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Factors Related to the Recruitment and Retention of Nurse Practitioners in Rural Areas

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RETENTION OF NURSE PRACTITIONERS

IN RURAL AREAS

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ABSTRACT

FACTORS RELATED TO THE RECRUITMENT AND
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by

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For the past several decades, rural America has experienced significant health disparities. Changes in the demographics of rural locations in the U.S. have led to a) an increase in an aging population, b) an increase in minority populations, and c) a large number of unemployed individuals due to the shifting of jobs. In some locations, a large number of these unemployed or underemployed are uninsured or underinsured. Parallel to the changes in demographics, there has been a decrease in primary care providers in rural areas. Consequently, rural America is facing reduced and unequal access to healthcare. One solution to limited healthcare access is increasing the number of primary care nurse practitioners (NP) in rural areas. A significant number of NPs currently offer effective primary care; however, only 40% accept positions in rural settings. Thus, the purpose of this qualitative study is to explore factors related to recruiting and retaining NPs to rural areas.

The conveniently selected sample was composed of 29 rural NPs throughout the U.S. The data collection method was semi-structured interviews. A qualitative study, using constant

comparison analysis of categories and themes, determined that three of the concepts of the rural nursing theory, a) lack of anonymity, b) outsider versus insider status, and c) self-reliance, were pertinent. Deconstruction of categories and themes identified NP transition to rural practice through personal, social, and professional adaptation. The ability of NPs to adapt in these three areas produces role success and gratification thus in turn leads to job retention.

This study concluded that rural NPs, through adaptation, achieved role success and gratification thus in turn leads to job retention. Based on these findings, recommendations are offered for changes to NP educational programs and federal agencies involved in the recruiting and retention of NPs in rural areas.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

The phenomenon of why nurse practitioners (NPs) decide to practice, and sometimes, continue to practice in rural America is worthy of study. The purpose of this qualitative study is to explore factors related to recruiting and retaining NPs to rural areas. It was anticipated that the knowledge gained through inquiry would contribute to understanding NP choices to practice and remain in rural areas, and, further inform the developing rural NP educational programs, and existing federal agencies involved in recruiting and retaining NPs in rural areas.

This chapter begins with an overview of the content and background framing the study. Following the overview are the problem statement, statement of purpose, research question, assumptions, and significance of the study.

Background and Content

Rural America is facing unequal access to healthcare (Johnson, 2006) due to changing demographics, such as increases in aging, immigrants, and uninsured (Hamilton, Hamilton, Duncan, & Colocousis, 2008). The increase in the aging population increased demands on the healthcare system. Immigrants from different countries brought different health issues, cultures, and languages (Hamilton et al., 2008). New community members increased the demands on an already stressed system because of limited insurance and finances to pay for healthcare. Thus, the changes in the demographics of rural America contribute to rural health disparities.

To address national health disparities, the U.S. Department of Health and Human Services (DHHS) established Healthy People 2010. Goals of Healthy People 2010 focus on increasing quality of life and eliminating health disparities for Americans. Stated objectives are;

a) promoting healthy behaviors, b) protecting health, c) assuring access to quality healthcare, d) insurance coverage and e) healthcare providers (U.S. DHHS, 2000).

However, Healthy People 2010's objective of assuring access to quality healthcare for all Americans proved much more effective in urban areas than in rural areas. Rural residents are disproportionately uninsured, 24% of rural residents lacked insurance, compared to 18% of urban residents (Institute of Medicine of the National Academies, 2008).

Along with the numbers of uninsured rural Americans, there are fewer primary care providers in rural areas. Physician-to-population ratios are consistently lower. Rural areas experience difficulty recruiting physicians to their communities due to; a) dysfunctional healthcare systems, b) lack of amenities, and c) distance from larger population areas (Fordyce, Chen, Doescher, & Hart, 2007).

Continuing efforts have been made to increase sources of healthcare for Americans. In 1998, federal agencies initiated an effort to address the average American's access to healthcare. When reviewing the source of care for rural residents, they found a 7% decrease in the number of rural residents who had access to healthcare (Institute of Medicine of the National Academies, 2008). This statistic directly resulted from the limited number of healthcare providers in rural areas, a shortage hindering their access to healthcare (Institute of Medicine of the National Academies, 2008).

The number of primary care physicians is not expected to increase, as fewer than 7% of medical students are pursuing primary care practices (Johnson, 2008). Meanwhile, the number of NPs and physician assistants (PAs) responsible for primary care is growing. In the U.S., about one-third of primary care practitioners are NPs, with more than 140,000 NPs providing primary

care (Scripps News Service, 2009). About 81.6% of NPs practice in primary care, with only 40% working in rural areas (Salsberg, Forte, Martiniano, & Kouznetsova, 2005).

Nurse practitioners provide a substantial portion of primary care in rural areas compared to physicians. In 2000, there were 33.7 NPs for each 100,000 rural patients (Salsberg et al., 2005). Even with an increase of 3.6% in the number of NPs from 2000-2004, the ratio of NPs to patients continues to be alarmingly low (Salsberg et al., 2005).

The growing shortage of primary care providers, combined with uninsured patients, location, and an aging population, left many individuals with decreased access to care. NPs were filling this gap, providing healthcare, health promotion, and disease prevention to the underserved, regardless of their insurance status, availability of transportation, or language.

Nurse practitioners provide valuable healthcare in rural areas. Three decades ago, Lawler and Valand (1988) conducted an evaluation study exploring the impact of NPs on access to care in rural, isolated communities. These researchers concluded NPs had improved access to care for rural residents, offering care to patients in areas experiencing physician shortage (Lawler & Valand, 1988).

In summary, focusing on increasing quality of life and eliminating health disparities are more effective in urban areas (Institute of Medicine of the National Academies, 2008). Rural communities continue to have a significant number of uninsured persons and a limited number of primary care providers. The low ratio of primary care physicians to residents in rural areas is expected to continue because fewer medical students were focusing on primary care practice (Johnson, 2008). As the number of physicians pursuing careers in primary care is decreasing, the number of NPs in this specialty is growing (Salsberg et al., 2005). In the U.S., about one-third of

primary care practitioners were NPs. Thus, recruiting NPs to rural America would increase access to care for rural residents.

Statement of the Problem

Rural America is experiencing unequal access to healthcare which threatens to escalate. Demographics in rural areas have led to, a) an increase in aging population with increased demands on a stressed healthcare system, b) an increase in minority population with different needs, c) a decrease in economics status, d) an increase in the numbers of uninsured and underinsured, and e) distance from larger population areas. Parallel to these demographics changes, rural areas experience a lack of primary care providers. Currently, NPs provided 40% of rural healthcare. Thus, an understanding of the factors related to recruiting and retaining NPs in rural areas is warranted to aid in increasing access to healthcare for rural America.

Purpose of the Study

The purpose of this qualitative study is to explore factors related to recruiting and retaining NPs to rural areas.

Research Question

What factors are related to recruiting and retaining NPs to rural areas?

Assumptions

1) NPs working in rural areas are aware of the rural status of the communities in which they are employed, and 2) NPs are impacted by practicing in rural areas.

Significance of the Study

Rural community members receive limited and disrupted healthcare services due to inadequate access. One solution is to increase the number of primary care providers in rural areas by recruiting and retaining NPs as primary care providers. A better understanding of the factors

related to recruiting and retaining NPs in rural areas is justified. Results from this study will contribute to understanding NPs' choices to practice and remain in rural areas. Results will help developing rural NP educational programs to prepare NPs for rural America. Results will also benefit federal agencies, such as the National Health Service Corps (NHSC), in developing strategies for recruiting and retaining NPs in rural areas.

CHAPTER 2

REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

Introduction

The purpose of this qualitative study is to explore factors related to recruiting and retaining NPs to rural areas. This chapter presents; a) a review of literature as it pertains to the definition of rural, b) a description of rural America including aging, income and ethnic diversity, c) an overview of Healthy People 2010, d) a summary of healthcare access, e) an outline of the role of the NP and, f) the conceptual framework.

Review of the Literature

Definition of Rural

There are varying definitions of rural. The U.S. Census Bureau classifies rural and urban areas by population density. Urban areas are defined as areas with a density of 1,000 people or more per square mile and combined with any surrounding census blocks with densities of at least 500 people per square mile. Areas not classified as urban areas, or areas with less than 1,000 people per square mile, are classified as rural (Texas Comptroller, 2001).

A second definition identifies urban areas as "all territory, population, and housing units in places of 2,500 or more persons incorporated as cities, villages, boroughs and towns" (Zhang, Bowman, & Mueller, 1998, p. 6). Rural areas are defined as the areas and population that do not fall into the "urban" population definition (Zhang et al., 1998).

