. The three lowest ranking statements in the subscale included, *I get regular feedback about my performance from my organization*; *administration shares information equally with NPs and physicians*; and *in my organization, there is constant communication between NPs and administration*. In the subscale NP –

Physician Relations, seven statements had means ranging from 2.57 to 3.5. The two statements with lowest means of 2.77 and 2.57 respectively, were *physicians may ask NPs for advice to provide patient care* and *physicians seek NPs' input when providing patient care*. The last Factor, Independent Practice and Support, had two statement means < 3.00. The two statement means 2.88 (Disagree) were, *my organization create an environment where I can practice independently* and *there are enough ancillary staff to prepare my patients (e.g., height, weight, bring patient to examining room) for their visit*.

Table 5

NP-PCOCQ Results by Factor in descending order

| Factor 1: Professional Visibility | Mean | SD | N |
|--|------|------|----|
| Cronbach's alpha = .81 | | | |
| ... staff have a good understanding about NP roles in the organization | 2.93 | 0.47 | 14 |
| Administration is well informed of the skills and competencies of NPs. | 2.85 | 0.38 | 13 |
| In my organization, NP role is well understood. | 2.79 | 0.58 | 14 |
| NPs are represented in important committees in my organization. | 2.71 | 0.73 | 14 |
| Factor 2: NP – Administration Relations | | | |
| Cronbach's alpha = .92 | | | |
| I feel valued by my organization. | 3.07 | 0.47 | 14 |
| Administration is open to NP ideas to improve patient care. | 3.00 | 0.55 | 14 |
| Administration informs NPs about changes taking place in the organization. | 2.93 | 0.47 | 14 |
| Administration makes efforts to improve working conditions for NPs. | 2.86 | 0.53 | 14 |
| Administration takes NP concerns seriously. | 2.69 | 0.63 | 13 |
| Administration treats NPs and physicians equally. | 2.64 | 0.93 | 14 |
| I get regular feedback about my performance from my organization. | 2.57 | 0.85 | 14 |
| Administration shares information equally with NPs and physicians. | 2.57 | 0.85 | 14 |
| there is constant communication between NPs and administration. | 2.57 | 0.51 | 14 |
| Factor 3: NP – Physician Relations | | | |
| Cronbach's alpha = .75 | | | |
| I have colleagues who I can ask for help. | 3.50 | 0.52 | 14 |
| physicians and NPs practice as a team. | 3.38 | 0.51 | 13 |
| I feel valued by my physician colleagues. | 3.23 | 0.44 | 13 |
| NPs and physicians collaborate to provide patient care. | 3.23 | 0.44 | 13 |
| Physicians in my practice setting trust my patient care decisions. | 3.00 | 0.41 | 13 |
| Physicians may ask NPs for advice to provide patient care. | 2.77 | 0.73 | 13 |
| Physicians seek NPs' input when providing patient care. | 2.57 | 0.76 | 14 |
| Factor 4: Independent Practice and Support | | | |
| Cronbach's alpha = .84 | | | |
| I do not have to discuss every patient care detail with a physician. | 3.46 | 0.66 | 13 |
| NPs are an integral part of the organization. | 3.43 | 0.51 | 14 |
| I freely apply all my knowledge and skills to provide patient care. | 3.36 | 0.50 | 14 |
| Physicians support my patient care decisions. | 3.31 | 0.48 | 13 |
| Physicians and NPs have similar support for care management. | 3.25 | 0.46 | 8 |
| My organization does not restrict my abilities to practice within my SOP. | 3.00 | 0.76 | 8 |
| In my organization, I can provide all patient care within my SOP. | 3.00 | 0.53 | 8 |
| My organization creates an environment where I can practice independently. | 2.88 | 0.64 | 8 |
| There are enough ancillary staff to prepare my patients for their visits. | 2.88 | 0.64 | 8 |

Note: SOP - Scope of practice

Qualitative Data

Each survey had a designated area for the respondents to write comments. The last two statements of the survey gathered qualitative data and were (1) *Comments about current job satisfaction in your role as an NP*, and (2) *Comments about organizational climate at your place of employment*. Comments were provided to both statements by all six respondents that completed paper surveys in 2016. Participants who completed the survey electronically in 2016 (1) and 2017 (7), provided four additional comments. Response themes from the first statement on NP job satisfaction, from both years, reported: support from organization, fellow providers, and supervisors; positive relations with physicians; working independently as an NP in a facility with no physicians; mentorship program as a key to satisfaction; and feeling valued, proud, satisfied, and accomplished when large numbers of NPs are hired in the organization.

Other responses included lack of feedback in the first six months of employment led to feelings of failure. Performance review by a supervisor later revealed the NP was doing well in the new role. Another response was not feeling prepared for the new role and wanting more education in disease processes. A response from a NP without a physician present in the work environment, related it would be beneficial to have someone present to answer questions about critical patients or labs.

Comments about organizational climate included: when many NPs are present in the workplace, NPs feel well received; physicians paired with NPs as a resource, provide comfort and support; NPs perceived they had independent practice (within their comfort level) despite physician oversight; overseeing physicians agree with NP treatment plans upon review. Additional comments reporting persistent change within the workplace that caused loss of support staff, created a strain on providers and ultimately patients. Excluding NPs from

administrative meetings and decisions that affect NP practice devalued NP ability and education. However, a NP recently placed on a medical executive committee (Privileging/Credentialing) showed willingness to incorporate NPs on administrative decisions. Having a single physician that viewed NPs negatively caused animosity in the work environment; and using NPs for trivial care, represented underestimation of NP role, education, and skill.

CHAPTER SIX. DISCUSSION AND RECOMMENDATIONS

The number of NPs graduating and entering primary care is rapidly increasing. According to the IOM (2011), NPs who practice to the full extent of their education and scope of practice are positioned to be part of the solution to the shortage of primary care providers in the U.S. The journey from novice NP to expert NP is a process wrought with barriers, some that are in the NP's control (intrinsic factors), and factors in the control of others (extrinsic factors). The purpose of this project was the identification of barriers that hinder successful transition and result in poor job satisfaction. Identification of the roadblocks or barriers is the first step to creating change. When barriers are reduced or eliminated, novice NPs, healthcare organizations, patients, and the public serve to benefit. Additionally, preparation for transition could begin while the NP is in graduate school. An open dialogue between faculty and students about the transition process and strategies to address the barriers is a start. Healthcare organizations should also shoulder the responsibility for transition once the new NP is employed.

The MNPJSS was given to a small, convenience sample of ND NPs who graduated two or less years prior. The NPs surveyed tended to have more job satisfaction than dissatisfaction for novice NPs. The results were consistent with Kacel, Miller, & Norris's (2005) results. NP job satisfaction is highest the first year of practice; and NP satisfaction decreases with each year of experience. The Kacel et al. (2005) study included NPs that had been practicing for one to 20 years. Results showed NP job satisfaction scores were highest for NPs with 0-1 year of experience, continued to fall with each year of experience, and plateaued between the eight and eleventh year. Job satisfaction is high, yet, novice NPs transitioning to practice have a steep learning curve dominated by a sense of overwhelming complexity, exhaustion, and vacillating confidence (Flitner & Hart, 2017).

