

REDUCING NURSE PRACTITIONER TURNOVER IN HOME-BASED PRIMARY CARE: A
DEPARTMENT OF VETERANS AFFAIRS QUALITY IMPROVEMENT PROJECT

A Doctor of Nursing Practice Project Report

by

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This Doctor of Nursing Practice Project Report meets the standards for scope and quality of Texas A&M University-Corpus Christi College of Nursing and Health Sciences and is hereby approved.

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August 2018

DEDICATION

I would like to dedicate this work to my parents, Jay and Charmaine Murello, who have provided unending support, to my amazing, inspirational children, Jovi and Jedi, who have had to put up with the late nights, early mornings, and short temper during the days, and to my husband, Jeffrey, who was supportive and understanding throughout this program.

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ABSTRACT

Objective: To identify factors in the Department of Veteran Affairs (VA) Home Based Primary Care (HBPC) program that may contribute to nurse practitioner (NP) retention and decrease provider gaps and access to primary care disparities for veterans.

Background: For a Texas VA Medical Center, high and rapid HBPC NP turnover was identified and a program evaluation was conducted to explore factors associated with turnover.

Methods: To determine factors with potential to decrease NP turnover, a program evaluation was conducted using the Anticipated Turnover Scale (ATS) and the Misener NP Job Satisfaction Scale (MNPJSS), administered to currently employed, non-supervisory NPs, who had been in HBPC for more than six months.

Results: ATS responses reflected 57.1% of the participants intended to stay; however, mean responses to individual questions represented the group was equally divided on intent to leave. Of the 43 MNPJSS questions, 24 were answered as dissatisfied and 19 were answered as satisfied by the group.

Conclusions: Recommendations resulting from this program evaluation may help retain NPs in HBPC, reduce organizational costs, and support optimal veteran outcomes.

PROJECT REPORT

Reducing Nurse Practitioner Turnover In Home Based Primary Care: A Department Of Veterans Affairs Quality Improvement Project

Introduction

Since 2002, enrollment in the Department of Veterans Affairs (VA) health care system has increased from 6.8 million veterans to over 8.9 million veterans and is expected to increase beyond 9.3 million by 2019.¹ Access to quality health care has been identified as a significant health challenge for the VA. Not only has this challenge received considerable media and congressional interest, it has affected veterans of all ages. Access to primary health care (care provided for common medical problems) is becoming a challenge for the veteran population, as well as for the general population across the nation.² By 2025, it is projected there will be a deficiency of approximately 35,000 to 44,000 primary care providers (PCPs) in the United States (U.S.).³⁻⁵ Nurse practitioners (NPs) are a solution to address the projected PCP deficiency.³ Simultaneously, to keep up with national veteran health care demands, the VA implemented Home Based Primary Care (HBPC), a program which allows the health care team to go to the veteran's home to provide primary care.⁶ The mission of HBPC is to provide comprehensive, interdisciplinary primary care in the homes of veterans with complex medical, social, and behavioral health conditions, for whom clinic-based care is not effective.⁷ For a Texas VA Medical Center, high and rapid HBPC NP turnover was identified and a program evaluation was conducted to explore factors associated with turnover.

Background

The NP role was developed in the 1960's and during this time, NPs quickly became the provider of choice for millions of Americans.^{8,9} Over the past five decades, the number of NPs has expanded from 15,000 to now more than 248,000 across the U.S.⁹ Multiple studies have demonstrated NP care is equivalent to and, in some measures (quality, safety, and effectiveness), surpasses physician-provided care.^{10,11} Despite education, training, and outcomes, individual state legislation and restrictions prohibit NPs from practicing to the fullest extent of their license. There are three types of practice categories for NPs in the U.S. restricted, reduced, and full. Restricted Practice entails supervision of the NP throughout one's career delegation, or being managed by another health care provider in order for the NP to practice.¹²

Reduced Practice entails a regulated collaborative agreement with another health provider throughout the NP's career in order for the NP to practice or limits the setting of one or more components of NP practice.¹² Full Practice Authority (FPA) allows for NPs to assess patients, diagnose, order tests and interpret results, and initiate and manage treatments under the exclusive licensure authority of the state board of nursing.¹² Presently, there are 23 states (plus the District of Columbia and Guam) who support FPA, 16 states with Reduced Practice, and 12 states with Restricted Practice.¹² FPA was granted by the VA in December 2016 to address the current and future shortage of PCPs. FPA within the VA allows NPs to practice to the fullest extent of their education, training, and certification.¹³

The interdisciplinary health care team is determined by each VA medical center but can include any of the following combinations of disciplines: NP or physician assistant (PA), registered nurse (RN), case manager, rehabilitation therapists such as occupational, physical, or kinesiological, psychologist, registered dietitian, pharmacist, social worker (SW), and physician.

HBPC NPs must be certified and licensed in family, adult, acute, or geriatric specialties to provide primary care to veterans. From 2007-2015, a Texas VA Medical Center's HBPC program model included one physician and several NPs, RNs, case managers, occupational therapists, psychologists, dietitians, pharmacists, and SWs. In late 2015, the model was restructured. This restructuring resulted in an expanded NP role to include tasks typically performed by RNs and case managers. Within one year after the restructuring, 40% of NPs left the HBPC program.

Significance

NP turnover is costly, both monetarily and in terms of patient satisfaction, disrupting continuity of patient care.⁵ NP salaries in the Texas VA's HBPC program range from \$67,638-\$113,413.¹⁴ The average HBPC NP makes \$88,000 annually.¹⁴ The average turnover cost for one NP who makes \$88,000 is \$22,000.¹⁴ Meaning the cost to the Texas VA Medical Center from the turnover of HBPC NPs after the restructure has sharply risen to \$132,000 (Table 1).

Similar to non-VA health care organizations, departments within the VA can experience rapid or high-volume NP turnover, despite attempts to provide veterans with timely, high-level care. In non-VA studies, patients reported experiences of disruption in provider continuity and a lack of timely access to health care needs associated with provider turnover.^{15,16} Likewise, the VA faces logistical challenges in providing timely, quality care because of high caseloads, workload demands, and complex veteran needs.² Identifying and addressing the reason for costly NP turnover was essential for the Texas VA Medical Center as increasing levels of turnover could cause less than optimal veteran experiences and decreased timely access to high-quality primary care.²

Review of the Literature

Prior to the program evaluation of HBPC, an extensive integrated literature review was conducted. The aim of the review was to discover current best evidence-based practice. Articles were critically appraised and chosen based on being the highest-level evidence and most significant to the purpose of this project. Professional stress, workload, and satisfaction were found to be determining factors in whether NPs remained in their current work.¹⁷ NP turnover was found to be costly and to disrupt continuity of patient care as well as expensive both monetarily and in terms of patient satisfaction.⁵ NPs experience similarities in job satisfaction and dissatisfaction perception which in turn leads to retention or turnover.¹⁸