Furthermore, urban and rural areas are divided into 10 categories by the U.S. Department of Agriculture (Texas Comptroller, 2001). The first four types refer to urban areas ranging from over one million residents to fewer than 250,000. The remaining six types refer to rural areas.

Type 4 includes counties with urban populations of 20,000 or more and adjacent to a metropolitan area. Type 5 includes counties with urban populations of 20,000 or more, but not adjacent to a metropolitan area. Types 6 and 7 are counties with populations from 2,500-19,999 either adjacent or not adjacent to a metropolitan area. The remaining types, type 8 and type 9, have fewer than 2,500 residents either adjacent or not adjacent to a metropolitan area.

Rural America

Over the past four decades, the demographics of rural America have changed and continue to change. These changes are due to, a) declining natural resources, b) decreases in employment, and c) decreased economic status (Hamilton et al., 2008). The Carsey Institute explained the changes in America's rural areas by dividing rural areas into four different groups, a) amenity-rich, b) declining resource dependent, c) chronically poor, and d) amenity-decline (Hamilton et al., 2008). Amenity-rich rural areas experience economic changes, as agriculture and manufacturing jobs declined and jobs requiring advanced education increased. Declining resource-dependent rural areas were shaped by a depletion of natural resources affecting mining, farming, and logging. Chronically poor areas also experience a depletion of natural resources; the prolonged depletion of natural resources in these communities leading to decreased revenue, further impacting community services. Amenity-declining areas are in transition, with weak economies due to employment shortages causing community members to commute longer distances.

In-migration and out-migration affect rural demographics (Hamilton et al., 2008). Traditionally, most rural areas experience population losses as residents move to urban areas for better opportunities (out-migration). Out-migration remained consistent until the late 1970 when in-migration into rural areas was higher than urban population gains. Since the 1970s, rural

populations continue to increase. For example in 2000, the rural population increased by 4.1 million people (Johnson, 2006). During this growth period, there was an increase in the number of employees commuting to jobs in urban areas and a parallel increase in the number of urban residents moving to rural areas (Institute of Medicine of the National Academies, 2008). According to Hamilton et al., individuals and families who relocated to rural areas were seeking safe environments in which to raise their families and were also looking for easier access to recreational activities (2008).

Also, rural areas experience an out-migration. Primarily, young residents leave rural areas due to limited local employment options and the high cost of fuel needed to commute to urban areas for employment (Hamilton et al., 2008). With these younger residents leaving, rural communities are left with an elderly aging population.

Income. Also, income affects insurance status. A significant number of low-income persons comprise a large proportion of the uninsured rural population (Institute of Medicine of the National Academies, 2008). Poor Americans under age 65 are insured at a rate of 59%, with near poor- and middle/high-income Americans are insured at a rate of 70% and 90% (Institute of Medicine of the National Academies, 2008). Half of the uninsured were below 200% of the poverty level guideline, 35% were below the poverty level, and 28% were between 100% and 199% of poverty (Table 1). This high level of uninsured poor was attributed to unemployment or part-time work, lack of insurance from employers, and inability to afford insurance (U.S. DHHS, 2005).

According to the U.S. Department of Health and Human Services, Hispanics are disproportionately uninsured. White non-Hispanics comprise 48% of the uninsured. In 2004, Hispanics represented 14% of the U.S. population, but comprised 30% of the uninsured. The

high number of uninsured Hispanics was due to employment that did not offer health insurance (U.S. DHHS, 2005).

Table 1. 2009 Poverty Guidelines

Persons in Family	Poverty Guideline
1	$10,830
2	$ 14,570
3	$ 18,310
4	$ 22,050
5	$ 25,790
6	$ 29,530
7	$ 33,270
8	$ 37,010

For families with more than 8 persons, add $3,740 for each additional person.

Note. Adapted from, "The 2009 HHS Poverty Guidelines," by U.S. DHHS, 2009.

In addition to uninsured rural Americans, there are fewer primary care providers. Physician-to-population ratios are consistently lower in poverty areas (Figure 1). Rural areas have difficulty recruiting physicians to their communities due to dysfunctional healthcare systems, lack of amenities, and distance from larger population areas (Fordyce et al., 2007).

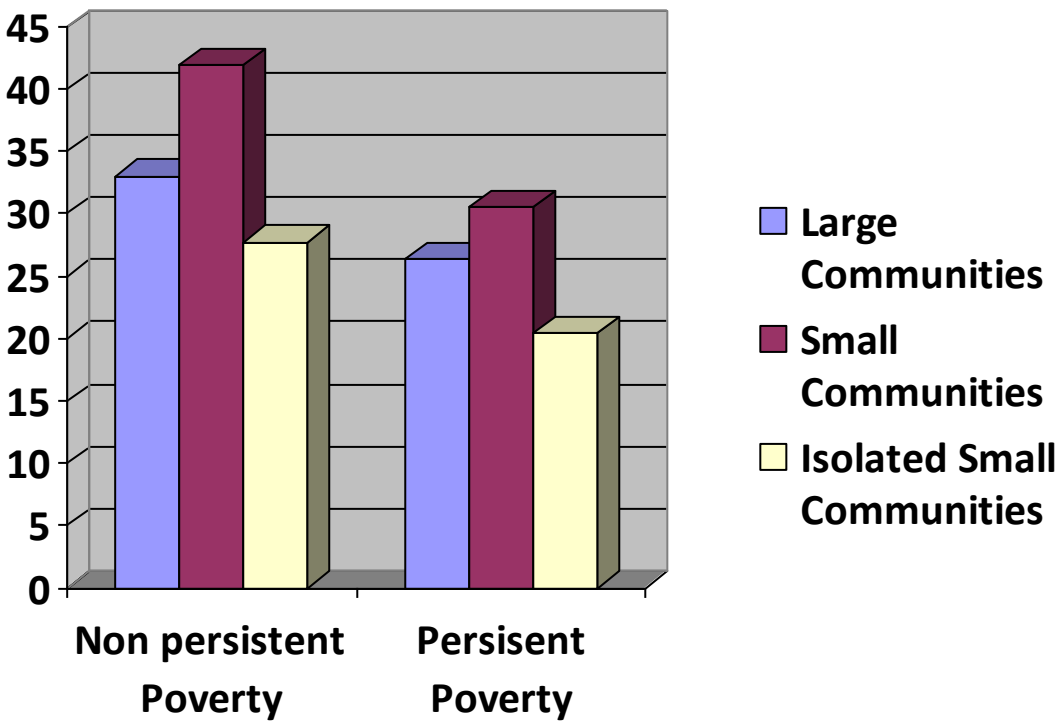

Figure 1. Physician/Population Ratios in Rural Areas.

Note. Adapted from, 2005 Physician Supply and Distribution in Rural Areas of the United States: Final Report #116, by Fordyce et al., 2007.

In 1996, the U.S. DHHS set the objective of increasing the number of persons who have regular providers for continuation of care (2000). Since that declaration, there was only a 3% increase in the number of rural residents under 17 years of age with regular medical providers (Institute of Medicine of the National Academies, 2008). Lack of a regular provider is more evident among poor rural Americans. Many have no health insurance, and two-thirds are also from low-income families with minimal finances to devote to healthcare costs (Institute of Medicine of the National Academies, 2008) (Figure 2).

Previous effects have failed to increase American's source of healthcare. In 1998, federal agencies initiated an effort to address the average American's source of care. Between 1998 and 2004 for individuals of all ages throughout the U.S., there was no improvement in their source of healthcare access. Conversely, there was a 7% decrease in the number of rural residents with a primary care provider (Institute of Medicine of the National Academies, 2008). This statistic correlates with limited number of healthcare providers in rural areas, a shortage which directly hindered access to care (Institute of Medicine of the National Academies, 2008), proving the need for NPs in rural areas.

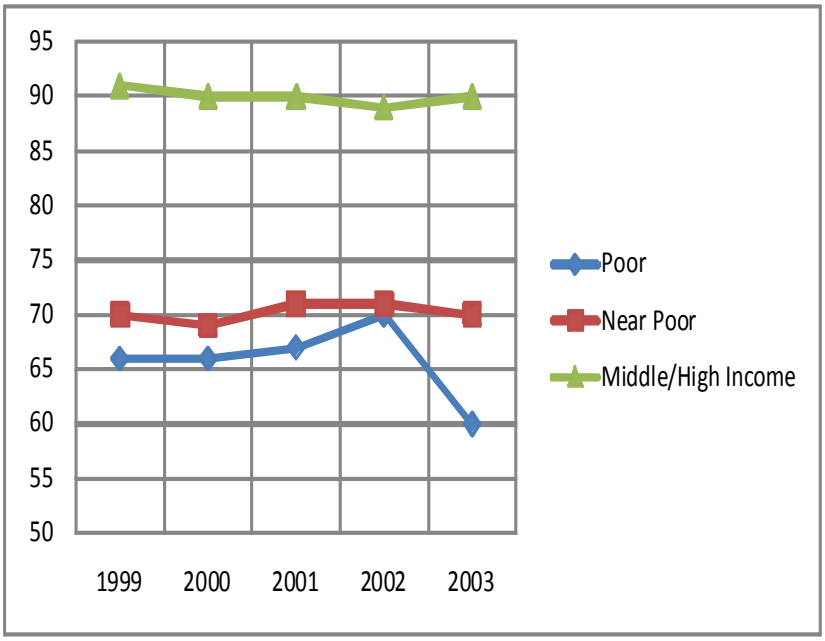

Figure 2. Percentage of Persons with Health Insurance by Income Category.