Results

Demographic Data

The average age of participants was 31 years old, which is younger than the national average of NPs, which is 49 years (AANP, 2018, January 22). The criteria for participation of two years' practice experience or less makes this an expected finding. Most participants were female, Caucasian, and educated in ND. Furthermore, most attended a hybrid education to obtain their DNP degree. All participants practiced in ND and half practiced in primary care. The homogenous make up of participating NPs is consistent with national averages of NP demographics (AANP, January 22).

Objective One

The first objective was to identify barriers that affect novice NP role transition and therefore, job satisfaction the first two years of practice in a primary care setting. As more NPs enter the primary care workforce, creating environments conducive to transition is essential for promoting a fulfilling career. There is decreased turnover, improved productivity, and reduced cost to the healthcare system when transition is successful and job satisfaction ensues for the NP (Barnes, 2015b; Pasarón, 2013; Poghosyan et al., 2013a). Successful transition requires support of intrinsic and extrinsic factors (Hill & Sawatzky, 2011). The intrinsic factors involve emotions, confidence, competence, a sense of mastery, and well-being. Examples of extrinsic factors include orientation; having a mentor, or support person; feedback on performance; and adequate time for patient visits (Barnes, 2015b; Hill & Sawatzky, 2011).

Surveys

MNPJSS

The barriers to transition were found by analyzing responses of the MNPJSS, NP-PCOCQ, and respondent comments. The MNPJSS has 44 statements that are divided into six subscales of intrinsic and extrinsic factors of job satisfaction. Responses are on a 6-point Likert scale where 6 indicate Very Satisfied. Eleven participants answered all of the statements resulting in a total mean score of 214 out of a possible score of 264 and survey mean of 4.86 corresponding to Minimally Satisfied. Results are slightly higher than Misener & Cox's (2001) total score of 193 and statement mean of 4.39. Horner's (2017) sample had a total score of 195 and statement mean response of 4.44. Misener and Cox, and Horner's results indicate NPs had minimal job satisfaction. Objective two will review MNPJSS in greater depth.

NP-PCOCQ

Poghosyan et al. (2013a) developed a survey to assess organizational climate to find organizational barriers that affect NP utilization and workforce expansion. The purpose of the survey is to implement organizational improvements to promote NP practice. The NP-PCOCQ consists of 29 statements pertaining to organizational climate divided into four subscales rated on a 4-point Likert scale. The four subscales are Administration Relations, Physician Relations, Professional Visibility, and Independent Practice and Support. Poghosyan et al. reasoned that the survey was an indirect measurement of NP job satisfaction. As the organization level means increased, similarly, NP job satisfaction increased. Conversely, as the means scores decreased, the NP intent to leave and job dissatisfaction increased. Professional Visibility mean scores of 2.71 to 2.93 indicate the participants perceive that the NP role is not well understood by staff, administration, or the organization. Comprehensibly, the novice NP may feel misunderstood and

invisible within the organization. Not unlike any new employee, the NP's learning curve is very steep. To believe that the process of getting to know a new role and all the ins and outs of the organization occurs quickly is naïve. However, if seasoned NPs also felt misunderstood and underutilized, an organization level problem exists, which if left unchecked, could result in NPs choosing to leave.

The second subscale, Administration Relations also had several low mean scores. Specifically, participants felt excluded from decision-making that affected practice. Additionally, participants thought that the organization did not value or ask for their input on decisions affecting NP practice. Participants perceived that administration was unconcerned about their requests in comparison to physician colleague requests. An unsupportive organization impede NP scope of practice and diminishes NP autonomy. One explanation for the participants perceived lack of involvement and input may be the fact that the novice NP's initial practice focus is heavily weighted on learning the clinical role. Once the NP feels comfortable and confident with diagnostic and clinical skills, career focus broadens to include involvement in organizational level activities and decisions.

Qualitative Responses

Qualitative responses revealed actual and perceived transition barriers. One response detailed feeling like a failure for the first six months of practice, which the respondent believed, could have been avoided with a mentor. Had a supportive role model been available to provide prompt feedback, finding out the NP was performing well in the new role would have encouraged confidence and competence much earlier. Another account of being disregard by a single physician in the practice caused the NP to feel devalued and negatively affected job performance. A third respondent reported feeling inadequately prepared to care for patients with

chronic and complex disease processes that resulted in feeling incompetent, frustrated, and delayed confidence.

Collective barriers from the two surveys and qualitative responses showed a lack of: monetary reward and compensation for work outside of the scheduled workday; time to be involved in research; supportive ancillary staff; and recognition (feedback) from peers and supervisors. Other barriers included poor administrative relationships; lack of administrative communication to NPs; and feeling underutilized by physicians and administrators. NP – Physician relations was one subscale that most NPs agree is a positive element of work. Within the subscale responses to two statements in the NP – Physician relations showed the relationship between physician and NP was not reciprocal. Specifically, physicians did not consult NPs on patient care issues.

To mitigate barriers new NPs could request an individualized orientation to the position, input to work schedule, education on efficient use of health information systems, and understand organizational policy. The organization providing a readily available mentor to answer questions and offer feedback cultivates feelings of confidence and mastery of the new role. Meleis' theory, according to Smith & Parker (2015), suggests that when the NP becomes proficient, a subjective sense of well-being becomes apparent. A sense of well-being, an intrinsic factor, is defined by each individual, was associated with increased job satisfaction and decreased turnover (Barnes, 2015a, 2015b; Goldschmidt et al., 2011; & Pasarón, 2013).

Objective Two

The MNPJSS survey measured specific job satisfiers and dissatisfiers. Top satisfiers found with the survey were from both intrinsic and extrinsic domains. The satisfier with the highest mean was the intrinsic factor – Challenge/Autonomy. The global finding from the

MNPJSS is that NPs are most satisfied when they are autonomous in practice. Participant response mean (5.21) indicated satisfaction with the level of autonomy afforded. Misener and Cox (2001), and Horner (2017) research results also recognized autonomy as related to satisfaction. Autonomy means in the studies were 5.15 and 5.35, respectively. North Dakota NPs have full practice authority; therefore, a rating of Very Satisfied was expected on statements related to autonomous practice. Despite state-based licensure laws allowing full scope of practice, organizational structures can limit NP independence by requiring physician oversight. Added intrinsic statements in the satisfied range were: sense of challenge in the job, spending quality time with patients, seeing a variety of patients, and having a sense of accomplishment. Having time to foster relationships with patients, provide patient education, and deliver quality care appeared to be important to NP respondent's job satisfaction.

There were 16 scale items, equally distributed between intrinsic and extrinsic values indicating job satisfaction. The intrinsic qualities of patient care contribute to job satisfaction and several satisfiers related to patient care. NPs value delivering autonomous and meaningful care a variety of patients. The universal theme in the research on NP job satisfaction is that autonomy plays a key role in job satisfaction, intent to stay, patient outcomes, as well as cost savings for the organization (Choi & De Gagne, 2015; Malone et al., 2011). However, Faraz (2016) commented that there are nominal research studies that examine professional autonomy in relation to the novice NPs. A single study of novice NPs with 3-12 months experience showed organizational support and practice autonomy were the most important predictors of job satisfaction, and prevented NPs from leaving a job. Having a sense of challenge in the job by learning new skills and procedures prevents monotony in the job. Increased competence enhances confidence when the NP becomes more self-reliant in providing care. Caring for a

variety of patients across the lifespan is an important satisfier for NPs. The sense of accomplishment is evident when NPs become comfortable in the job, have a sense of well-being, and find the job gratifying. The time spent in patient care is essential to fostering relationships with patients and providing quality care, facets of the NP role that lead to job satisfaction. NP care emphasizes preventive care, education, and health maintenance. Taking time to provide appropriate education that leads to optimal patient health outcomes is what makes the job worthwhile and rewarding for NPs.