Commonalities of job satisfaction and retention include: job benefits, time spent with and relationship between patients, salary, holistic care, working to the fullest of their scope of practice (SOP), schedules and flexibility of hours, autonomy, independent prescribing authority, experience – greater than ten years, mentorship, positive patient experiences, increased access to and quality of health care, and decreased costs to health care organizations.^{2,4,5,17} Commonalities of job dissatisfaction and turnover include: professional and monetary recognition, assertive influence, administrative support, collegial relationships, autonomy, inexperience – less than ten years, inability to serve on committees due to time constraints, reporting to a supervisor who is not a NP, professional growth, intrapractice partnership, caseload/workload, bonus availability, research involvement, negative patient experiences, decreased access to and quality of health care for patients, and increased costs to health care organizations.^{3,18-20}

Findings concluded NP turnover was found to disrupt continuity of patient care and be expensive both monetarily and in terms of patient satisfaction.^{21,22} Access to and quality of patient care, outcomes, and experiences are closely linked to PCP turnover.²³ The higher the

turnover, the worse the care whereas the lower the turnover, the better the care.² Findings also determined turnover was primarily associated with professional dissatisfaction and retention was primarily associated with professional satisfaction.⁴

Results from the studies exposed unaddressed turnover was costly, adversely affecting patients' access to and quality of health care and was toxic to the workplace environment. The studies' findings also clarified NP satisfaction was a key factor in turnover and retention. If NPs are satisfied, they remain in their current setting; if NPs are dissatisfied, they anticipate leaving their current setting. The results of these studies will reinforce factors derived from the program evaluation of HBPC could reduce turnover and provide optimal access to and quality of health care for veterans.

Purpose

The purpose of this quality improvement (QI) project was to make recommendations based on the results of a program evaluation of HBPC, by identifying intended anticipated voluntary turnover through the Anticipated Turnover Scale (ATS) and intrinsic and extrinsic factors through the Misener NP Job Satisfaction Scale (MNPJSS) (Appendices A, B).

This program evaluation sought to answer the following question: For NPs employed at the Texas VA Medical Center in the HBPC program, which factors derived from NP survey data through this four-month program evaluation, have the greatest potential to reduce NP turnover?

Conceptual Framework

The conceptual framework used to guide this project was Cheryl Stetler's model of research utilization.²⁴ The purpose of the model is to formulate a series of critical-thinking and decision-making steps intended to ease the translation of research findings into practice.²⁴ The model is an individual practitioner-oriented model rather than an organization-focused model.²⁴

The research model promotes the use of both internal and external data.²⁴ Internal data is represented by: QIs and operational, evaluation, and practitioner experience.²⁴ The external data is represented by: primary research and consensus of national experts.

Preparation is the first phase of the model where the nurse searches for and selects research to be assessed for practice application.²⁴ This phase is motivated by critical thinking about potential internal and external influencing factors.²⁵ Validation is the second phase where the nurse appraises the findings of the study using specific methodology and utilization considerations.²⁴ Comparative evaluation or decision-making is the third phase where a decision about whether a practice change can be made is determined.²⁴

Project Description

A program evaluation is a systematic method for collecting, analyzing, and using data to observe the effectiveness and efficiency of programs and to contribute to ongoing program improvement.²⁶ Best practice research refers to nursing practices based on the most recent, relevant, and useful nursing interventions, and incorporating them into current practice.²⁶ A program evaluation, at the microsystem level, is necessary and is currently considered best practice to identify the root cause of and contributing factors to NP turnover in HBPC.

This project has two goals that, according to the literature, are best practices to identify when completing a program evaluation.²⁷ The goals were to identify NP anticipated turnover and NP job satisfaction. The VA strives to provide benefits, care, and services in a timely manner and is committed to ensure veterans can choose if they want traditional clinic care or if HBPC is better suited to their needs.²⁸ The VA's 2018-2024 strategic goals of greater choice of care for veterans and to improve timeliness are in congruence with this program evaluation.²⁸

Methods

Project Design

First, the Texas VA Medical Center granted approval of this QI program evaluation of HBPC to be conducted. Next, the program evaluation project plan was submitted to Texas A&M University – Corpus Christi's (TAMUCC's) Institutional Review Board (IRB) and was determined to be a QI project and not human subjects research. (Appendices C, D).

Sample and Setting

In spring 2018, a convenience sample of NPs in HBPC at the Texas VA Medical Center who had been with the HBPC program for a minimum of six months and who were not in a supervisory position were invited to participate in the survey. The eligible NPs were sent an email describing the purpose of the survey as well as an electronic link to it. Participants were informed participation was voluntary and by completing the survey they were providing consent (Appendix E).

Instruments

The survey included the following 11 demographic elements: gender, age, race/ethnicity, nursing experience, highest level of education, accrediting agency of nursing specialty certification, type of certification, employment status, and annual salary (Table 2).

The ATS is a 12-item self-reported survey to determine employees' perception or opinion of the possibility of voluntarily terminating their present job.⁵ The ATS uses a seven-point Likert scale with options of agree strongly, moderately agree, slightly agree, uncertain, slightly disagree, moderately disagree, and disagree strongly.⁵ Questions are designed to determine the participants' anticipated length of time to leaving and certainty of leaving the job.⁵ Questions were either positive or negative and scored on a seven-point scale: questions 2, 4, 5, 7, 11, and

12 are positive while 1, 3, 6, 8, 9 and 10 are negative.⁵ If the question is positive, then it is scored on a scale of 7 to 1, with agree strongly being 7 points and disagree strongly being 1 point. A negative survey question is scored from 1 to 7 points, with agree strongly being equal to 1 point, and disagree strongly equal to 7 points. A score of 1 would indicate no intent to leave a nursing position, while a score of 7 would indicate intent to leave a nursing position. The mean score is obtained by calculating the sum of all items in the scale divided by the number of items in the scale.⁵ Higher scores reflect greater intent to leave the present position or job.⁵ Individual responses with scores over 3.50 were considered as an indication for turnover intention.⁵ The ATS has established reliability and validity (Cronbach's alpha = 0.84).⁵