Note. Adapted from, "Quality through Collaboration: The Future of Rural Health (2nd ed.), by the Institute of Medicine of the National Academies, 2008.

Ethnic Diversity. The ethnic diversity of rural areas is changing. Although immigrants remain a small proportion of the rural population, immigration accounts for a disproportionate share of rural growth. For example, immigration accounted for 62% of rural migration gains and 31% of overall rural population increases from 2000-2004 (Johnson, 2006). According to this study, the proportion of rural population that was White non-Hispanic was 82% versus 66% in urban areas. Although African Americans made up the largest rural minority group at 8.4%, and showing a modest growth, Hispanics represented 5.4% of the rural population and the fastest growing rate of any racial and ethnic group. Hispanics constituted 3.6% of the rural population in 1990; in 2004, they accounted for 29% of the rural population.

In summary, the changes in rural demographics affect rural healthcare systems. The increase in an aging population in rural areas likewise increase healthcare system demands. Larger communities intensify demands on an already financially stressed system. Immigrants affect the rural healthcare system in various ways. Individuals moving to rural areas from different countries bring with them different health issues, cultures, and languages (Hamilton et al., 2008). Thus, demographic changes led to, a) an increase in an aging population, b) an increase in minority populations, and c) an increase in the number of individuals out of work due to job-shifting. In some locations, a large number of unemployed or underemployed are uninsured or underinsured (Hart, Salsberg, Phillips, & Lishner, 2002). Due to these demographic changes in rural America, healthcare access has become more limited for this population.

Healthy People 2010

Healthy People 2010 is designed to increase quality and years of healthy life and to eliminate health disparities. Healthy People 2010, an extension of Healthy People 2000, is a prevention initiative to promote health and prevent disease for all Americans. Healthy People

2010 expand objectives of Healthy People 2000 to include eliminating health disparities for populations based on measurable population-based objectives. The aims of Healthy People 2010 are to increase Americans' quality of life and eliminate health disparities by focusing on, a)promoting healthy behaviors, b) protecting health, c) assuring access to quality healthcare, including insurance coverage and healthcare providers, and d) strengthening disease prevention (U.S. DHHS, 2000).

Healthy People 2010's objective of assuring access to quality healthcare for all Americans has been more effective in urban areas than in rural areas due to insurance status (Institute of Medicine of the National Academies, 2008). The DHHS (2005) estimated that 45.8 million (15.7%) of Americans were uninsured. Rural residents were disproportionately uninsured; 24% of rural residents lacked insurance, compared to 18% of urban residents (Institute of Medicine of the National Academies, 2008).

Access to Healthcare

Access to primary healthcare in rural areas is a top-ranking national health priority, but the shortage of primary care providers hindered access to primary care. In 2000, there were 225 primary care physicians per 100,000 residents in urban areas (Institute of Medicine of the National Academies, 2008) (Figure 3). In 2005, the ratio of primary care providers to residents 100,000 residents (Fordyce et al., 2007).

In 2008, Johnson reported that less than 7% of medical students pursue primary care practices. Meanwhile, the number of NPs and PAs responsible for primary care was growing. In the U.S., about one-third of primary care providers were NPs, with more than 140,000 of them providing primary care (Scripps News Service, 2009). A nationwide study conducted in 1999

estimated that 81.6% of NPs practiced in primary care, while 40% worked in rural health professional shortage areas (Salsberg et al., 2005).

Nurse practitioners provide a substantial portion of primary care in rural areas as compared to physicians. In 2000, there were 33.7 NPs for each 100,000 rural patients. Even with an increase of 3.6% in the number of NPs from 2000-2004, the ratio of NPs to patients continued to be alarming (Salsberg et al., 2005).

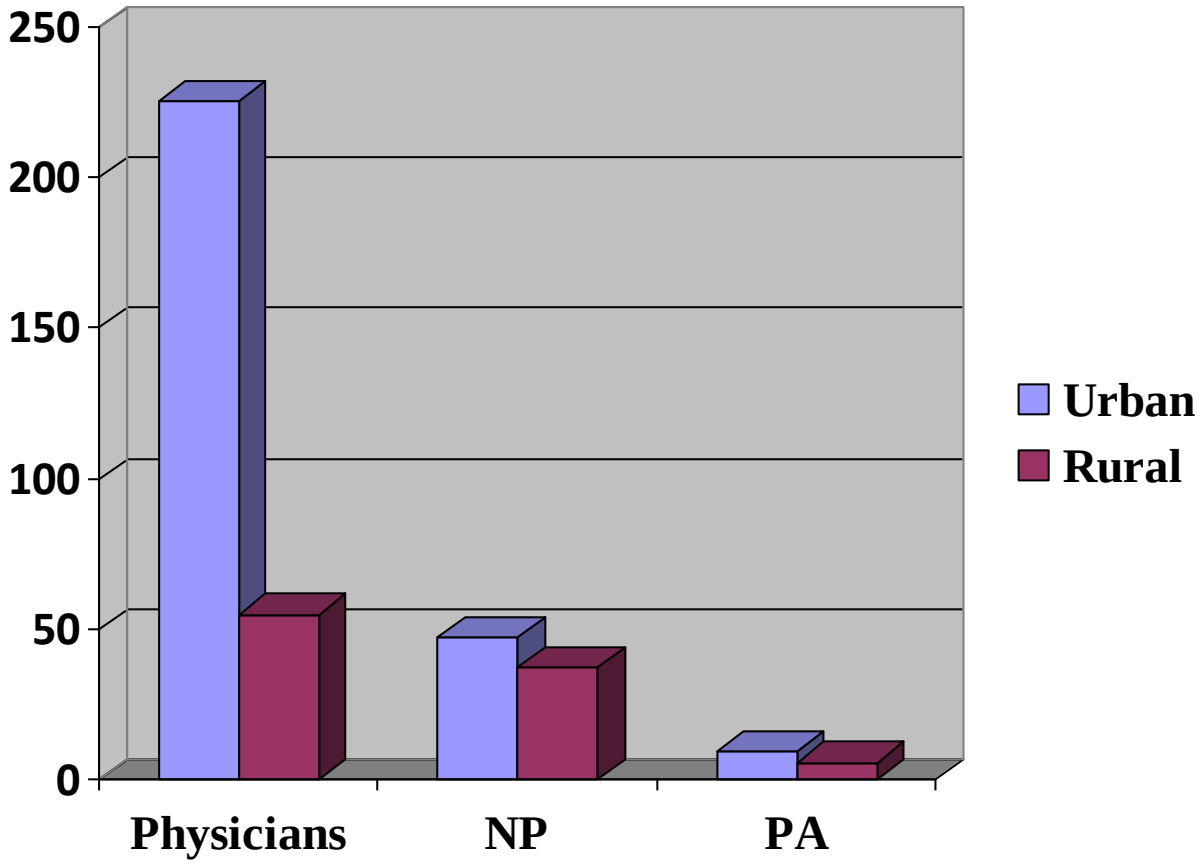

Figure 3. Healthcare Provider to 100,000 U.S. Residents. *Note*. Adapted from, "2005 Physician Supply and Distribution in Rural Areas of the United States: Final Report #116, by Fordyce et al., 2007

In response to the limited amount of primary care providers offering care to rural residents, the government established the National Health Service Corps (NHSC) and Area Health Education Centers (AHECs). In the 1950s and 1960s, rural physicians retired or moved, leaving many areas of the rural U.S. without essential healthcare. The NHSC offers both educational scholarships and educational loan repayment in exchange for a healthcare provider's commitment to practice in a rural or underserved area. Since its inception, more than 30,000 primary care physicians, NPs, certified nurse midwives, PAs, dentists, dental hygienists, and mental health professionals have served in the NHSC. According to the National Area Health Education Center Organization (2009), the NHSC had 3500 clinicians caring for approximately 4 million people in underserved areas. About 80% of NHSC clinicians continued to work in rural or underserved areas beyond their initial commitment, with 70% staying at least five years and about 50% caring for underserved people their entire career (NHSC, 2009).