Minimal dissatisfiers fell within the intrinsic domain. Low mean scores corresponded to the least rewarding aspects of NP practice. In factor 4, Professional Growth, all respondents indicated they were Minimally Satisfied. Specifically, the lack of opportunity to expand professional scope of practice, continuing education opportunities, and profession growth opportunities indicated low satisfaction. The acquisition of knowledge and new skills allowing participation in professional activities rejuvenates the NP and keeps work satisfying.

Dissatisfiers within the extrinsic domain were abundant. Extrinsic factors incorporate work environment, compensation, organizational policy, administration, status, and supervision. The lowest means align with the Intrapractice Partnership/Collegiality subscale. The statement concerning the availability of monetary bonuses in the addition to salary had the lowest mean score (3.36). The lack of involvement in organizational decisions and lack of recognition were also dissatisfiers. The highest rated overall mean was related to involvement in the evaluation process and organizational policy (5.86). A well-defined method of evaluation and feedback related to increased satisfaction and a feeling of fairness. Another area of importance was adequate time for paperwork, review of patient diagnostic test results, and designated time to respond to patient messages. Timely completion of paperwork is a requirement of organizations.

Establishing a balance of all the aspects of employment responsibility is important to NP satisfaction. Having time to attend social activities and to fulfill personal commitments within the community (extrinsic) increased job satisfaction. Relationships formed at work and extended to social settings increased satisfaction at work.

The current study results were consistent with previous research on job dissatisfaction (Bush & Lowery, 2016; DeMilt et al., 2011; Horner, 2017; Misener & Cox, 2001; Pasarón, 2013; Ryan & Ebbert, 2013). Dissatisfaction related to monetary bonuses paralleled the Misener and Cox (2001) research. Extrinsic factor related to monetary reward are areas for improving NP satisfaction, but as Pasarón (2013) suggests, benefits (money) can merely prevent dissatisfaction and not lead to long-term gratification when compared to intrinsic factors. New NPs should heed what more seasoned NPs consider satisfying or dissatisfying job aspects when considering employment opportunities.

Objective Three

The third aim was the identification of organizational barriers that affect NP role transition, therefore, job satisfaction. The NP-PCOCQ has 29 statements that measure organizational climate on a 4-point Likert scale. The statements are divided into four subscales. Lower means corresponded to NP disagreement with survey statements. NP – Administration Relations had the lowest means (2.57 to 2.93) with most responses on statements indicative of prevalent administrative barriers in the workplace. Respondents perceived administration's lack of NP value in: (a) communication, (b) decision making, and (c) respecting NP input. Furthermore, the type of communication in the organization was important to NPs. Open lines of communication between administration, NPs, and physicians builds understanding of common workplace goals and develops professional relationships. Respondents wanted involvement in

change within the organization and input to decisions affecting practice. When NPs are new to practice the adjustment to the environment, work flow, and time management can be overwhelming. The expectation the novice NP immediately become involved in committees and decision making is premature. Once mastery of the role is established and trusting relationships have developed, involvement in organizational responsibilities, and decision-making increases. Meaningful practice requires that administrators value NP opinions, concerns, and suggestions to improve practice.

Within the Professional Visibility subscale, the respondents' answers reflected feelings of lack of merit, visibility, and role clarity within the organization. When the NP role is not clear to administration and to other healthcare providers, the possibility of underutilization of a valuable patient care resource exists. A national study of over 8,000 NPs found the “strongest predictor for NP job satisfaction... was whether or not NPs felt that their skills were fully utilized” (Athey et al., 2016, p. 324). Furthermore, the authors found that NPs were less satisfied when they did not feel valued. Poghosyan (2015) also found that the NPs with clear role visibility had higher levels of job satisfaction.

Respondents found NP – Physician Relations a favorable aspect of the organizational climate. NPs indicated satisfaction in work environments where physicians support, trust, and value NP judgement in patient care. In addition, respondents felt working side by side with physicians and collaborating with physicians in providing patient care was important. Having physician support and guidance for patient care, when needed, was the highest rated statement in NP – Physician relations (3.50). Despite finding positive NP – Physician relationships, respondents concluded physicians do not consult them for practice advice or input. Presumed reasons for this finding may be based on physician perceived hierarchy, differing discipline

philosophy, or genuine misunderstanding of the NP role in primary care. The study findings reflect comparable results as other literature using the NP-PCOCQ (Poghosyan et al., 2013b; Poghosyan & Aiken, 2015, Poghosyan, Mannini, Stone & Smaldone, 2013c).

The last factor, Independent Practice and Support, respondents valued independence in practice and felt equally qualified as physicians to make decisions and changes in the organization. Respondents also felt supported by physicians in patient care decisions and by the ability to provide all care within their scope of practice. Respondents strongly agreed (3.46) that physicians supported care decisions without validation of every care detail. Respondents disagreed (2.88) that the organization provides an independent practice environment. Researchers have found NP freedom to provide care, independent of physicians, and with equal management support, is important to NP job satisfaction (DesRoches et al., 2015; Pasarón, 2013; Poghosyan & Aiken, 2015; Poghosyan et al., 2013a, 2013b).

Additionally, Independent Practice and Support subscale respondents disagree with statements pertaining to administration understanding of the NP role and values. Furthermore, administrative practices exclude NPs from organizational decision-making. The perception of NP autonomy and realities of organizational structure restrictions are not congruent.

NPs value independent practice and have positive relationships with physicians. NP - Administrative relationships are dissatisfying. Lack of understanding of the NP role, unsatisfying relationships with administration are barriers to satisfying jobs and contribute to NP intent to leave.

Objective Four

Share the findings of the project with healthcare organizations; NP faculty; students in NP and DNP programs; and practicing NPs, with the goal of working collaboratively toward

reducing or eliminating barriers to ease transition to practice. A Brown Bag luncheon was offered on the campus of NDSU to disseminate the practice improvement project results. Sharing the study results with faculty and DNP students increased awareness of the job satisfiers, dissatisfiers, and work environment barriers for graduating NP students. Awareness of organizational climate issues and major satisfiers and dissatisfiers may help the new NP when considering an employer. Perhaps, course content in DNP programs could include negotiation skills, responding to scope of practice barriers, professional relationship, job satisfaction, and leadership roles.

Theory

Meleis' Transition Theory was used in the project to understand the processes one must navigate to attain successful transition leading to job satisfaction. Transition starts with the anticipation of change (Smith & Parker, 2015). For example, transition begins with leaving graduate school, interviewing, accepting a position, working, and becoming a confident NP. Transition theory has been used to assess proficiency and confidence in NP roles (Barnes, 2015a). NPs can positively influence fundamental internal and external factors that lead to successful transition. Recognizing personal characteristics, strengths, and weaknesses, and requesting terms of employment that foster transition, can reduce barriers to successful transition. Requesting adequate support from mentors, the orientation process, and negotiating workload are interventions that ease transition. The process of transition for the novice NP has known, perceived, expected, and unexpected barriers. This practice improvement project aim was to assess the barriers to successful transition and job satisfaction.