The MNPJSS is a 44-item, self-administered, six-factor survey designed to measure NP job satisfaction.²⁹ The MNPJSS uses a six-point Likert scale with options of very satisfied, satisfied, minimally satisfied, minimally dissatisfied, dissatisfied, and very dissatisfied. Questions are designed to assess six dimensions of NP job satisfaction. The six factors correlated with total job satisfaction are: (1) intrapractice partnership/collegiality; (2) challenge/autonomy; (3) professional, social and community interaction; (4) professional growth; (5) time; and (6) benefits.²⁹ Possible total scores range from 44–264 and are calculated by summing the responses for each of the 44 items; subscale scores are obtained from the sum of each item in the subscale. None of the items are reverse scored. Factors 1, 3, 5 and 6 are considered extrinsic, external, or uncontrollable, factors. Factors 2 and 4 are intrinsic, internal, or self-controlled, factors.²⁹ The MNPJSS has established reliability and validity measured through internal consistency by calculating Cronbach's alpha.²⁹ Cronbach's alpha reliability estimates for each of the six subscales are: 0.94, 0.89, 0.84, 0.86, 0.83 and 0.79 respectively.²⁹ The reported Cronbach's alpha for the entire tool is 0.96.²⁹

Data Collection

The project plan and timeline were discussed with and submitted to HBPC leadership and a letter of support from leadership was received. The plan was submitted to TAMUCC's IRB and determined to be a QI project. This survey time was extended from two weeks to four weeks due to one participant being on leave during the initial two weeks. Therefore, the timeline for survey completion was from February until March 2018. From March until May 2018, data was analyzed via SPSS 25 for mean, standard deviation, significance, and correlations. Once empirical indicators identified NP satisfaction and anticipated turnover (feedback from surveys), recommendations for strategies to improve NP retention (iterative adjustments = proposals which can mitigate the causes and probability of turnover) were presented to HBPC leadership at the conclusion of the program evaluation.

The demographic questions, ATS survey, and the MNPJSS survey were all combined into one survey in Survey Monkey. The survey required 10-15 minutes to complete. The 67-question survey was administered via Survey Monkey – a secure, online survey tool – over a one-month timeframe. The data collected in Survey Monkey was analyzed via Statistical Package for the Social Science (SPSS) 25. The risk of identification was minimized by removing the associated internet protocol addresses, using no identifiers, and sharing of aggregate data only.

Analysis and Evaluation Plan

The analysis method was quantitative and displayed using a frequency distribution format using raw survey responses as well as summary information with charts and trends. Filters were utilized to focus on specific data and segments.

For the specific goal of NP intent to leave, the ATS was administered via Survey Monkey and quantitative results were presented to leadership using charts, graphs, and distribution frequencies. The goal of this analysis was to determine the likelihood of a HBPC NP voluntarily leaving his/her current position. The purpose was to communicate the need to implement evidence-based recommendations to deter the HBPC NPs from voluntarily leaving their current position. For the specific goal of NP job satisfaction, the MNPJSS was administered via Survey Monkey and quantitative results were presented to leadership using charts, graphs, and distribution frequencies. The purpose of this analysis was to identify intrinsic and extrinsic factors whether satisfied (scoring 4.00-6.00) or dissatisfied (scoring 1.00-3.99) to formulate recommendations to leadership to increase factors that score between 1.00 and 3.99 and thereby increase retention rates. The outcomes of the recommendations presented to leadership when concluding the program evaluation were to intended decrease future HBPC NP turnover.

Evaluation Framework

The nursing services delivery theory (NSDT) was proposed by Katz and Kahn (1978) as a systems approach to understand complex problems.³⁰ The theoretical foundation of the NSDT is an open systems theory that is applied to large-scale organizations.³⁰ An organization constitutes an energetic input–output system. The open systems approach takes inputs from the environment, processes and transforms the inputs, then sends the changed inputs back as outputs to the environment.³¹ As an open system, the organization adapts its functioning in response to negative feedback and external informational signals through a series of iterative adjustments that allow the system to evolve while maintaining its character.³¹ The program evaluation of HBPC was integrated with the NSDT and empirical indicators because the goal was to survey

the NPs using the MNPJSS to identify current NP job satisfaction, and the ATS to determine the likelihood of anticipated turnover.

Results

An email with the survey link was distributed to NPs in February 2018. After receiving the email, seven of the eight (87.5%; $n = 7$) NPs responded to the survey over a one-month period. Not every survey participant answered every demographic question.

Anticipated Turnover Scale (ATS)

Individual participant total scores ranged from 28 to 64. If a completely ambivalent score was totaled (all questions answered as uncertain on the Likert scale), then a cut off score determining intent to leave could be set at 48 (meaning all 12 questions answered as uncertain or “4” on the Likert scale). Based on this assertion, 57.1% of the participants scored below 48 and thus reflected intent to stay.

Mean scores were calculated for each question across participants. Likert responses with aggregate means 3.50-7.00 were interpreted as intent to leave and responses with means between 1.00-3.49 were interpreted as intent to stay. When responses to questions were considered individually, half the responses were answered as intent to leave and half as intent to stay. Total scores indicated the majority of the group did not anticipate leaving; however, mean responses to individual questions represented the group was equally divided on intent to leave (Tables 3, 4).

Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS)

Individual participant total scores ranged from 91 to 185. Maximum score for the survey is 264; however, because one participant did not respond to the first question, it was removed from the scale making the maximum score in this project was 258. Mean scores were calculated for each question across participants. Likert responses for each question, across all participants,

with aggregate means 1.00-3.99 were interpreted as *dissatisfied* and responses with means between 4.00 and 6.00 were interpreted *satisfied*. Of the 43 questions, 24 were answered as dissatisfied and 19 were answered as satisfied by the group.

Qualitative data analysis categorized questions by survey factor (intrinsic and extrinsic factors 1-6) and then further categorized the questions with overall dissatisfied responses by subject matter. Responses indicating dissatisfaction were then used to develop recommendations to leadership.

- Extrinsic factor 1 – Intrapractice Partnership/Collegiality had 14 associated questions. Responses indicating dissatisfaction were divided into three categories and each category was associated with a recommendation(s) (Table 5).
- Intrinsic factors 2 and 4 – Challenge/Autonomy and Professional Growth had 13 associated questions. Responses indicating dissatisfaction were divided into three categories and each category was associated with a recommendation(s) (Table 6).
- Extrinsic factor 3 – Professional, Social, and Community Interaction had eight associated questions. Responses indicating dissatisfaction were divided into two categories and each category was associated with a recommendation (Table 7).
- Extrinsic factors 5 and 6 – Time and Benefits has six associated questions (one question was removed for lack of participant response). There were no responses indicating dissatisfaction in these categories (Table 8).

Discussion

From the ATS results, approximately half of the NPs intended to stay, and half the NPs anticipated leaving their positions, therefore no conclusions could be drawn. The MNPJSS results indicate the NPs are currently more dissatisfied than satisfied.

Categories and Recommendations

Results from the MNPJSS were divided into alike categories and then a recommendation(s) was assigned to each category. Extrinsic factor 1 was divided into three categories, and three recommendations were derived from the 13 dissatisfied responses. Intrinsic factors 2 and 4 were divided into two categories, and three recommendations were derived from the 10 dissatisfied responses. Extrinsic factor 3 was divided into two categories, and two recommendations were derived from the two dissatisfied responses.