The AHECs were also instrumental in recruiting healthcare providers to rural areas. AHECs developed community health education and health provider training programs in severely underserved areas. AHECs place health professional students in diverse settings (migrant, urban, rural, community health clinics, and health departments working with underserved populations) to motivate students to provide additional services and to practice in underserved areas following their training. In 2007-2008, AHECs worked with 17,530 community-based training sites, educating 44,675 physicians and 4,155 advanced practice nurses and PAs (National Area Health Education Center Organization, 2009).

Despite the efforts of the NHSC and AHEC, recruiting providers to rural areas continues to be problematic. Rural areas compete unsuccessfully with prosperous medical practices that

offer higher reimbursement, more interaction with other professionals, and job opportunities for spouses. Rural communities lack resources to provide the technologically sophisticated facilities that many healthcare providers desire (Fordyce et al., 2007).

The lack of a primary care provider and easy access to healthcare resulted in many persons experiencing limited care, disruptions in care, and seeking care in the emergency room (Simonet, 2009). For decades, rural patients were treated by primary care providers. Rural providers offered medical treatment and education related to disease management. The medical treatment and education patients received from their primary care provider led to a decrease in the number of emergency room visits (Hurley, Freund, & Taylor, 1989). Simonet (2009) cited that patients with chronic illness such as diabetes and asthma who could not access continued care and disease management were two to three times more likely to visit the emergency room than those who had proper access to healthcare. Emergency room visits by persons without a primary provider led to a high percentage (approximately 49%) of non-urgent emergency room presentations, increasing overall healthcare costs (Simonet).

Due to the growing shortage of primary care providers, combined with uninsured residents and an aging population, healthcare access decreased for many individuals. Nurse practitioners filled this gap, taking action to provide healthcare, health promotion, and disease prevention to the underserved regardless of their ability to pay for services. Care offered by NPs to the underserved without insurance or a primary care provider led to a decrease in the backlog of physician patients, hospital admissions, emergency room visits, and healthcare cost (Rose, 2009).

While members of our government worked on a plan to offer healthcare to all Americans, nurses and NPs were influential in improving access to care (Orth, 2009). Public health nurses

(PHNs) were instrumental in caring for communities throughout the U.S. Public health nurses provided information on a) disease prevention, b) communicable diseases, and c) environmental health hazards at community health centers, senior centers, and churches (Rose, 2009). With the increase in unemployment and decrease in insurance benefits, some states expanded the role of the PHNs to allow more autonomy. Georgia changed its nurse practice act to allow PHNs to work within a scope similar to that of NPs (Rose, 2009).

Nurse practitioners and PHNs ventured beyond the walls of traditional clinics to offer healthcare. In response to the limited access to healthcare, due to lack of insurance but also due to the lack of transportation, NPs and PHNs established healthcare services in a variety of venues. They established clinics in our nation's schools offering healthcare to the students and staff (Reinhart, 2009). Providers traveled to rural and remote areas to offer healthcare to residents who lacked the means or ability to travel to urban areas (Rose, 2009). Nurse practitioners established clinics in areas with large immigrant populations, offering translation services to ensure maximum healthcare services (Rose, 2009).

Three decades ago, Lawler and Valand (1988) conducted an evaluation study exploring the impact of NPs on access to care in rural isolated communities, concluding that NPs had improved access to care for rural residents. The major contributions of NPs were in offering care to patients who were previously without care, and increasing primary care in physician shortage areas. Despite the efforts of the NHSC and AHEC to recruit rural providers, rural areas continue to have fewer primary care providers than urban areas. The shortage of primary care providers hinder access to care. The low ratio of primary care physicians to residents in rural areas is expected to continue (Johnson, 2008). While the number of physicians pursuing careers in primary care is decreasing, the number of NPs responsible for primary care grew. In the U.S.,

about one-third of primary care practitioners are NPs. NPs provided a substantial portion of primary care in rural areas, thus demonstrating they are effective primary care providers for rural residents.

Role of Nurse Practitioners

The NP role originated as one strategy to increase access to primary care, and in response to the shortage of primary care physicians (Sherwood, Brown, Fay, & Wardell, 1997). The first successful program to introduce NPs was developed in 1965. Originally confined to pediatrics, NPs were soon trained to work in a wide variety of settings. By the mid-1970s, there were over 500 programs across the country preparing NPs to deliver primary care (Sherwood et al., 1997). Programs gradually shifted from certificate to master's degree preparation as accrediting bodies required a minimum master's degree. By the 1980s, master's degree programs far outweighed certificate programs. Soon, NPs held master's or doctoral degrees, and were licensed to provide complex and difficult healthcare interventions in a variety of settings, including homes, hospitals, institutions, offices, industries, schools, community agencies, clinics, and private practices. In response to healthcare reform in the 1990s, NP programs multiplied at an astonishing rate to meet increasing demands for primary care services (Sherwood et al., 1997).

The scope of practice for NPs is regulated by the board of nursing, and by each state's Nurse Practice Act (Christian, Dower, & O'Neil, 2007). Some states permit NPs to practice independently. Christian et al. found that NPs were authorized to practice independently without physician collaboration in 11 states (2007).

NPs had both an independent and a collaborative practice with other healthcare professionals to deliver healthcare services. They diagnose and manage common illnesses and injuries, stabilize acute conditions, and treated chronic conditions. They are responsible for, a)

ordering, conducting, and interpreting diagnostic and laboratory tests, b) prescribing medications, c) ordering treatments, and d) referring non-pharmacologic therapies (such as massage and acupuncture), and other therapeutic interventions (American Academy of Nurse Practitioners, 2007).

Nurse practitioners main focus is health promotion (Sharp, 2009b). Their focus is to prevent disease and strengthen relationships with their patients through communication and education, a connection that often helps patients reach their health goal. The NP provides information and encourages patients to independently manage their health needs. As nurses, they place part of the focus on holistic care, which involves the patient, the patient's family, the community, and the relationship of all parties to one another.

Venning, Durie, Roland, Roberts, and Leese (2000) found that NPs often were more cost-effective than primary-care providers. Their study concluded that the care provided by NPs is generally equivalent to physician care and based on patient satisfaction, interpersonal skills, and patient outcomes. Their patients tend to exhibit greater satisfaction and greater compliance with health promotion and treatment recommendations than the patients of physicians. Their role includes educating patients on how to meet their health goals, as well as finding resources that help patients gain greater control of their own care (Venning et al., 2000).

The role of NP was first envisioned for practice in rural underserved communities (American Academy of Nurse Practitioner, 2007). In a rural area, an NP was often the only healthcare provider. In this setting, the NP functioned fairly independently, with physician consultants available when needed. Conversely, some NPs functioned autonomously while in a joint practice with a physician or group of physicians. Rural NPs oftentimes exercised their full

scope of practice as compared to NPs in urban areas (Christian et al., 2007). Thus, rural NPs were prepared to act as primary care providers for rural America.

Transition. As nurses transitioned to the NP role, they face barriers from physicians who are unsupportive and from some nurses who are resentful (Kelly & Mathews, 2001). Some are professionally isolated and frustrated when they feel they are not accepted by physicians or nurses in the community (Kelly & Mathews). Many NPs are left out of *both* physician meetings and nurse meetings.

NP practice differs from state to state, from rural areas to urban areas, and from practice to practice. Nurse practitioners lacked consistency in their role, which creates anxiety and frustration (Kelly & Mathews, 2001). Despite these issues, NPs identify gains in personal satisfaction as a result of the role transition. They generally believe they made the right choice when deciding to become an NP. Additionally, NPs experience an increase in self-confidence and autonomy (Kelly & Mathews).

Nurse practitioners transitioned from their role as registered nurses (RNs) to NPs in two phases (Heitz, Steiner, & Burman, 2004). Phase I occurred during the educational process and included six categories: a) extrinsic obstacles, b) intrinsic obstacles, c) turbulence, d) positive extrinsic forces, e) positive intrinsic forces, and f) role development (Heitz et al.). During phase I, the extrinsic obstacles included external stressors such as clinical sites and preceptors. The intrinsic obstacles were internal stressors, identified by the researchers as a) sacrifices, b) self-perception, and c) role confusion. Sacrifices were both personal and emotional. Self-perception concerned how the student felt about being an NP, and included feelings of inadequacy or vulnerability. Role confusion resulted from the inability to separate their RN role from the role of an NP. The category of turbulence concerned alternating emotions and perceptions that were

affected by both extrinsic and intrinsic obstacles (Heitz et al., 2004). With turbulence, the student needed to attain stability, which was achieved by employing positive extrinsic and intrinsic forces. Positive intrinsic forces included a) life experiences, b) acceptance of responsibility, and c) independence. Positive extrinsic forces included a) faculty, b) preceptors, and c) personal support systems.