Limitations

During data collection and completion of this project several limitations were identified. First, there were less participants than expected at the initial survey offered at the NDNPA Pharmacology Conference in 2016. Annually, over 300 NPs attend the NDNPA conference, from ND and surrounding regions. Therefore, the conference was thought to be an ideal venue to recruit participants. Recent NP graduates are less likely to seek continuing education in the first year of practice due to recently completing a graduate education. Due to a sample size of six participants at the first NPNPA Pharmacology Conference the survey was amended and offered at the second conference. In addition, the six paper surveys completed at the NDNPA conference had the last four statements from the NP-PCPOCQ excluded in error, yielding one complete online survey from the first data collection. The conclusion was to offer the survey at the next NDNPA Pharmacology Conference a year later on September 28 and 29, 2017. The convenience sample size remained small with 14 total participants. Secondary to a small sample size, the results were not generalizable and may not be reflective of ND NPs. In addition, implications of compromised reliability and relevance are present (McClave & Sincich, 2013).

The NDBON was contacted and a list of licensed NPs was purchased for a nominal fee. The list did not have email or physical workplace addresses; therefore, the list was not useful for recruitment of NPs for survey participation. The NDBON passed bylaws in March 2016 deleting personal information. The list was aborted due to the challenge of gathering correct contact information from each individual NP. In order to increase sample size, the co-investigator contacted the ND Academy of Physician Assistants to recruit more participants. More participants were sought at this venue as NPs also attend the seminar, however permission was denied.

Other considered limitations included not tracking the Internet Protocol (IP) address of online participants, subsequently a respondent could have taken part in the survey more than once, therefore affecting the validity of the results. The demographic responses were unique, which decreases the likelihood of one respondent completing more than one survey. One survey was excluded because the respondent was age 68 and the qualitative responses indicated the participant had more than two years' experience as a NP.

In Factor 4: Professional Growth, the initial Cronbach's alpha was .03 which was not consistent with previous studies. The statistician indicated the one statement, *support for continuing education (time and money)*, in the subscale markedly decreased the reliability of that subscale. The Cronbach's alpha increased from .03 to .68 with the removal of the single statement. Statistics computed without the statement and the Cronbach's alpha of .68, was more in line with results of other researchers (DeMilt et al., 2011; Faris, 2010; Horner, 2017; Misener & Cox, 2001; Pasarón, 2013).

The MNPJSS was developed 17 years ago and multiple changes in healthcare have occurred since that time. The practice environments and culture of healthcare have changed in many ways since the survey's inception. The universal use across all levels of NP expertise, all ages of NPs, and all scopes of practice may result in unreliable information. After implementation of the project, the co-investigator found a new survey, the NP Role Transition Scale, which may have provided richer information on NP transition. Additional research is needed to assess NP transition and job satisfaction in the first few years of practice.

Research and Practice Recommendations

Care delivery systems and organizations are constantly adapting to the rapid changes occurring in the many fronts of healthcare. Opportunity exists for further study of NP job

satisfaction in relation to care models; organizational climate; intrinsic and extrinsic factors; satisfiers and dissatisfiers; and factors known to create or foster transition. Organizations, administrators, healthcare professionals, and policy makers need sound evidence-based decisions that support NP transition. Research confirms the advantageous outcomes of successful transition including, best practices for transition, retention of knowledgeable NPs, increased patient satisfaction, and cost containment (De Milt et al., 2011; Faraz, 2016; Hill & Sawatzky, 2011; Poghosyan et al., 2013a).

The IOM report (2011) suggests that NPs are not practicing to the full extent of their education and training. As the NP workforce increases, and organization's administration considers employing more NPs, designing changes that eliminate practice restriction barriers will help improve job satisfaction and therefore, increased retention. NPs permitted to practice to the full scope of the law, report better practice environments than NPs in restrictive practice environments (Poghosyan et al., 2014b). Full autonomy and independent practice improves access in rural settings and reduces disparity (Bae, 2016; Hauenstein et al., 2014). Does working in a state that legally allows full scope of practice lead to feeling independent despite having work place restrictions? Further research in states with varying levels of practice authority may shed light on how organizational restrictions affect NP practice outcomes, job satisfaction, and NP role.

DNP education prepares NPs to be leaders of change. Skill in analysis and synthesis of research is the core of practice improvement, quality care, and improved patient outcomes. Effective change requires expert use of technology, and understanding of healthcare systems, and interdisciplinary collaboration. DNP knowledge of health policy is valuable when forging alliance with local, state, and national policy makers to decrease scope of practice barriers and

allow NPs to practice at the full extent of their education. Collectively, the increased number of NP providers can fill the gap in primary care, rural, and underserved areas, thereby, improving patient access and outcomes. A logical next step is to conduct further study of NPs within the state and implement organization and environment changes that mitigate barriers to transition, job satisfaction, and utilization issues. Reassessment of job satisfaction and organizational climate in a longitudinal study may provide guidance in successful formation of workplace environments that have positive outcomes for patients, practitioners, and healthcare businesses.

Conclusion

The assessment of job satisfaction of ND NPs new to practice is important in a rural state where healthcare disparity exists and access to care is challenging. Recruitment and retention of NPs fill a critical gap in a rural state in need of NP workforce. Working closely with administrators and organizations to foster assimilation of new NPs to the healthcare system will reap benefits of cost containment and quality care that all stakeholders will appreciate. Meeting and exceeding both patient outcomes and financial goals are important beyond the local clinic. Global organizational goals are to improve patient outcomes while containing costs; foundations vital to the survival of healthcare systems. Currently, organizations are prioritizing the need for increased access, high-quality care, and retention of healthcare providers, not only for the subsistence of business, but for compliance to regulations.

The study did not lead to change in NP practice or organizational climate. However, the hope is that by increased awareness at the local level with dissemination to graduate students, faculty, and healthcare organizations, open dialogue with healthcare organizations and policy makers will ensue. Recognition that change is mandatory across healthcare systems and by many stakeholders necessitates working together for instrumental change. Organizations,

administrators, physicians, and NPs are all invited to participate in decreasing barriers to transition, so valuable outcomes of NP job satisfaction are fulfilled.

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APPENDIX A. DRAFT COVER LETTER & INFORMED CONSENT TO NDNPA

ATTENDEES

NDSU School of Nursing
Dept. 2670
PO Box 6050
Fargo, ND 58108-6050
701.231.5692

Barriers to New Nurse Practitioner Job Satisfaction

Nurse Practitioner and Doctor of Nursing Practice Colleagues,

My name is Deanna Weiser. I am a student in the Doctor of Nursing Practice at North Dakota State University. As part of my degree requirements, I am conducting an assessment of Nurse Practitioners and Doctors of Nursing Practice that have been employed in primary care since May 2015 or less. The focus is to discover barriers to job satisfaction in primary care practitioners, that may be related to difficult transition of novice practitioners, organizational barriers, or personal feelings of dissatisfaction. The results of the assessment questionnaires will help guide future study to resolve barriers and create a collaborative work environment for future NPs.

I invite all Advance Practice Registered Nurses who have been in primary care practice since May 2015 or less to take part in this survey.

The data collected will be general demographics, Misener Nurse Practitioner Job Satisfaction Survey ©, and the Nurse Practitioner Primary Care Organizational Climate Questionnaire. Questionnaire responses will be kept anonymous and confidential. Participation is voluntary and completion of the surveys implies consent of participation in this project. You may change your mind or quit taking the survey at any time. There are no legal or physical risks in completing the survey. A small risk of emotional distress may exist due to questions asked in the surveys. IRB approval has been obtained from North Dakota State University.