Recognition. The first category for the MNPJSS extrinsic factor of intrapractice partnership and collegiality is recognition. Recognition that is meaningful is one method to establish and maintain a positive working environment.³² Recognition is important because it serves as a form of feedback which helps apprise employees of how well they are performing.³² Research has demonstrated the significance of feedback is so meaningful to individuals they will actively monitor and pursue feedback information from their environment. Pursuing feedback has been found to be essential for accurate self-assessment. Receiving feedback can increase an employee's self-esteem; and having a positive self-identity has been identified with satisfaction at work which can lead to retention.³²

The VA bestows recognition in forms of honorary, monetary, and time off awards for overall superior performance and special or unique achievements.³³ While monetary awards are rare, honorary awards can be presented to employees who meet or exceed criteria.³³ Certificates of recognition for performance can be issued to employees during monthly staff meetings or service meetings. Furthermore, VA administrators have authority to grant employees a time off award.³³ Feedback can be given during monthly staff meetings to groups or during performance evaluations during rating periods.

Shared governance. The second category for the MNPJSS extrinsic factor of intrapractice partnership and collegiality is shared governance. In a study by Hastings, Armitage, Mallinson, Jackson, and Suter,³⁴ shared governance was positively related to job satisfaction. Researchers observed in health care institutions with few or no opportunities for professional input into policies, employees were dissatisfied by their lack of influence over practice resulting in turnover. Simultaneously, the study identified improvements among relationships with interdisciplinary team members and administrators as a result of a shared governance program.³⁴ VA policies and procedures continually need to be updated and revised or implemented if new. To implement a shared governance within HBPC, administrators could send policies which need to be addressed to the NPs during the month, the NPs can individually review and have recommendations to present during monthly provider meetings. At monthly provider meetings, each NP who has input on the policy(ies) needing to be addressed can bring forth their recommendations and the team of NPs and administrators could vote on the changes.

Orientation. The third category for the MNPJSS extrinsic factor of intrapractice partnership and collegiality is orientation. Orientation was an important variable characterized during an organizational culture improvement study by Pasaron.²⁹ Appropriate institutional orientations have been linked to effective and positive interdisciplinary teams and patient outcomes.²⁹ Without an appropriate orientation, NPs were not only underused, but also interdisciplinary teams were not effective and patient outcomes were effected through safety and continuity of care, with miscommunication related to patient care being the most significant result.²⁹

As identified through demographic results, of the NPs who answered, four are new to HBPC. As timely and quality veteran care is essential, when the NPs were hired because of high

turnover, orientation was brief. Policies and procedures were not thoroughly reviewed because of a critical, time-sensitive need to provide primary care. In addition, NPs being located at various community-based outpatient centers and not centralized at one location – made standardized education difficult. Educating NPs via email, online modules, or monthly staff meetings would allow for policies and procedures to be disseminated equally.

Full practice authority. The first category for the MNPJSS intrinsic factors of challenge/autonomy and professional growth is FPA. Regulatory practices requiring excessive and unnecessary physician oversight for care that NPs are educated, credentialed and competent to provide unfairly limits NP SOP and may endanger patient safety and health outcomes.³⁵ Limiting SOP of NPs has been found to constrain direct reimbursement for NP care, decrease autonomy, and lowers job satisfaction.³⁵

FPA was granted by the VA in December 2016; however, each Medical Center's facility leadership must decide if and how they are going to implement it.³⁶ Additionally, each VA Medical Center must ensure their medical staff bylaws are in accordance with VA directive 1350.³⁷ Currently, the Texas VA Medical Center has not fully integrated FPA. For example, many of the HBPC NPs lack a Drug Enforcement Administration (DEA) number - a number assigned to specific health care providers allowing them to prescribe medications, including controlled substances legally,³⁸ making them unable to prescribe certain medications and dependent on the HBPC physician.

Collaboration. The second category for the MNPJSS intrinsic factors of challenge/autonomy and professional growth is collaboration. In a study by Poghosyan, Norful, and Martsolf,²¹ new and ongoing education requirements for PCPs is needed to keep up with the intensifying clinical complexity of the current and future patient population. Development and

expansion of the use of NPs equates to efficiency, both in cost and work flow, as NPs are educated and credentialed to meet most preventive, recurring, and chronic care needs of diverse patient populations.²¹ NPs have also been found to increase efficiency in the primary care setting by linking gaps identified between specialty care and primary care clinics by accomplishing training and ascertaining new procedures and treatment algorithms with specialists and returning back to the primary care setting to disseminate and implement the new knowledge.²¹

With the expansion of the NP role and workforce, it is imperative NPs remain dynamic in their health care organization through committees and research. There are numerous committees, QI projects, and research opportunities within the VA of which NPs can be a part of. In a study by Hayes,³⁹ the most valuable reasons for NPs to be involved in research or educational activities are: learning, networking, advocating, and disseminating. While most HBPC administrators cannot send more than one or two HBPC providers to a conference at a time (due to coverage of patients), it remains paramount each NP attend at least one conference per year. This allows NPs to bring back the knowledge and tools learned and disseminate with other members of the health care team. Collaboration along with committee, QI, and research involvement allows for current, evidence-based practice research and findings to be maintained and implemented within facilities.

Organizational workflow maps. The first category for the MNPJSS extrinsic factor of professional, social, and community interaction is designing organizational workflow maps. Workflow maps are developed to guide the health care team to goal or task accomplishment. Health care organizations frequently face the pressure to develop, or remodel, workflow maps to become more efficient, effective, and improved at communication.⁴⁰ A good workflow will help accomplish organizational goals with timeliness, leading to care that is delivered more

consistently, reliably, safely, and in compliance with standards of practice.⁴⁰ Workflow maps can acclimate to deviations that unavoidably occur in health care through collaboration with assistive personnel, as well as environmental factors such as workload and schedules.⁴⁰ In a study by Cain and Haque,⁴⁰ collaborative workflow maps demonstrated to improve the efficiency of existing work processes and communication between interdisciplinary team members. When designing workflow maps with multi-disciplinary input, it is imperative to clearly define roles and responsibilities.⁴⁰

As HBPC consists of multiple teams across multiple service areas, some current processes are not consistent. It would behoove administrators to have an all-staff meeting and allow for multi-disciplinary and resource utilization input to standardize processes for common goals and tasks while being efficient, effective, and improving communication amongst team members. This would ensure fairness and equity across multiple teams with multiple team members.