Heitz et al. (2004) reported that Phase II, the transition from graduate to independent NP, took anywhere from 6 months to 2 years. This phase included turbulence, created by intrinsic and extrinsic obstacles also. Extrinsic obstacles included a) environmental issues, b) colleague negativity, and c) defensive encounters. Intrinsic obstacles were divided into two subcategories, a) self-doubt and b) disillusion as related to their new role. Self-doubt was caused by the new providers' fears, apprehensions, and turmoil in their new roles. Disillusion arose from the internal perceptions created by role realities and led to questioning whether to remain in the role.

Heitz et al. (2004) reported that turbulence was relieved by positive intrinsic and extrinsic forces. Positive intrinsic factors were a) role immersion, b) optimism, and c) role acceptance. Positive extrinsic factors included a) positive support and encouragement from colleagues and b) acceptance from community members. Through positive intrinsic and extrinsic factors, the NPs could move toward role development. As role development progressed, NPs became effective rural primary care providers.

Recruiting and Retaining. Minimal research was identified regarding exploring recruiting and retaining NPs (specifically) in rural areas. Research findings related to PAs is therefore presented herein, because PAs performed a comparable role to NPs. PAs were licensed healthcare providers who practice under physician supervision, making clinical decisions and providing diagnostic, therapeutic, preventive, and health maintenance services. Nurse

practitioners work with clients, physicians, and other professionals to assess, manage, and diagnosis common illnesses. Thus, NPs and PAs perform in similar roles.

Researchers have explored recruiting and retaining PAs and gender differences in rural settings (Larson, Hart, Goodwin, Geller & Andrilla, 1999; Lindsay, 2007). A study by Larson et al. describing the location histories of PAs demonstrated stable work histories, 71% spent their entire career in the same location, with 3.6% shifting back and forth from rural and urban areas. The researchers reported that 19% of PAs started their career in rural areas, and 59% of those PAs remained in a rural setting. The proportion of PAs in rural areas remained relatively constant at approximately 20%; however, this trend was beginning to change. Early PA graduates (21%) are more apt to seek a position in a rural setting, yet only 9% of graduates in the last 4-7 years chose to practice in a rural area. The decrease in PAs choosing rural practice is expected to continue with the increase of female PA students. It was found that females, approximately 75% of PA students, avoided rural practice (Larson et al.).

Lindsay (2007) examined gender difference among PAs (29%), NPs (42%), and certified registered nurse anesthetists (29%). Female providers (52%) chose rural practices due to, a) the ability to have independence and autonomy in their practice, b) increases in client acceptance as compared to urban practices, and c) personal rewards. Male providers (48%) enjoyed autonomous broad scope practice. Both genders identified limited resources and geographic and professional isolation as negative aspects of rural practice.

Although the role is the same, the scope of practice differs for PAs and NPs. The PA works under the supervision of the physician, and the physician is responsible for the supervision of the PA in all settings (AAPA, 2009). The physician is required to be available for consultation at all times, either in person or through telecommunication systems. Thus, the physician is

ultimately responsible for coordinating and managing the care of patients, with input of the PA ensuring the quality of healthcare provided to patients. The care offered by the PA is based on guidelines which are mutually agreed upon by the physician and the PA and based on the physician's delegatory style (AAPA, 2009).

While PAs have been compared to NPs, there have been differences in their scope of practice and in practice guidelines. Nurse practitioners have independence, practicing under their own license, while PAs practice under the license of their supervisory physician. In rural underserved areas, NPs are entrusted to practice with minimal or no physician involvement (Christian et al., 2007), giving them the ability to care for rural residents.

Pilot Study

Four of the six concepts of Weinert and Long's (1987) rural nursing theory, a) lack of anonymity, b) outsider/insider, c) isolation/distance, and d) self-reliance, were identified as relevant in a NP's transition to a rural area (1987). Four NPs working in rural west Texas (identified via mutual contacts) were interviewed, using a semi-structured interview to evaluate their transition to rural practice. The analysis of this pilot study, conducted with four NPs, demonstrated lack of anonymity is prevalent in their rural practices. One NP, who lives in a neighboring town to maintain her privacy, stated:

> It is a small town, I don't want to live where I work. I don't want everybody to come knock on my door, or see me at the post office or grocery store … there's a lot of people that don't understand that I have a family too and my family needs my time … that is probably the main reason why we don't live here, there needs to be … separation.

Other NPs incorporate techniques to avoid community members, "You don't have listed phone numbers because you don't want anybody to get a hold of you. They call me 2, 3 o'clock in the morning," and, "I've learned to dodge people."

Some NPs separate their personal and private lives, "I have to draw … [a] line between personal and business."

Others mesh their personal and professional lives, "I'm on call for my church and so sometimes, even though I'm separate when those pagers go off, I'm back on that professional role," and,

> I spend a lot of time doing stuff at home … since this clinic is under the hospital JCAHO certified credit, you have … paperwork [to do] … I have to do all that [the paperwork] at home ... I'm also a sexual assault nurse examiner so … I'm spending time printing out the pictures at home, so I do a lot of stuff at home.

The outsider concept is not prevalent, as many of the NPs have previous connections to rural communities by either living or training in a rural setting. The insider concept is evidenced by an NP who spoke about being accepted as an NP by physicians who cared for her as a child: "I used to go to both of them [doctors]. They were both my doctors growing up, so it [felt] … weird that [they] are looking [at my] stuff [charts] … I was a patient and was supposed to be this little girl."

NPs mentioned isolation and distance as obstacles to obtaining continuing education. One NP told about limiting the number of providers attending a conference due to the cost of traveling, "In order for us to maintain [our] level of expertise, we had to go to Dallas, Houston, and San Antonio, and we made a tough decision that there was going to be a need for three of us instead of the six of us."

Another NP talked about receiving emergency care for community members from 30 miles away because the community has no ambulance. She stated they used to have an ambulance:

> However, all we could get was a driver … at that time there was no EMT in town so she [the driver] and I took the patient to [closest town with a hospital]. I can't just send

> somebody with the ambulance driver if they are not stable, so those are the ones [patients] that are most stressful.

One provider feels isolated from other healthcare providers when she had physicians who did not accept her as a NP: "A pediatrician at Lubbock wouldn't take a report from me because I wasn't a doctor."

Self-reliance is evident as one NP conversed about her transition into the NP role:

> I had been here a month and a half, and he [the physician] went out for two months sick. It was either figure it out or don't figure it out, and I did that … so in hindsight now, that's probably the best thing that could have ever happened to me.

Another NP who had practiced for over 10 years also mentioned anxiety with her position, "I'm the one who has to find something wrong with this [the patient]. Something is wrong, it is me, there is nobody else they are going to go to."

Through analysis, we found four of the six concepts from Weinert and Long's (1987) rural nursing theory that are pertinent to rural NPs. While this study included only four NPs practicing in a rural area, the concepts, a) lack of anonymity, b) outsider/insider status, c) isolation/distance, and d) self-reliance, were evident. The concept of self-reliance includes concepts related to the NPs' transition to their NP role. Based on these results, four of the six concepts from Weinert and Long's rural nursing theory and the concepts from the theory of cultural marginality are included in the conceptual framework to help understand transitioning to the role of a rural NP as it related to recruitment and retention.

Conceptual Framework

As a result of pilot study findings, this study is based on a conceptual framework (Figure 4) adapted from the theory of cultural marginality (Choi, 2008) and four concepts from Wienert & Long's (1987) rural nursing theory, a) isolation and distance, b) insider versus outsider, c) lack of anonymity, and d) self-reliance.

The theory of cultural marginality focuses on the transition that occurs when individuals come into contact with a new culture and thus change their original cultural patterns (Choi, 2008). During the transition period, an individual begins to understand the differences between their previous culture (RN) and their new culture (rural NP) with its contradicting cultural values, customs, behaviors, and norms. Simultaneously, the person experiences a divided self, formed by conflicts between the old and new identities that are based on personal roles, status, and experiences of the two cultures (Choi, 2008).

The theory of cultural marginality is comprised of four major concepts, a) marginal living, b) across-culture conflict recognition, c) easing cultural tension, and d) contextual/ personal influences. Marginal living is the push-pull tension experienced by the individual caught between two different cultures (Choi, 2008). This is a feeling of not truly belonging in either culture. The transition from the old to new culture does not occur overnight, but is a transition affected by varying factors. In order to transition to a new culture, the individual needs to be accepted into the new culture. This acceptance can be affected by both overt and covert discrimination leading to anxiety, feelings of uncertainty, and apprehension about the future (Choi, 2008).

Across-culture conflict recognition occurs when the person begins to understand the differences between the two cultures and their contradicting cultural values, customs, behaviors, and norms. In response to these conflicts, the individual intentionally will adjust his/her responses to ease the cultural tension. He/she will strive to acquire new language and customs, and to interact with members of the community. After encountering the new culture, individuals may return to their previous culture as a result of resistance, obstacles, and conflicts. The final step in this transition is the merging of the two cultures, the old and new. The transition from the

old culture to the new is affected by contextual/personal influences. Contextual/personal influences include the dominant society's openness and tolerance to outsiders (Choi, 2008).