Survey questions will take approximately 10-15 min. to complete. Upon completing the surveys electronically or returning the completed paper surveys, you may enter a drawing for a \$50.00 Target gift card. An enclosed box will be available to enter your name and address. A name will be drawn by the dissertation committee chair, Dr. Tina Lundeen, and delivered to you during the NDNPA Pharmacy Conference.

Thank you in advance for your participation in this important research. The responses about barriers to job satisfaction for novice NPs is valuable to identify the needs and commonalities, so additional research can be done to address and resolve areas of dissatisfaction in a rapidly changing healthcare environment.

If you have any questions, please contact me at deanna.weiser@ndsu.edu or call 701-320-4798. You may also contact my dissertation chairperson, Dr. Tina Lundeen, by email at tina.lundeen@ndsu.edu or phone at 701-231-7747. You have rights as a research participant. If you have questions about the rights of human participants in research, or to report a problem, contact the North Dakota State University IRB Office by e-mail at NDSU.IRB@ndsu.edu, by telephone at 701.231.8995, toll-free 855.800.6717, or by mail at NDSU Sponsored Programs Administration, 1735 NDSU Research Park Drive, NDSU Dept. 4000, PO Box 6050, Fargo, ND 58108-6050.

Thank you again for your participation in this assessment.

Sincerely,

Deanna Weiser, RN, BSN
Doctoral Student in the Department of Nursing

APPENDIX B. DEMOGRAPHIC AND WORK CHARACTERISTICS OF NPS

Demographic and work characteristics of NPs

Please check the appropriate box or write in response where indicated

| | |
|---|--|
| Age (write in) | <input type="text"/> |
| Gender | |
| Female | <input type="checkbox"/> |
| Male | <input type="checkbox"/> |
| Race | |
| Caucasian | <input type="checkbox"/> |
| African-American | <input type="checkbox"/> |
| Asian | <input type="checkbox"/> |
| Hispanic | <input type="checkbox"/> |
| Native American | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |
| In what state did you complete your NP education (write in) ND, MN, etc. | <input type="text"/> |
| NP Program degree earned | |
| Certificate | <input type="checkbox"/> |
| Masters | <input type="checkbox"/> |
| DNP | <input type="checkbox"/> |
| PhD | <input type="checkbox"/> |
| Was your NP program primarily | |
| Online | <input type="checkbox"/> |
| Partially Online (Hybrid) | <input type="checkbox"/> |
| On Campus | <input type="checkbox"/> |
| What state are you currently practicing in? (write-in) ND, MN, etc. | <input type="text"/> |
| Clinical area of practice (write in) i.e. primary care, cardiac, women's health etc. | <input type="text"/> |
| Did you graduate after April 2015? | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Are you working in the same institution now that you did when employed as a RN? | yes <input type="checkbox"/> no <input type="checkbox"/> |

APPENDIX C. MISENER NURSE PRACTITIONER JOB SATISFACTION SCALE ©

Misener Nurse Practitioner Job Satisfaction Scale ©

Instructions:

The following is a list of items known to have varying levels of satisfaction among NPs. There may be items that do not pertain to you, however please answer it if you are able to assess your satisfaction with the item based on the employer's policy, i.e., if you needed it would it be there?

HOW SATISFIED ARE YOU IN YOUR CURRENT JOB AS A NURSE PRACTITIONER WITH RESPECT TO THE FOLLOWING FACTORS?

| | |
|--|---|
| <p>V.S. = Very Satisfied S. = Satisfied M.S. = Minimally Satisfied</p> | <p>M.D. = Minimally Dissatisfied D. = Dissatisfied V.D. = Very Dissatisfied</p> |
|--|---|

| | | V.S. | S. | M.S. | M.D. | D. | V.D. |
|-----|--|------|----|------|------|----|------|
| 1. | Vacation/Leave policy | 6 | 5 | 4 | 3 | 2 | 1 |
| 2. | Benefit package | 6 | 5 | 4 | 3 | 2 | 1 |
| 3. | Retirement plan | 6 | 5 | 4 | 3 | 2 | 1 |
| 4. | Time allotted for answering messages | 6 | 5 | 4 | 3 | 2 | 1 |
| 5. | Time allotted for review of lab and other test results | 6 | 5 | 4 | 3 | 2 | 1 |
| 6. | Your immediate supervisor | 6 | 5 | 4 | 3 | 2 | 1 |
| 7. | Percentage of time spent in direct patient care | 6 | 5 | 4 | 3 | 2 | 1 |
| 8. | Time allocation for seeing patient(s) | 6 | 5 | 4 | 3 | 2 | 1 |
| 9. | Amount of administrative support | 6 | 5 | 4 | 3 | 2 | 1 |
| 10. | Quality of assistive personnel | 6 | 5 | 4 | 3 | 2 | 1 |
| 11. | Patient scheduling policies and practices | 6 | 5 | 4 | 3 | 2 | 1 |
| 12. | Patient mix | 6 | 5 | 4 | 3 | 2 | 1 |
| 13. | Sense of accomplishment | 6 | 5 | 4 | 3 | 2 | 1 |
| 14. | Social contact at work | 6 | 5 | 4 | 3 | 2 | 1 |
| 15. | Status in the community | 6 | 5 | 4 | 3 | 2 | 1 |
| 16. | Social contact with your colleagues after work | 6 | 5 | 4 | 3 | 2 | 1 |
| 17. | Professional interaction with other disciplines | 6 | 5 | 4 | 3 | 2 | 1 |

HOW SATISFIED ARE YOU IN YOUR CURRENT JOB AS A NURSE PRACTITIONER WITH:

V.S. = Very Satisfied
 S. = Satisfied
 M.S. = Minimally Satisfied

M.D. = Minimally Dissatisfied
 D. = Dissatisfied
 V.D. = Very Dissatisfied

| | V.S. | S. | M.S. | M.D. | D. | V.D. |
|--|------|----|------|------|----|------|
| 18. Support for continuing education (time and \$\$) | 6 | 5 | 4 | 3 | 2 | 1 |
| 19. Opportunity for professional growth | 6 | 5 | 4 | 3 | 2 | 1 |
| 20. Time off to serve on professional committees | 6 | 5 | 4 | 3 | 2 | 1 |
| 21. Amount of involvement in research | 6 | 5 | 4 | 3 | 2 | 1 |
| 22. Opportunity to expand your scope of practice | 6 | 5 | 4 | 3 | 2 | 1 |
| 23. Interaction with other NPs including faculty | 6 | 5 | 4 | 3 | 2 | 1 |
| 24. Consideration given to your opinion and suggestions for change in the work setting or office practice | 6 | 5 | 4 | 3 | 2 | 1 |
| 25. Input into organizational policy | 6 | 5 | 4 | 3 | 2 | 1 |
| 26. Freedom to question decisions and practices | 6 | 5 | 4 | 3 | 2 | 1 |
| 27. Expanding skill level/procedures within your scope of practice | 6 | 5 | 4 | 3 | 2 | 1 |
| 28. Ability to deliver quality care | 6 | 5 | 4 | 3 | 2 | 1 |
| 29. Opportunities to expand your scope of practice and time to seek advanced education. | 6 | 5 | 4 | 3 | 2 | 1 |
| 30. Recognition for your work from superiors | 6 | 5 | 4 | 3 | 2 | 1 |
| 31. Recognition of your work from peers | 6 | 5 | 4 | 3 | 2 | 1 |
| 32. Level of autonomy | 6 | 5 | 4 | 3 | 2 | 1 |
| 33. Evaluation process and policy | 6 | 5 | 4 | 3 | 2 | 1 |
| 34. Reward distribution | 6 | 5 | 4 | 3 | 2 | 1 |
| 35. Sense of value for what you do | 6 | 5 | 4 | 3 | 2 | 1 |
| 36. Challenge in work | 6 | 5 | 4 | 3 | 2 | 1 |
| 37. Opportunity to develop and implement ideas. | 6 | 5 | 4 | 3 | 2 | 1 |
| 38. Process used in conflict resolution | 6 | 5 | 4 | 3 | 2 | 1 |
| 39. Amount of consideration given to your personal needs | 6 | 5 | 4 | 3 | 2 | 1 |
| 40. Flexibility in practice protocols. | 6 | 5 | 4 | 3 | 2 | 1 |
| 41. Monetary bonuses that are available in addition to your salary | 6 | 5 | 4 | 3 | 2 | 1 |
| 42. Opportunity to receive compensation for services performed outside of your normal duties. | 6 | 5 | 4 | 3 | 2 | 1 |
| 43. Respect for your opinion | 6 | 5 | 4 | 3 | 2 | 1 |
| 44. Acceptance and attitudes of physicians outside of your practice (such as specialist you refer patients to) | 6 | 5 | 4 | 3 | 2 | 1 |