Mentoring. The second category for the MNPJSS extrinsic factor of professional, social, and community interaction is mentoring. In a study by Horner,⁴¹ a mentoring experience provided a positive work environment, which led to increased job satisfaction and productivity amongst NPs. Although mentoring programs have been found to be positive, there are associated opportunities and barriers.⁴¹ Opportunities include collaboration, improved patient outcomes, organizational role modeling, problem solving, and networking.⁴¹ Barriers include time, scheduling, and space constraints.⁴¹ Other hindrances include lack of monetary incentive or decrease in workload while mentoring.⁴¹ However, if implemented, a higher level of satisfaction in the work environment has been associated with reduced turnover, improved retention and patient outcomes.⁴¹

The VA health care system requires increased knowledge to navigate a multifaceted system, and mentoring can help translate this understanding into daily practice.⁴¹ Because HBPC is structured in such a way that each NP is independent across various service areas, the HBPC NPs have very little interaction with each other. If administrators value and implement mentoring for current and future HBPC NPs, it could lead to increased satisfaction, productivity, and retention.

Limitations

The first identified limitation of the findings of this program evaluation was the small participant size (n=7). The Texas VA Medical Center's HBPC current model is set up to have a total of 12 NPs in the program. At the time of this study, there were nine eligible participants, including the Project Director for this assessment. The Project Director did not participate in the survey to avoid bias and result contamination leaving eight eligible NPs. One NP did not participate, seven participated. There was one supervisory NP and two NPs who had less than six months experience. At the time of the program evaluation, there was a total of 12 HBPC NPs. A second limitation was the program evaluation being conducted at a single VA Medical Center and because of varying state practice acts and facility bylaws it is difficult to generalize these findings to other VA and non-VA institutions. Another identified limitation was the collection of quantitative data only. Qualitative data would have been noteworthy to report.

There were contextual elements that could have affected the validity and reliability participants' responses. The seven participating NPs worked across five different locations and resources such as transportation support, assistive personnel, and available supplies, are not the same in each of these different areas. Their responses to questions referencing satisfaction in these types of areas could have been influenced by location. Additionally, the seven NPs were

from differing backgrounds and cultures – speaking one’s mind as a female is not acceptable in some cultures;⁴² NPs might not have provided true responses if they were negative and instead selected responses they felt were more favorable. Despite these limitations, the QI findings provide valuable information about NPs’ characteristics, anticipated turnover, and job satisfaction, with the results suggesting several emphases on further research and implementation of recommendations by health care administrators.

Implications

The outcomes identified from the program evaluation are recommendations to leadership aimed to reduce HBPC NP turnover. By identifying factors contributing to turnover, leadership now has the knowledge and evidence to mitigate some or all factors by implementing evidence-based practice recommendations. By decreasing NP voluntary turnover, the Texas VA Medical Center can decrease organizational costs associated with turnover, recruitment and orientation, and maintain alignment with the VA’s 2018-2024 strategic goals. This program evaluation can be adopted by the Texas VA Medical Center’s leadership team and be sent to the entire NP workgroup. This would allow the Texas VA Medical Center’s leadership to survey NPs throughout the institution versus one department and analyze trends through the data and make changes based on input from the NPs to reduce turnover throughout the institution. Non-VA institutions can also implement a program evaluation and identify employee perception of anticipated turnover and job satisfaction within their organization.

Funding

No funding was provided for this QI program evaluation of HBPC. Institutional support was provided to participants in the form of on-duty time for NPs to complete the survey and time for the Project Director to present findings to HBPC leadership.

Conclusion

Program evaluations can benefit health care administrators by providing evidence-based data through systematic methods of collecting, analyzing, and interpreting data to observe the effectiveness and efficiency of programs and to contribute to ongoing program improvement.²⁶ When a program evaluation is supported by literature and presented as objective and unbiased, intended and expected outcomes are best practice recommendations addressing identified problems and improving care processes.

REFERENCES

1. Tsai J, Rosenheck RA. US veterans' use of VA mental health services and disability compensation increased from 2001 to 2010. *Health Affairs*. 2016;35(6):966-973.
2. Reddy A, Pollack CE, Asch DA, Canamucio A, Werner RM. The Effect of Primary Care Provider Turnover on Patient Experience of Care and Ambulatory Quality of Care. *JAMA Intern Med*. 2015;175(7):1157-1162.
3. Athey EK, Leslie MS, Briggs LA, et al. How important are autonomy and work setting to nurse practitioners' job satisfaction? *J Am Assoc Nurse Pract*. 2016;28(6):320-326.
4. Moreland JJ, Ewoldsen DR, Albert NM, Kosicki GM, Clayton MF. Predicting Nurses' Turnover: The Aversive Effects of Decreased Identity, Poor Interpersonal Communication, and Learned Helplessness. *J Health Commun*. 2015;20(10):1155-1165.
5. De Milt DG, Fitzpatrick JJ, Sister Rita M. Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. *J Am Acad Nurse Pract*. 2011;23(1):42-50.
6. Eric De Jonge K, Jamshed N, Gilden D, Kubisiak J, Bruce SR, Taler G. Effects of home-based primary care on Medicare costs in high-risk elders. *Journal of the American Geriatrics Society*. 2014;62(10):1825-1831.
7. Affairs USDoV. Home Based Primary Care. 2016; https://www.va.gov/geriatrics/guide/longtermcare/home_based_primary_care.asp. Accessed 11/10/2016, 2016.
8. Practitioners TAAoN. What's an NP? 2018; <https://www.aanp.org/all-about-nps/what-is-an-np>.

9. Practitioners TAAoN. Historical Timeline. 2018; <https://www.aanp.org/about-aanp/historical-timeline#1960-s>.
10. Stanik-Hutt J, Newhouse RP, White KM, et al. The Quality and Effectiveness of Care Provided by Nurse Practitioners. *The Journal for Nurse Practitioners*. 2013;9(8):492-500.e413.
11. Swan M, Ferguson S, Chang A, Larson E, Smaldone A. Quality of primary care by advanced practice nurses: a systematic review. *International journal for quality in health care*.27(5):396-404.
12. Practitioners TAAoN. State Practice Environment. 2018; <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-type>.
13. Affairs USDoV. VA Grants Full Practice Authority to Advance Practice Registered Nurses. 2016; <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847>. Accessed 12/14/16, 2016.
14. Li Y, Jones CB. A literature review of nursing turnover costs. *Journal of nursing management*. 2013;21(3):405-418.
15. Martin-Misener R, Kilpatrick K, Donald F, et al. Nurse practitioner caseload in primary health care: Scoping review. *Int J Nurs Stud*. 2016;62:170-182.
16. Lui N, Ozen A, Balasubramanian H. Primary Care Practice Design under Case Mix: Joint Consideration of Access to Care and Continuity of Care 2013.
17. Brom HM, Melnyk BM, Szalacha LA, Graham M. Nurse practitioners' role perception, stress, satisfaction, and intent to stay at a Midwestern academic medical center. *J Am Assoc Nurse Pract*. 2016;28(5):269-276.