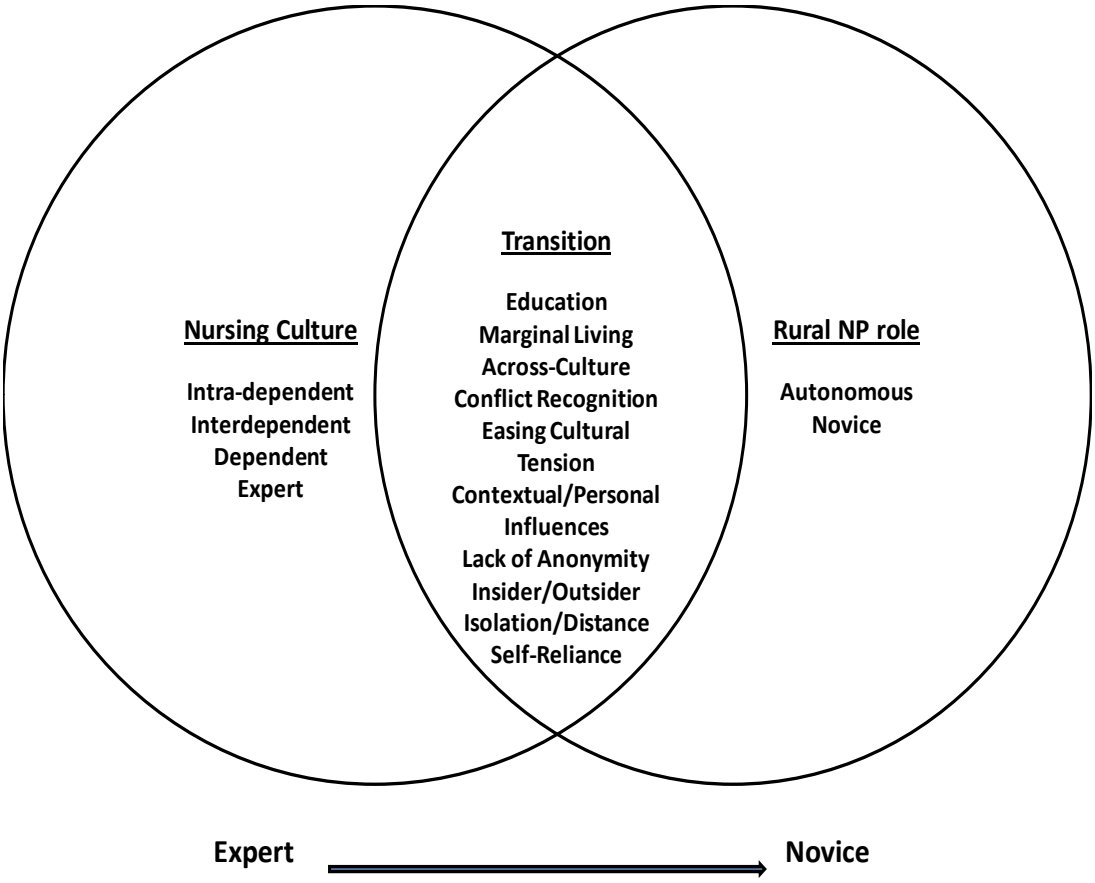

Figure 4. Conceptual Framework.

Note. From, "Theory of Cultural Marginality," by H. Choi, in M. J. Smith & P. R. Lieht (Eds)., *Middle Range Theory for Nursing* (2nd ed.), 2008; "Understanding the Health Care Needs of Rural Families," by C. Weinert & K. A. Long, 1987, *Family Relations*, 63, 450-455.

The role of the RN is different from the role of the NP; RNs typically work in non-independent roles, often following the orders of a physician or another healthcare provider, and

adhering to the policies of the agency where they practice. The RN's basic duties include, a) advocating for the patient, b) treating and educating patients, and c) providing emotional support to patients. Additionally, these nurses administer treatments and medications prescribed by other healthcare providers (Kelly & Mathews, 2001). Nurses who were confident and secure in their role described their transition to the autonomous role of a NP as exciting, but also reported anxiety, uncertainty, and stress (Kelly & Mathews, 2001). NPs practicing in rural and urban areas reported benefits and disadvantages, including, a) personal role satisfaction, b) a loss of control, c) a sense of isolation, and d) role ambiguity. Many NPs experienced a loss of control because they had no time to themselves (Kelly & Mathews, 2001). They worked long hours in outpatient clinics with few breaks, seeing all scheduled patients in addition to any ill patients who presented to the clinic.

Unique extrinsic factors related to rural communities can have an impact on NP role development and transition. The rural NPs' understanding of the distinctive features of rural communities can assist them in transitioning from a graduate NP to an autonomous NP. The concepts of Weinert and Long's (1987) rural nursing theory can help healthcare workers to understand rural community members. Although the rural nursing theory examined rural populations in general, four of its concepts, a) isolation and distance, b) lack of anonymity, c) self-reliance, and d) outsider versus insider status, were identified by pilot data as being relevant in explaining factors related to transitioning from RN to NP in rural areas (Sharp, 2009a) (Figure 5).

Isolation and Distance

The concept of isolation and distance was especially apt, because rural providers often felt isolated due to long travel times to urban areas, and often were isolated from other healthcare

providers. Heitz et al. (2004) reported that rural providers unable to contact other members of the healthcare community for consultation, support, and continuing education opportunities became frustrated and depressed.

Lack of Anonymity

According to Weinert and Long (1987), lack of anonymity was common in rural communities where community members had a lack of privacy in their personal lives. Lack of anonymity expanded to the NPs, who often had difficulty keeping their personal lives private

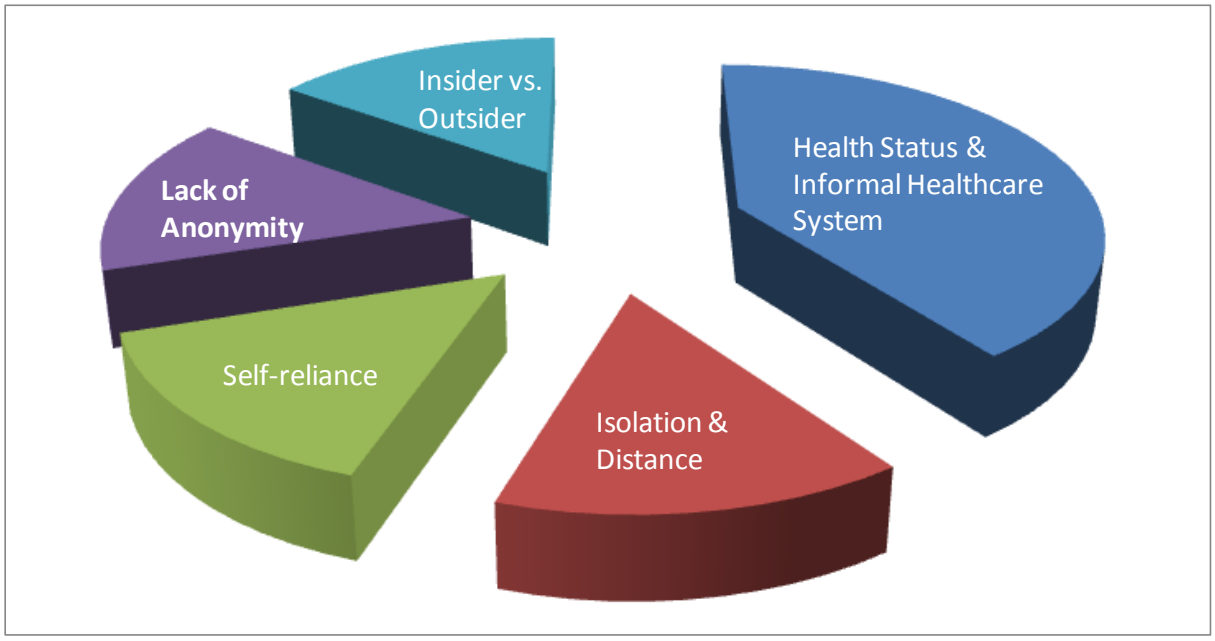

Figure 5. Rural Nursing Theory

Note. From, "Understanding the Health Care Needs of Rural Families," by C. Weinert & K. A. Long, 1987, *Family Relations*, *63*, 450-455.

from others in the community. Lack of anonymity was experienced at personal and professional levels. Raph and Buehler (2006) determined four responses to lack of anonymity, a) personally

affirming, b) professionally affirming, c) personally threatening, and d) professionally threatening.