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**APPENDIX D. NURSE PRACTITIONER PRIMARY CARE ORGANIZATIONAL
CLIMATE QUESTIONNAIRE**

Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ)

For each item, please indicate the extent to which you agree that the following items are present in your practice site.

Indicate your degree of agreement by selecting **ONE** option that best applies to you.

| | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|----|---|-------------------|-------|----------|----------------------|
| 1 | In my organization, NP role is well understood | | | | |
| 2 | NPs are represented in important committees in my organization | | | | |
| 3 | In my practice setting, staff members have a good understanding about NP roles in the organization. | | | | |
| 4 | Administration is well informed of the skills and competencies of NPs. | | | | |
| 5 | I feel valued by my organization. | | | | |
| 6 | I get regular feedback about my performance from my organization. | | | | |
| 7 | Administration is open to NP ideas to improve patient care. | | | | |
| 8 | Administration takes NP concerns seriously. | | | | |
| 9 | Administration shares information equally with NPs and physicians. | | | | |
| 10 | Administration treats NPs and physicians equally. | | | | |
| 11 | Administration informs NPs about changes taking place in the organization. | | | | |
| 12 | Administration makes efforts to improve working conditions for NPs | | | | |
| 13 | In my organization, there is constant communication between NPs and administration. | | | | |
| 14 | I feel valued by my physician colleagues. | | | | |
| 15 | In my organization, physicians and NPs practice as a team. | | | | |
| 16 | Physicians may ask NPs for advice to provide patient care. | | | | |

| | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|----|--|-------------------|-------|----------|----------------------|
| 17 | In my organization, NPs and physicians collaborate to provide patient care. | | | | |
| 18 | Physicians seek NPs' input when providing patient care. | | | | |
| 19 | Physicians in my practice setting trust my patient care decisions. | | | | |
| 20 | In my practice setting, I have colleagues who I can ask for help. | | | | |
| 21 | Physicians support my patient care decisions. | | | | |
| 22 | NPs are an integral part of the organization. | | | | |
| 23 | I do not have to discuss every patient care detail with a physician. | | | | |
| 24 | In my organization, I freely apply all my knowledge and skills to provide patient care. | | | | |
| 25 | My organization does not restrict my abilities to practice within my scope of practice. | | | | |
| 26 | In my organization, I can provide all patient care within my scope of practice. | | | | |
| 27 | Physicians and NPs have similar support for care management (e.g., help with patient follow-up, referrals, laboratories, etc.) | | | | |
| 28 | My organization creates an environment where I can practice independently. | | | | |
| 29 | There are enough ancillary staff to prepare my patients (e.g., height, weight, bring patient to examining room) for their visit. | | | | |

APPENDIX F. INSTITUTIONAL REVIEW BOARD APPROVAL



September 21, 2016

Dr. Tina Lundeen
School of Nursing

Re: IRB Certification of Exempt Human Subjects Research:
Protocol #PH17055, "Barriers to New Nurse Practitioner Job Satisfaction"

Co-investigator(s) and research team: Deanna Weiser

Certification Date: 9/21/2016 Expiration Date: 9/20/2019
Study site(s): Fargo, ND
Sponsor: n/a

The above referenced human subjects research project has been certified as exempt (category # 2b) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, Protection of Human Subjects). This determination is based on the original protocol submission (received 9/20/2016).

Please also note the following:

- If you wish to continue the research after the expiration, submit a request for recertification several weeks prior to the expiration.
- The study must be conducted as described in the approved protocol. Changes to this protocol must be approved prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
- Notify the IRB promptly of any adverse events, complaints, or unanticipated problems involving risks to subjects or others related to this project.
- Report any significant new findings that may affect the risks and benefits to the participants and the IRB.

Research records may be subject to a random or directed audit at any time to verify compliance with IRB standard operating procedures.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.

Sincerely,

Digitally signed by Kristy Shirley
DN: cn=Kristy Shirley, o=NDSU,
ou=Institutional Review Board,
email=kristy.shirley@ndsu.edu,
c=US
Date: 2016.09.21 13:28:31 -0500

Kristy Shirley, CIP, Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult http://www.ndsu.edu/research/integrity_compliance/irb/. This Institution has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

INSTITUTIONAL REVIEW BOARD

NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | ndsu.edu/irb

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

NDSU is an EQ/IAA university.

APPENDIX G. AMENDED INSTITUTIONAL REVIEW BOARD APPROVAL



INSTITUTIONAL REVIEW BOARD
office: Research 1, 1735 NDSU Research Park Drive, Fargo, ND 58102
mail: NDSU Dept. #4000, PO Box 6050, Fargo, ND 58108-6050
p: 701.231.8995 f: 701.231.8098 e: ndsu.ibr@ndsu.edu w: www.ndsu.edu/ibr

Date Received
8/16/2017

IRB Protocol #:
PH17055

Protocol Amendment Request Form

Changes to approved research may not be initiated without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to participants. Reference: SOP 7.5 Protocol Amendments.

Examples of changes requiring IRB review include, but are not limited to changes in: investigators or research team members, purpose/scope of research, recruitment procedures, compensation strategy, participant population, research setting, interventions involving participants, data collection procedures, or surveys, measures or other data forms.

Protocol Information:


Protocol #: PH17055 Title: **Barriers to New Nurse Practitioner Job Satisfaction**

Review category: Exempt Expedited Full board

Principal investigator: **Dr. Tina Lundeen, DNP, APRN, FNP-BC** Email address: tina.lundeen@ndsu.edu
Dept: **School of Nursing** 516/2014

Co-investigator: **Deanna Weiser, BSN, RN** Email address: deanna.weiser@ndsu.edu
Dept: **School of Nursing** 414/2016

Principal investigator signature, Date: Tina Lundeen (email) 8/16/2017

 In lieu of a written signature, submission via the Principal Investigator's NDSU email constitutes an acceptable electronic signature.