18. Bae SH. Nurse practitioners' job satisfaction in rural versus nonrural areas. *J Am Assoc Nurse Pract.* 2016;28(9):471-478.
19. Asegid A, Belachew T, Yimam E. Factors Influencing Job Satisfaction and Anticipated Turnover among Nurses in Sidama Zone Public Health Facilities, South Ethiopia. *Nurs Res Pract.* 2014;2014:909768.
20. Faraz A. Novice nurse practitioner workforce transition and turnover intention in primary care. *J Am Assoc Nurse Pract.* 2017;29(1):26-34.
21. Poghosyan L, Norful AA, Martsolf GR. Primary care nurse practitioner practice characteristics: Barriers and opportunities for interprofessional teamwork. *The Journal of ambulatory care management.* 2017;40(1):77.
22. Wild P, Parsons V, Dietz E. Nurse practitioner's characteristics and job satisfaction. *J Am Acad Nurse Pract.* 2006;18(11):544-549.
23. Pron AL. Job satisfaction and perceived autonomy for nurse practitioners working in nurse-managed health centers. *J Am Assoc Nurse Pract.* 2013;25(4):213-221.
24. White K. Evidence-based practice. In: White KM, Dudley-Brown S, Terhaar M, eds. *Translation of Evidence into Nursing and Health Care.* 2nd ed. New York: Springer Publishing Company; 2016.
25. O'Keeffe AP, Corry M, Moser DK. Measuring job satisfaction of advanced nurse practitioners and advanced midwife practitioners in the Republic of Ireland: a survey. *J Nurs Manag.* 2015;23(1):107-117.
26. Prevention CfDCa. Program performance and evaluation office. 2018; <https://www.cdc.gov/eval/index.htm>.

27. Hunt S. Nursing Turnover: Costs, Causes, & Solutions. 2009;
<https://www.scribd.com/document/159576411/Nursing-Turnover>.
28. Affairs DoV. Department of Veterans Affairs FY 2018-2024 Strategic Plan. 2018;
<https://www.va.gov/oei/docs/VA2018-2024strategicPlan.pdf>.
29. Pasaron R. Nurse practitioner job satisfaction: looking for successful outcomes. *J Clin Nurs*. 2013;22(17-18):2593-2604.
30. Katz D, Kahn RL. Organizations and the system concept. *Classics of organization theory*. 1978:161-172.
31. Meyer RM, O'Brien-Pallas LL. Nursing Services Delivery Theory: an open system approach. *J Adv Nurs*. 2010;66(12):2828-2838.
32. Associates P, Foundation D. Literature Review on Meaningful Recognition in Nursing. 2009.
33. Affairs DoV. VA Employee Awards and Recognition. In: Affairs DoV, ed. Washington, DC2014.
34. Hastings SE, Armitage GD, Mallinson S, Jackson K, Suter E. Exploring the relationship between governance mechanisms in healthcare and health workforce outcomes: a systematic review. *BMC health services research*. 2014;14(1):479.
35. Blazek N. Physician oversight hinders NP scope of practice. 2013;
<https://www.clinicaladvisor.com/aanp-2013/physician-oversight-hinders-np-scope-of-practice/article/299936/>.
36. Bosse J, Simmonds K, Hanson C, et al. Position statement: Full practice authority for advanced practice registered nurses is necessary to transform primary care. *Nursing Outlook*. 2017;65(6):761-765.

37. Affairs DoV. Advanced Practice Registered Nurse Full Practice Authority. In: Affairs DoV, ed. Washington, DC: Veterans Health Administration; 2017.
38. Liu JS, Lu LY, Lu W-M, Lin BJ. A survey of DEA applications. *Omega*. 2013;41(5):893-902.
39. Hayes E. Promoting nurse practitioner practice through research: opportunities, challenges, and lessons. *J Am Acad Nurse Pract*. 2006;18(4):180-186.
40. Cain C, Haque S. Organizational workflow and its impact on work quality. 2008.
41. Horner DK. Mentoring: Positively Influencing Job Satisfaction and Retention of New Hire Nurse Practitioners. *Plast Surg Nurs*. 2017;37(1):7-22.
42. Mahalingam R. Cultural psychology of immigrants: An introduction. In: *Cultural psychology of immigrants*. Psychology Press; 2013:17-28.

Table 1. Cost-Benefit Analysis

HOME BASED PRIMARY CARE PROGRAM EVALUATION BUDGET		
Cost Category	Cost	Description/Comment
PROJECTED EXPENSES FOR Texas VA Medical Center IF RECOMMENDATIONS ARE NOT IMPLEMENTED		
Estimated CTVCHS costs per Veteran		
Emergency Room Visit	\$1,300.00	Per visit
ICU Stay (3 days)	\$60,000.00	\$20,000.00 per day
Hospital Stay (7 days)	\$56,000.00	\$8,000.00 per day
Long Term Rehab/Nursing Home Stay (6-8 weeks)	\$12,600.00-\$16,800.00	\$300.00 per day
Total	\$129,900.00-\$134,100.00	
Estimated costs per NP		
Cost per NP turnover	\$22,000.00	Average NP salary of \$88,000
Cost per NP to orient (8-12 weeks)	\$13,600.00-\$20,400.00	Average NP salary is \$42.50 per hour, times 8-12 weeks of orientation working 40 hours per week.
Total	\$35,600.00-\$42,400.00	
Total Projected Expenses for Texas VA Medical Center if Recommendations are not Implemented	\$165,500.00-\$176,500.00	
PROJECTED REVENUE FOR Texas VA Medical Center IF RECOMMENDATIONS ARE IMPLEMENTED		
Estimated Costs for Home Based Visits		
HBPC NP Visit Cost	\$250.00	Average cost of outpatient visit rate to Texas VA Medical Center.
NP Hourly Cost	\$42.50	Average NP salary is 42.50 per hour, times average length of visit of 1 hour.
Travel Expenses	\$54.00	Average Travel at a Milage Cost of \$0.54 for 100 miles.
Total	\$346.50	
Estimated Savings		
Hospital Savings	\$129,553.50-\$133,753.50	Savings for Texas VA Medical Center if NP is able provide care to veteran at home vs. an admission to the hospital. (Estimated Texas VA Medical Center costs per Veteran - Estimated Costs for Home Based Visits.)
Total	\$129,553.50-\$133,753.50	
Total Projected Revenue for Texas VA Medical Center if Recommendations are Implemented	\$165,153.50-\$176,153.50	Total Projected Expenses for Texas VA Medical Center if Recommendations are not Implemented - Estimated cost of HBPC visits
Texas VA Medical Center BENEFIT/LOSS		
Total Revenue	\$165,153.50-\$176,153.50	Total Projected Revenue for Texas VA Medical Center if Recommendations are Implemented
Texas VA Medical Center TOTAL PROJECT BENEFIT/LOSS	\$161,494.00-\$172,494.00	Savings to the VA