Personally affirming interactions are friendly encounters that take place outside of the provider's clinic. These include simple questions from community members outside the clinic such as, "Do you think I should receive the flu shot this year?" Professionally affirming encounters are from other healthcare professionals in the community and include consultations about mutual patients. Both are examples of lack of anonymity; however, they are positive occurrences leading to an enhancement of the relationship between community members and the provider (Raph & Buehler).

Conversely, personally and professionally threatening encounters are negative perceptions of lack of anonymity. Personally threatening is when the provider feels like his/her personal life is being watched by community members. Professionally threatening is when the provider feels he/she has been put into a situation where he/she can potentially do harm (Raph & Buehler, 2006). This related to the rural nursing theory as a sense of always "being on duty."

Self-reliance

Self-reliance refers to the rural dwellers' ability to provide for their own needs, and includes a resistance to accepting help or services from those seen as outsiders. A corollary to help includes needed healthcare. Rural residents preferred treatment from someone they know over a new provider (Weinert & Long, 1987). Self-reliance includes self-confidence and self-competence. Self-confidence allows an individual to make decisions that are affected by changes in life circumstances. Self-competence is the ability to complete necessary daily tasks (Chafey, Sullivan, & Shannon, 1998). Self-reliance was deemed essential for the NP who had moved from an expert registered nurse to a novice NP. Registered nurses have established support systems

and develop confidence in their roles. Novice NPs, however, experienced anxiety related to their new autonomous role (Kelly & Mathews, 2001).

Insider/Outsider Concept

The insider/outsider concept addressed the time it takes for an individual to be accepted as part of the community. In quantitative terms, this is defined by, a) the number of years an individual has lived within a community, b) the number of years the person's family has lived in the area, and c) whether the individual owns property in the area (Weinert & Long, 1987). Insider/outsider also impacts the acceptance of the healthcare provider who is new to an area. It is important for the NP to be accepted by the community. Acceptance by the community offers an avenue through which the provider can begin to understand the rural community.

In summary, the transition from the RN culture to the NP culture (and from an urban to a rural culture) is affected by the four major concepts of the theory of cultural marginality (Choi, 2008) and by four of the six concepts of the rural nursing theory (Weinert & Long, 1987). Marginal living, the tension the individual experiences between the two different cultures, can be impacted in the rural setting by the NP's feeling of lack of anonymity. If the NP feels he/she is "being watched," he/she may be unable to exhibit aspects of his/her old culture. In order to transition to a new culture, the individual needs to be accepted into the new culture (Choi, 2008). This acceptance can be adversely affected if the community treats him/her as an outsider, leading the NP to experience anxiety, feelings of uncertainty, and apprehension about the future.

Across-culture conflict recognition is when the person begins to understand the differences between the two cultures. In order to understand their new culture, the individual must be accepted by the new culture (Choi, 2008). It is only through interaction with members of the community that an understanding of the new culture can be achieved. After encountering the

new culture, individuals may return to their previous culture as a result of resistance, obstacles, and conflicts. The ability to return to their previous culture or urban area can be affected by the isolation and distance of rural areas. The final step in this transition is the merging of the two cultures, the old and new. The transition is affected by contextual/personal influences, including the dominant society's openness and tolerance to outsiders (Choi, 2008). It is through the transition from the old to the new culture that the NP becomes confident in the new role, thus leading to self-reliance.

Summary

To summarize, successfully recruiting and retaining NPs to rural communities is important in increasing access to healthcare for rural residents. While recruiting and retaining physicians and PAs has been studied, little is known about this issue for NPs. Thus, a qualitative descriptive study is warranted to understand the factors related to recruiting and retaining NPs to a rural setting.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of this qualitative study is to explore, with a sample of rural NPs, the factors related to recruiting and retaining NPs in rural areas. Given the lack of literature on the topic, this study will contribute to understanding an NP's choice to practice and remain in rural areas. Results will inform the development of rural NP educational programs and federal agencies involved in recruiting and retaining NPs in rural areas. In seeking to understand this phenomenon, I addressed one research question: What factors are related to recruiting and retaining NPs to rural areas?

This chapter describes the study's research methodology, and includes discussions on the following areas: a) rationale for the study, b) study design, c) research sample, d) data collection and analysis, e) ethical considerations, f) issues of trustworthiness, and g) limitation of the study.

Rationale

Rural America is facing unequal access to healthcare due to changes in demographics and limited access to care as a result of a lack of primary care providers. One solution to increase primary care providers in rural areas is recruiting and retaining NPs. A better understanding of the factors related to recruiting and retaining NPs in rural areas justifies research in this area.

Successful recruitment and retention of NPs to rural communities is important in increasing access to healthcare for rural residents. While recruitment and retention of physicians and PAs has been studied, little is known about this issue in the case of NPs. Thus, a descriptive qualitative study is warranted to explore factors related to recruiting and retaining NPs to rural areas.

Design of Study

A descriptive qualitative research design was chosen to, a) explore the in-depth issues related to practice, b) assist with an understanding of phenomena, and c) answer questions related to rural practice. Insight into the attitudes of NPs working primarily in rural areas, their behaviors, and their lifestyles can be gained.

A qualitative study using a focused ethnographic approach was used to explore the cultural constructions of rural NP roles, based on the assumption that NPs experience transition to their role as rural NPs. As a result of the transition and due to the unique characteristics of rural areas, they develop a culture different from NPs who practice in an urban setting. This study focused on the common behaviors and beliefs related to participant experiences in rural NP roles. Because the research question under consideration concerns the values, beliefs, and practices of cultural groups, ethnography was an appropriate strategy.

Ethnographic research is used to understand and represent important cultural aspects of everyday life that have meaning for a group of people (Morse & Richards, 2002). This ethnographic study examines the cultural interpretation of rural NPs as they transition into their rural practice. A conceptual model, adapted from the theory of cultural marginality (Choi, 2008) and the rural nursing theory of Weinert and Long (1987), was developed. The conceptual model was based upon, a) a thorough literature review, b) the researcher's related experience c) the pilot study, d) previously conducted research, and e) the gaps in current literature. The conceptual framework was developed to provide a basis for data gathering and analysis.

Research Sample

Recruitment

Rural NPs were identified across the United States, using network sampling. Over 400 NHSC ambassadors and AHEC representatives were contacted to assist with recruiting because of their understanding and involvement with rural areas. Email addresses were obtained through the NHSC website. All NHSC ambassadors and AHEC representatives were sent a flyer (Appendix A) explaining the study and recruiting potential rural NPs to participate in the study. Shortly after contacting the NHSC ambassadors and AHEC representatives, I received responding emails from potential subjects. These NPs were then personally contacted by email by the researcher, describing the study and requesting their participation. Participants were chosen based, first, on their willingness to participate in the study and then on their geographic location to ensure a geographically dispersed sample according to the inclusion and exclusion criteria.

Data were collected from NPs based on the following inclusion criteria, a) NPs of all racial and ethnic origins, b) NPs practicing in rural America, c) NPs working as primary care providers in rural outpatient clinics, d) NPs working either part- or full-time as rural providers, e) NPs living within 50 miles from their practice location (allowing inclusion of NPs living in neighboring communities), and f) NPs who had been practicing for more than 18 months (due to required 6-24 month period required for transition to an autonomous NP).

Criteria for exclusion included NPs with, 1) limited Internet access, and 2) lack of private area for interviews.

Potential participants were mailed an informed consent form (including consent for video and audio recording) (Appendix B); a demographics questionnaire (Appendix C); and a web camera. A self-addressed stamped envelope was included for return of the signed informed

consent and demographics questionnaire. Once these items were received, I scheduled an electronic interview via the Internet using Elluminate™.

Sample

Over 100 potential rural NP participants were identified. Of these potential participants, 40 were sent an informed consent form including consent for video and audio recording, and a web camera. Of the 40 potential participants, 32 returned their signed consent forms, 29 returned their demographic questionnaires, and 24 were interviewed.

Data Collection

Data were collected in English, using video- and audio-tapes of electronic media interviews conducted through Web conferencing using Elluminate™, except two interviews which were conducted over the telephone.

Elluminate™ is an online media that offers both video and audio capabilities in real-time through different Internet connections, including DSL and dial-up (A. Mamangun, personal communication, September 11, 2009). Elluminate™ allows the researcher a private "suite" (electronic interview room) to conduct interviews. Once participants agree to an interview, they are invited into the suite by the researcher. Without an invitation, individuals are unable to enter the suite. Conversations are archived by Elluminate™. Purchasing Elluminatepublish™ allowed me to transfer recordings CD-ROM. After transferring the recordings to CD-ROM, I deleted the archived recordings to maintain subject confidentiality (Mamangun).

Electronic media offers advantages over face-to-face interviews. Respondents are more willing to talk freely and to disclose private information because they have a feeling of anonymity, privacy, and less social pressure. Additional advantages of electronic media interviews include, a) decreased costs, b) less travel, c) ability to reach geographically dispersed

respondents, and d) interviewer safety (Sturges & Hanrahan, 2004). The disadvantages of electronic media included, a) participants with limited computer skills, and b) faulty equipment, i.e., Internet connections, microphones, and web cameras.