Description of proposed changes:

1. Date of proposed implementation of change(s)*: **August 15, 2017**
* Cannot be implemented prior to IRB approval unless the IRB Chair has determined that the change is necessary to eliminate apparent immediate hazards to participants.
2. Describe proposed change(s), including justification:
Open survey to include Nurse Practitioners graduated within 2 years. Offer survey through social media. Offer survey at the North Dakota Nurse Practitioner Association's 9th Annual Pharmacology Conference, September 28-29, 2017 at Bismarck, ND.
Increased participation is needed due to a small number of participants with the initial data collection in September, 2016. Offering additional participation by social media and including those who have graduated within two years may help increase the number of participants.

3. Will the change(s) increase any risks, or present new risks (*physical, economic, psychological, or sociological*) to participants?

No

Yes: *In the appropriate section of the protocol form, describe new or altered risks and how they will be minimized.*

4. Does the proposed change involve the addition of a vulnerable group of participants?

Children: no yes - include the *Children in Research* attachment form

Prisoners: no yes - include the *Prisoners in Research* attachment form


Cognitively impaired individuals: no yes*

Economically or educationally disadvantaged individuals: no yes*

**Provide additional information where applicable in the revised protocol form.*

5. Does the proposed change involve a request to waive some or all the elements of informed consent or documentation of consent?

no

yes -  Attach the *Informed Consent Waiver or Alteration Request*.

6. Does the proposed change involve a new research site?

no

yes




If information in your previously approved protocol has changed, or additional information is being added, incorporate the changes into relevant section(s) of the protocol. Draw attention to changes by using all caps, asterisks, etc. to the revised section(s) and attach a copy of the revised protocol with your submission. (If the changes are limited to addition/change in research team members, research sites, etc. a revised protocol form is not needed.)

Impact for Participants (future, current, or prior):

1. Will the change(s) alter information on previously approved versions of the recruitment materials, informed consent, or other documents, or require new documents?

No

Yes -  attach revised/new document(s)

2. Could the change(s) affect the willingness of *currently* enrolled participants to continue in the research?

No

Yes - describe procedures that will be used to inform current participants, and re-consent, if necessary:

3. Will the change(s) have any impact to *previously* enrolled participants?

No

Yes - describe impact, and any procedures that will be taken to protect the rights and welfare of participants:

-----FOR IRB OFFICE USE ONLY-----

| | |
|--|--|
| Request is: <input checked="" type="checkbox"/> Approved <input type="checkbox"/> Not Approved | |
| Review: <input checked="" type="checkbox"/> Exempt, category#: <u>2b</u> | <input type="checkbox"/> Expedited method, category # ____ <input type="checkbox"/> Convened meeting, date: ____ |
| <input type="checkbox"/> Expedited review of minor change | |
| IRB Signature: <u>Ernsty Shuley</u> | Date: <u>8/21/2017</u> |
| Comments: | |

NDSU School of Nursing
Dept. 2670
PO Box 6050
Fargo, ND 58108-6050
701.231.5692

Title of Research Study: Barriers to New Nurse Practitioner Job Satisfaction

Dear Nurse Practitioner and Doctor of Nursing Practice Colleagues,

My name is Deanna Weiser. I am a student in the Doctor of Nursing Practice at North Dakota State University. As part of my degree requirements, I am conducting an assessment of Nurse Practitioners and Doctors of Nursing Practice that have been employed for two years. The focus is to discover barriers to job satisfaction in primary care practitioners, that may be related to difficult transition of new practitioners, organizational barriers, or personal feelings of dissatisfaction. The results of the assessment questionnaires will help guide future study to resolve barriers and create a collaborative work environment for future NPs.

I invite all Advance Practice Registered Nurses employed for one to two years to take part in this survey.

The data collected will be general demographics, Misener Nurse Practitioner Job Satisfaction Survey®, and the Nurse Practitioner Primary Care Organizational Climate Questionnaire. Questionnaire responses will be kept anonymous and confidential. Participation is voluntary and completion of the surveys implies consent of participation in this project. You may change your mind or quit taking the survey at any time without penalty. There are no legal or physical risks in completing the survey. A small risk of emotional distress may exist due to questions asked in the surveys. IRB approval has been obtained from North Dakota State University.

The survey will take approximately 10-15 min. to complete. Participants may enter an optional drawing for a \$20.00 Target gift card at the end of the survey. Completed online surveys will offer a place to provide name and email. Those completing paper surveys can submit name and email address on a slip of paper and place in a drop box. A volunteer, not associated with the survey, will draw the winners name after online names are provided and submitted by Qualtrics staff. The winner will be contacted by the email address they provided when entering the drawing.

Thank you in advance for your participation in this project. Your responses about barriers to job satisfaction and organizational climate will be analyzed and the results shared with NP faculty, student NPs, and healthcare organizations in an effort to address, reduce, and ultimately eliminate barriers NPs face.

If you have any questions, please contact me at deanna.weiser@ndsu.edu or call 701-320-4798. You may also contact my dissertation chairperson, Dr. Tina Lundeen, by email at tina.lundeen@ndsu.edu or phone at 701-231-7747. You have rights as a research participant. If you have questions about the rights of human participants in research, or to report a problem, contact the North Dakota State University IRB Office by e-mail at NDSU.IRB@ndsu.edu, by telephone at 701.231.8995, toll-free 855.800.6717, or by mail at NDSU Sponsored Programs Administration, 1735 NDSU Research Park Drive, NDSU Dept. 4000, PO Box 6050, Fargo, ND 58108-6050.

Thank you again for your participation in this assessment.

Sincerely,



Deanna Weiser, RN, BSN
Doctoral Student in the Department of Nursing

Demographic and work characteristics of NPs

Please check the appropriate box or write in response where indicated

| | |
|---|--|
| Age (write in) | |
| Gender | |
| Female | <input type="checkbox"/> |
| Male | <input type="checkbox"/> |
| Ethnicity | |
| Caucasian | <input type="checkbox"/> |
| African-American | <input type="checkbox"/> |
| Asian | <input type="checkbox"/> |
| Hispanic | <input type="checkbox"/> |
| Native American | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |
| In what state did you complete your NP education (write in) ND, MN, etc. | |
| NP Program degree earned | |
| Certificate | <input type="checkbox"/> |
| Masters | <input type="checkbox"/> |
| DNP | <input type="checkbox"/> |
| PhD | <input type="checkbox"/> |
| Was your NP program primarily | |
| Online | <input type="checkbox"/> |
| Partially Online (Hybrid) | <input type="checkbox"/> |
| On Campus | <input type="checkbox"/> |
| What state are you currently practicing in? (write-in) ND, MN, etc. | |
| Clinical area of practice (write in) i.e. primary care, cardiac, women's health etc. | |
| Did you graduate after April 2015? | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Are you working in the same institution now that you did when employed as a RN? | yes <input type="checkbox"/> no <input type="checkbox"/> |

**APPENDIX H. PERMISSION TO USE MISENER NURSE PRACTITIONER JOB
SATISFACTION SURVEY**

6/1/2016

Dear De Anna Cox,

I am writing to inquire about using the Misener NP Job Satisfaction Scale in developing my dissertation for the DNP program at North Dakota State University, Fargo, ND. I am in the initial year of the program and have done several research papers along the vein of Job Satisfaction and referenced the scale you and Dr. Terry Misener developed. I was unable to locate him online given the contact information from the original article.