Table 2: Sample Demographics

Characteristic	*N	Percentage	Characteristic	*N	Percentage
Gender:			Nursing experience in		
Female	6	100.00	HBPC:		
Male	0	0.00	0-2 years	4	66.67
			3-5 years	1	16.67
			6-10 years	1	16.67
			10+ years	0	0.00
Age (years)			Accrediting agency:		
20-29	0	0.00	ANCC	1	20.00
30-39	1	16.67	AANP	4	80.00
40-49	0	0.00			
50-59	3	50.00			
60+	2	33.33			
Race/Ethnicity:			Type of certification:		
Caucasian, non-Hispanic	3	50.00	FNP	4	66.67
African-American	0	0.00	ANP	0	0.00
Asian	1	16.67	ACNP	0	0.00
Native American	0	0.00	GNP	2	33.33
Hispanic/Latino	1	16.67	Other	0	0.00
Other	1	16.67			
Highest level of education:			Employment status:		
MSN	5	83.33	Full-time	7	100.00
Post mater's certificate	0	0.00	Part-time	0	0.00

PhD	0	0.00	Per Diem	0	0.00
DNP	1	16.67	Hourly	0	0.00
Other	0	0.00			
Nursing experience as a RN:			Annual Salary:		
0-9 years	1	16.67	\$60,000-\$69,000	0	0.00
10-19 years	0	0.00	\$70,000-\$79,000	0	0.00
20-29 years	1	16.67	\$80,000-\$89,000	0	0.00
30+ years	4	66.67	\$90,000-\$99,000	1	20.00
			\$100,000-\$109,000	1	20.00
			\$110,000+	3	60.00
Nursing experience as a NP:					
0-5 years	2	33.33			
6-10 years	0	0.00			
11-19 years	4	66.67			
20+ years	0	0.00			

Table 3. Anticipated Turnover Scale Individual Participant Total Scores, Frequencies, and Percentages

Participant Scores	Frequency	Cumulative Percent
28	1	14.3
33	1	28.6
44	1	42.9
46	1	57.1
51	2	85.7
64	1	100.0

Table 4. Anticipated Turnover Scale Mean Responses Across Participants

Anticipated Turnover Scale Responses	
Likert Response $M = 3.5-7.00$ (Indicating Overall Intent to Leave)	Likert Response $M = 1.00-3.49$ (Indicating Overall Intent to Stay)
If I got another job offer tomorrow, I would give it serious consideration 5.57	I have been in my position about as long as I want to 2.43
I know whether or not I will be leaving this agency within a short time 5.14	I plan to leave this position shortly 3.00
I do not have any specific idea how much longer I will stay 4.57	I plan to hang on to this job for a while 3.14
I am quite sure I will leave my position in the foreseeable future 4.00	There are big doubts in my mind as to whether or not I will really stay in this agency 3.29
I am certain I will be staying here a while 3.71	I plan to stay in my position a while 3.43
I have no intentions of leaving my present position 3.57	Deciding to stay or leave my position is not a critical issue for me at this point in time 3.43

Table 5. Misener Nurse Practitioner Job Satisfaction Scale Mean Extrinsic Factor 1 Responses and Recommendations

MNPJSS Extrinsic Factor 1 Results/Recommendations: Intrapractice Partnership/Collegiality		
Likert Response $M = 4.00-6.00$ (Indicating Overall Satisfaction)	Likert Response $M = 1.00-3.99$ (Indicating Overall Dissatisfaction)	Recommendations Based on Dissatisfied Responses
Immediate supervisor 4.29	Monetary bonuses that are available in addition to your salary 2.00	Recognize HBPC NPs with honorary, monetary, or time off awards
	Opportunity to receive compensation for services performed outside of your normal duties 2.86	
	Reward distribution 3.00	
	Recognition of work from superiors 3.43	
	Consideration given to your opinion and suggestions for change in the work setting or office practice 2.57	Shared governance of HBPC policy additions, changes, and revisions
	Input into organizational policy 2.71	
	Freedom to question decisions and practices 2.71	
	Respect for your opinion 3.14	
	Opportunity to develop and implement ideas 3.00	Orientation with emphasis on policies, procedures, evaluations/proficiencies, and conflict resolution
	Amount of administrative support 2.71	
	Evaluation process and policy 3.00	
	Process used in conflict resolution 3.00	
	Amount of consideration given to your personal needs 3.00	

Table 6. Misener Nurse Practitioner Job Satisfaction Scale Mean Intrinsic Factors 2 and 4 Responses and Recommendations

MNPJSS Intrinsic Factors 2 & 4 Results/Recommendations: Challenge/Autonomy and Professional Growth		
Likert Response $M = 4.00-6.00$ (Indicating Overall Satisfaction)	Likert Response $M = 1.00-3.99$ (Indicating Overall Dissatisfaction)	Recommendations Based on Dissatisfied Responses
Percentage of time spent in direct patient care 5.00	Expanding skill level/procedures within your scope of practice 3.29	Implement full practice authority
Patient mix 4.86	Opportunities to expand your scope of practice and time to seek advanced education 3.29	
Sense of accomplishment 4.57	Support for continuing education 2.71	Encourage collaboration through committee and research involvement within the healthcare organization; Allow administrative hours during the work day and funding to attend educational and professional opportunities
Ability to deliver quality care 4.43	Amount of involvement in research 2.86	
	Opportunity to expand your scope of practice 3.14	
	Opportunity for professional growth 3.29	
	Time off to serve on professional committees 3.43	
	Flexibility in practice protocols 3.43	
	Sense of value for what you do 3.86	
	Challenge in work 3.86	

Table 7. Misener Nurse Practitioner Job Satisfaction Scale Mean Extrinsic Factor 3 Responses and Recommendations

MNPJSS Extrinsic Factor 3 Results/Recommendations: Professional, social, and community interaction		
Likert Response $M = 4.00-6.00$ (Indicating Overall Satisfaction)	Likert Response $M = 1.00-3.99$ (Indicating Overall Dissatisfaction)	Recommendations Based on Dissatisfied Responses
Status in the community 4.43	Quality of assistive personnel 2.71	Design organizational workflow maps within HBPC
Social contact at work 4.14	Interaction with other NPs including faculty 3.43	Mentoring from experienced NPs to inexperienced NPs
Social contact with your colleagues after work 4.14		
Professional interaction with other disciplines 4.14		
Recognition of work from peers 4.00		
Acceptance and attitudes of physicians outside of your practice 4.00		