I am also wondering if I could adapt some of the questions to inquire of novice DNP's the barriers they perceive to job satisfaction as well as support they feel in their new position that leads to job satisfaction. I do not have specific questions for adaptation yet, as I am just getting started. I am hoping to have my dissertation proposal completed by mid-August.

I appreciate your consideration of my request. Please let me know if you have any questions regarding my request.

Respectfully,

Deanna Weiser, BSN, RN, DNP-S
Jamestown ND 58401

COX, DE ANNA <dlcox@mailbox.sc.edu>

6/3/2016

Deanna,

I am more than happy for you to use the instrument. Please let me know how your research progresses.

De Anna

De Anna Cox, MN, APRN, FNP-BC
Family Nurse Practitioner
Clinical Associate Professor
Office: College of Nursing Room 512
Phone: (803) 777-4390
CON Fax: (803) 777-0550
E-mail: dlcox@mailbox.sc.edu

**APPENDIX I. PERMISSION TO USE THE NURSE PRACTITIONER PRIMARY CARE
ORGANIZATIONAL CLIMATE QUESTIONNAIRE**

July 22, 2016

Dr. Poghosyan,

My name is Deanna Weiser and I am a graduate nursing student in the Doctor of Nursing Practice program at North Dakota State University located in Fargo, ND. I am preparing the proposal for my dissertation, Barriers to Job Satisfaction in novice DNPs. I would like to receive a copy of the Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ) as well as permission to use this as part of the research for my dissertation. If you have a word document or PDF version, I would appreciate receiving a copy of the questionnaire and any scoring information that accompanies it.

Thank you for considering my request.

Sincerely,

Deanna Weiser, BSN, RN, DNP-S
Jamestown ND 58401

July 25, 2016

Hi Deanna,

Of course. Please see the tool attached. the subscales are in the Nursing Research manuscript. We compute mean scores. Would love to hear what you will find.
Best wishes, Lusine

**APPENDIX J. PERMISSION TO USE THE IOWA MODEL REVISED: EVIDENCE-
BASED PRACTICE TO PROMOTE EXCELLENCE IN HEALTH CARE**

From: Kimberly Jordan - University of Iowa Hospitals and Clinics <noreply@qemailserver.com>
Sent: Thursday, August 25, 2016 3:28 PM
To: Deanna Weiser
Subject: Permission to Use and/or Reproduce The Iowa Model (2015)

You have permission, as requested today, to review/use *The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care (Iowa Model)*. Click the link below to open. Copyright will be retained by The University of Iowa Hospitals and Clinics.

Permission is not granted for placing the Iowa Model on the internet.

[The Iowa Model - 2015](#)

Citation: The Iowa Model Collaborative. (In review). *The Iowa Model Revised: Development and Validation*.

In written material, please add the following statement:

- *Used/Reprinted with permission from the University of Iowa Hospitals and Clinics. Copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at (319)384-9098.*

If you have questions, please contact Kimberly Jordan at 319-384-9098 or kimberly-jordan@uiowa.edu.

APPENDIX K. EXECUTIVE SUMMARY

NURSE PRACTITIONER (NP)

JOB SATISFACTION


Survey results of 14 novice NPs with ≤ 2 years' experience in North Dakota.

Job Satisfiers

- Fair evaluation policy
- Time to provide quality patient care
- Care for patients of all ages
- Preceptor availability
- Sense of value and accomplishment

Job Dissatisfiers

- Lack of monetary rewards, bonuses
- Organizational limit on practicing to full extent of education and what the law allows
- Lack of time to conduct research
- Lack of input to organization policy
- Lack of recognition from administration & peers
- Lack of quality ancillary staff



Introduction

A shortage of general practice physicians, aging baby boomers, and increased healthcare utilization is creating a shortage of primary care providers. As a result of the Institute of Medicine's solution to bolster nursing education, Nurse Practitioner numbers are growing exponentially.

Barriers prevent successful integration for new practitioners and job satisfaction suffers as a result. Unsatisfied employees move to other jobs. Twice as many NPs as physicians leave their practice. Turnover is costly to organizational bottom line.

NPs provide care similar to physicians. NP patient outcomes are equal and in some metrics, higher than those of physicians. Happy NPs provide quality care at a cost savings. The loss of such a valuable resource behooves organizations to improve undesirable organizational climates affecting job satisfaction for NPs.

BARRIERS TO SATISFACTION

- Lack of financial rewards/bonuses
- Lack of time for research
- Lack of input into organization
- Lack of feedback from peers/organization
- Lack of quality and number of ancillary personnel
- Lack of social contact with peers
- NP exclusion in organizational decision making and committees affecting NP practice
- Administration/physician's lack clarity of NP role
- Lack of administrative action toward NP concerns

Project Design

The project focused on assessing barriers to job satisfaction in novice NPs with ≤ 2 years' experience. Two different surveys were used to measure barriers to job satisfaction, and NP perceived organizational climates. Demographic information and personal comments about job satisfaction and organizational climate were solicited.

Results were presented to students and faculty at North Dakota State University. Awareness of barriers perceived by new NPs guided conversation of ways to mitigate those barriers. NP students anticipating employment learned terms of employment to negotiate to ensure a healthy and positive transition period that launches a successful career. Educational institutions can implement curriculum on increasing awareness of barriers and negotiating skills to mitigate barriers.

What NEW NPs are Saying...

- I am 1 of 100 NPs recently hired, I feel valued in this organization.
- Mentoring is key to job satisfaction.
- My clinic *finally* put a NP on the Executive Committee. Equal representation for doctors and NPs in decision-making gives me a sense of accomplishment.
- I *love* my new job, I practice *independently* and have no physician oversight.
- Nurse Practitioners are well received in my organization.
- Having just 1 physician that doesn't understand my skill and knowledge decreases my utilization, satisfaction, and sense of value in my job.
- There is so much change at work, people are quitting. Its's the patient who suffers.

248,000 NURSE PRACTITIONERS IN 2018



NP Satisfaction

= \$\$\$

On Organizational bottom line

Recommendations

- Request orientation period for development of clear role and provide feedback for successful transition
- Request mentor or support person to be a resource and role model
- Request decreased workload until comfortable
- Negotiate terms of employment
 - Vacation time
 - Length of patient visits
- Request to be placed on committees that make decisions about organizational policy change
- Request reimbursement for community intervention
- Request time for research with aims to improve patient outcomes, increase work flow efficiency, or other identified need
- Recommend Graduate NP curriculum include skill attainment in negotiating
- Increase awareness of barriers to job satisfaction for NPs about to enter practice
- Educate employers of NP role and scope of practice
- Add challenge to NP role by requesting to receive training on new procedures

Practice Implications

Increased NP job satisfaction leads to improved patient outcomes and satisfaction. Satisfied NPs provide higher quality healthcare, have longevity in their job, and turnover is decreased. NPs provide much of the same care as physicians, and at a cost savings for organizations.

“Nurse Practitioners in Primary Care Organizations provide many of the same services as physicians, and at a cost savings”

NPs are educated as leaders and trained to implement evidence-based changes to advocate job satisfaction. NPs can unite as champions of health and create policy, system, and environmental changes that have a lasting effect on the well-being of employees. Helping organizations to thrive while providing excellent patient-centered care is judicious use of the considerable resource NPs afford healthcare systems.

Implementing actions with the intent to ease transition across all ancillary professions will lead to gratification for the practitioner, staff, and most importantly, the patient.

234,000 NURSE PRACTITIONERS IN 2017