Table 8. Misener Nurse Practitioner Job Satisfaction Scale Mean Extrinsic Factors 5 and 6 Responses

MNPJSS Extrinsic Factors 5 & 6 Results/Recommendations: Time and Benefits		
Likert Response $M = 4.00-6.00$ (Indicating Overall Satisfaction)	Likert Response $M = 1.00-3.99$ (Indicating Overall Dissatisfaction)	Recommendations Based on Dissatisfied Responses
Patient scheduling policies and practices 4.71		
Time allotted for answering messages 4.57		
Time allocation for seeing patients 4.57		
Time allotted for review of lab and other test results 4.29		
Benefit package 4.86		
Retirement plan 5.29		

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APPENDIX A: Anticipated Turnover Scale

Anticipated Turnover Scale								
STA = Strongly Agree MA = Moderately Agree SLA = Slightly Agree		U = Uncertain		SLD = Slightly Disagree MD = Moderately Disagree STD = Strongly Disagree				
		STA	MA	SLA	U	SLD	MD	STD
1.	I plan to stay in my position a while	7	6	5	4	3	2	1
2.	I am quite sure I will leave my position in the foreseeable future	7	6	5	4	3	2	1
3.	Deciding to stay or leave my position is not a critical issue for me at this point in time	7	6	5	4	3	2	1
4.	I know whether or not I will be leaving this agency within a short time	7	6	5	4	3	2	1
5.	If I got another job offer tomorrow, I would give it serious consideration	7	6	5	4	3	2	1
6.	I have no intentions of leaving my present position	7	6	5	4	3	2	1
7.	I have been in my position about as long as I want to	7	6	5	4	3	2	1
8.	I am certain I will be staying here a while	7	6	5	4	3	2	1
9.	I do not have any specific idea how much longer I will stay	7	6	5	4	3	2	1
10.	I plan to hang on to this job for a while	7	6	5	4	3	2	1
11.	There are big doubts in my mind as to whether or not I will really stay in this agency	7	6	5	4	3	2	1
12.	I plan to leave this position shortly	7	6	5	4	3	2	1

APPENDIX B: Misener Nurse Practitioner Job Satisfaction Scale

Misener Nurse Practitioner Job Satisfaction Scale							
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.
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
18.	Support for continuing education (time and money)	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 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 specialists you refer patients to)	6	5	4	3	2	1

APPENDIX C: Letter of Support



DEPARTMENT OF VETERANS AFFAIRS
Central Texas Veterans Health Care System
1901 Veterans Memorial Drive
Temple, Texas 7650
254-743-2635

October 5, 2017

To Whom It May Concern,

RE: Doctorate of Nursing Practice Project Letter of Support

Title: Program Evaluation of Home Based Primary Care.

I, Dr. Khalid Khan, support Ashley Hughes, MSN, APRN, FNP-C, Doctor of Nursing Practice candidate at Texas A&M University Corpus Christi, regarding participation in her project of a Program Evaluation of Home Based Primary Care at the Central Texas Veterans Health Care System. The Program Evaluation will commence January 2018 and will conclude no later than July 2018.

If publication from a peer-reviewed journal is sought after completion of the Program Evaluation, permission must first be granted from the Central Texas Veterans Health Care System.

A handwritten signature in cursive script that reads "Khalid Khan".

Khalid Khan

APPENDIX D: Letter from Institutional Review Board



TEXAS A&M UNIVERSITY
CORPUS CHRISTI

OFFICE OF RESEARCH COMPLIANCE
Division of Research, Commercialization and Outreach
6300 OCEAN DRIVE, UNIT 5844
CORPUS CHRISTI, TEXAS 78412
O 361.825.2497 • F 361.825.2

Human Subjects Protection Program

Institutional Review Board

Date: January 10, 2018

TO: Ashley Hughes, DNP student
College of Nursing and Health Sciences, TAMU-CC

CC: Dr. Theresa J. Garcia, PhD, RN
Assistant Professor, Doctor of Nursing Practice Program Coordinator

Yolanda Keys, DHA, MSN, RN, NEA-BC, EDAC
Clinical Assistant Professor, College of Nursing & Health Sciences

FROM: Office of Research Compliance Institutional Review Board

SUBJECT: Not Human Subjects Determination

Activities meeting the DHHS definition of research or the FDA definition of clinical investigation and involves one or more human subjects are subject to IRB review and approval.

On January 10, 2018, the Texas A&M University-Corpus Christi Institutional Review Board reviewed the following submission:

Type of Review:	Not Human Subjects Determination
Title:	A Program Evaluation of Home-Based Primary Care at the Central Texas Veterans Health Care System
Project Lead:	Ashley Hughes, DNP student
IRB ID:	NHS 02-18
Funding Source:	None
Documents Reviewed:	Human Ethics Oversight Review Form dated 1/3/2018 Central Texas Dept. of Veteran Affairs Letter of Support dated 10/05/2017 Email to Nurse Practitioner Participants at CTVHCS

Texas A&M University-Corpus Christi Institutional Review Board determined that the proposed activity does not meet the DHHS definition of research or the FDA definition of a clinical investigation. Therefore, **this project does not require IRB approval.** You may proceed with this project.

This determination applies only to the activities described in the documents reviewed. **Any planned changes requires submission to the IRB to ensure that the research continues to meet criteria for a non-human subject research determination.**

Please do not hesitate to contact me with any questions at Rebecca.Ballard@tamucc.edu or 361-825-2497.

Respectfully,
Rebecca Ballard, JD, MA, CIP
Director, Research Compliance
Division of Research, Commercialization and Outreach

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APPENDIX E: Informed Consent Provided to Participants

12Feb18

PROJECT TITLE:

A Program Evaluation of Home Based Primary Care aimed at Reducing Nurse Practitioner Turnover

|

Purpose of the survey:

I am conducting a survey on Home Based Primary Care (HBPC) Nurse Practitioner (NP) satisfaction, intention to leave, and role perception. The query is being conducted in conjunction with the Texas A&M University Corpus Christi's Doctorate of Nursing Practice (DNP) program.

The survey will be sent out via Survey Monkey to each HBPC NP who has been with the program for a minimum of six months. Your participation is completely voluntary. If you feel uncomfortable with the questions being asked, you may exit the survey at any time without penalty. You may also choose to skip any questions you prefer not to answer. The estimated time for completion of the survey is 30 minutes. All responses are confidential. Please do not put your name or any identifying information in any of your answers. Aggregate data will be analyzed from the responses provided and used as a basis for recommendations to HBPC leadership.

By clicking the "Start Survey" button, you are verifying you agree to the terms of participation, understanding participation is strictly voluntary.

Thank you for your consideration of this request.

Ashley K Hughes