Elluminate™ interviews were chosen over phone interviews because the researcher could view the research participants during the interview, thus allowing for, a) nonverbal data, b) contextual data, and c) verbal data. Nonverbal data, which contains cognitive and emotional content, was viewed and recorded via Elluminate™. Contextual data provides an understanding of the participant's attire or environment. Participant attire and a limited amount of their environment were observed with Elluminate™. Elluminate™ allow the participant and researcher to view each other, facilitating a comfortable environment and increasing verbal data.

To determine the factors related to recruiting and retaining NPs in rural areas, participants were acquired from various parts of the U.S. Elluminate™ interviews allowed for decreased costs and travel, while also offering the ability to reach NPs practicing in geographically dispersed areas. Elluminate™ interviews also allowed the participants to avoid questions from members of their communities about visits from an outsider. Interviews lasted from 15 minutes to an hour.

Interview questions (Appendix D) were derived from the research question, What are the factors related to recruiting and retaining NP in rural areas? Using a semi-structured interview, the participant was asked to " . . . tell me about being a NP in your current position." Prompts were also used to elicit data if necessary. The prompts included five questions:

1. What is it like being a provider in the community?
2. What keeps you in your current position?
3. How is your life impacted by being a NP in the community?

4. How is your personal, private life impacted?

5. Tell me about your transition to your current position?

All interviews ended with one final question, Is there anything you would like to share with me that I did not ask?

Data Analysis

Archived interview data were transcribed verbatim. Written transcripts of the archived interviews were examined using content analysis. First, directed content analysis focused on the following concepts from the theory of cultural marginality, a) marginal living, b) across-culture conflict recognition, c) easing cultural tension, and d) contextual/personal influences (Choi, 2008). Content analysis then focused on the four concepts of Weinert & Long's (1987) rural nursing theory, a) lack of anonymity, b) outsider vs. insider status, c) self-reliance, and d) isolation and distance.

Therefore, there was a total of 8 a priori categories used for the initial content analysis. However, the cultural marginality categories did not prove as useful as Weinert and Long's (1987) categories. At the conclusion of the content analysis, three concepts from the rural nursing theory were identified (Figure 6). Two of the three concepts were divided into subgroups. Lack of anonymity was divided into respect and annoyance. Outsider versus insider was defined not as being an insider in the rural community, but as an outsider in the medical community.

Following content analysis, the narrative text was analyzed for patterns (recurring regularities), using a line-by-line analysis throughout the data collection period. Relevant sentences and phrases were coded. Findings developed through content analysis, patterns, and then emerging themes. Patterns and early emerging themes were then discussed to identify

themes which identified NP transition to rural practice. These were a) personal adaptation, b) social adaptation, and c) professional adaptation. NPs' abilities to adapt in these three areas led to role success and gratification (Figure 6).

Data were collected through 24 interviews with data saturation (i.e., when new themes cease to emerge). After data collection and coding, members of the dissertation committee and other qualitative researchers provided feedback on categorization of data. Data were reviewed by committee members and qualitative researchers to, a) ensure accuracy, b) guarantee that all themes were identified, and c) add rigor to the study. Throughout the data analysis process, discussions of the data occurred with the dissertation committee members and other qualitative researchers to ensure that multiple researchers analyzed data in the same way.

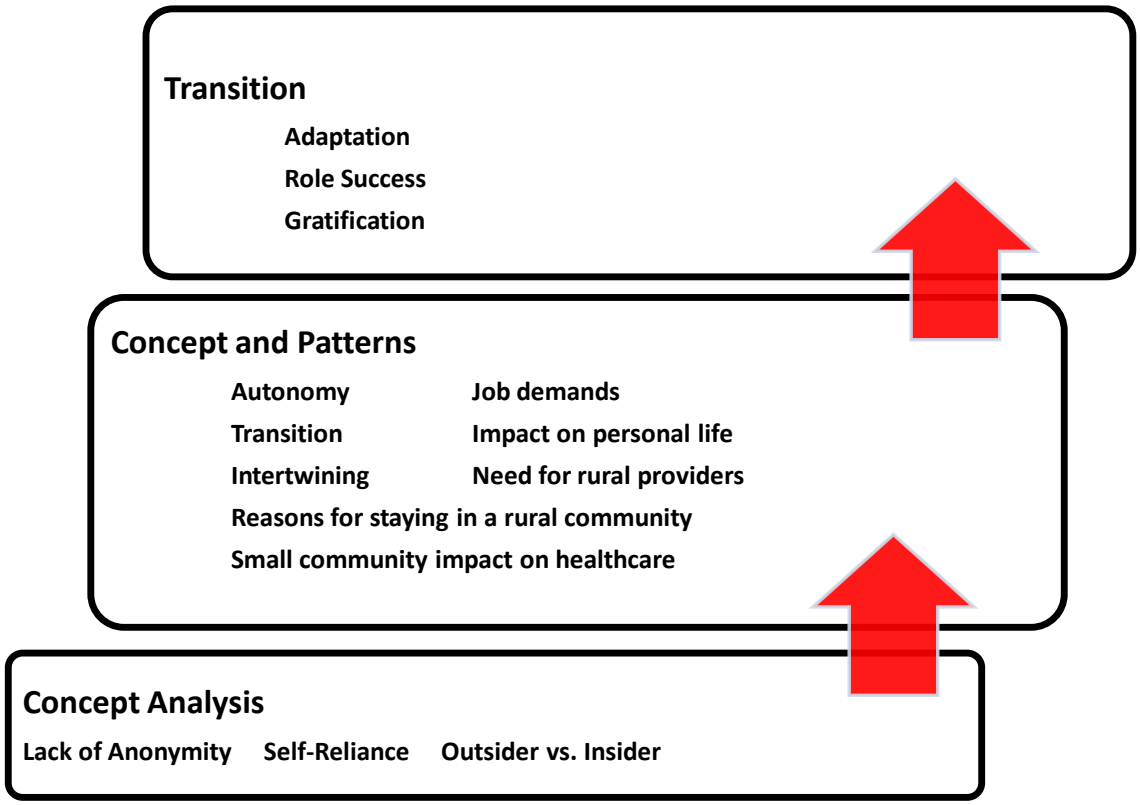

Figure 6. Data Analysis

Human Subjects Protection

Permission to conduct this study was obtained from the University of Texas at El Paso's Institutional Review Board prior to beginning the study (Appendix E). Confidentially was maintained throughout the study and after its completion. To avoid potential risks, interviews were conducted in a private Elluminate™ suite, with privacy and confidentially protected by limited access to Elluminate™. All audio and verbal data was archived on CD-ROM and kept in a locked cabinet in the researcher's locked office.

Names did not appear anywhere in the report or research, nor were they given to anyone. Anything that could be linked to a participant was excluded. Information obtained from interviews was reported in the aggregate to assure there was no way of linking NPs to a particular community.

All material obtained was used specifically for research purposes and was kept confidential. Data from human subjects included a) demographic information, b) archive recordings that captured audio and video data, c) CD-ROM recordings that captured audio and video data, and d) transcripts from audio tapes.

Issues of Trustworthiness

To ensure reliability and validity, the following aspects of trustworthiness, a) truth value or credibility, b) transferability, c) consistency and dependability, were incorporated into the study design (Cohen & Crabtree, 2006).

1. Truth value or credibility was achieved because of the time spent by the researcher in a rural area as an NP, which allowed for an understanding of rural culture and the culture of a rural NP.
2. Transferability of the results (a way of attaining external validity) was accomplished by ensuring the investigator's belief that everything was context-bound by using descriptive and context-relevant statements thus, ensuring the reader is able to identify with the setting.
3. Consistency and dependability were achieved by having other qualitative researchers examine the process and outcomes of the study. This allowed for evaluation of the accuracy and whether the findings, interpretations, and conclusions were supported by the data.

During the study, a trusting relationship with participants was established. Data were verified, ensuring, a) code reliability, b) identification of valid codes, and c) monitoring for data saturation.

Time was taken to understand all aspects of the study and ensure there was no loss in the study's credibility and rigor. Constant awareness of the study findings, asking questions before moving from one step to the next, and continuing to data saturation increased credibility and rigor. As the research was conducted, verification via a peer review was used to increase rigor. Audit trails were implemented to minimize bias and maximize accuracy, while increasing the rigor of fieldwork and confirming data collection (Patton, 2002). At the completion of data collection, findings were compared to previous studies. Assumptions were bracketed to avoid misinterpreting participant experiences (Burns & Grove, 1993). The researcher's personal experiences as a rural NP may lead to assumptions related to the study (Sandelowski, 1993b).

Limitations of the Study

This study contains limiting conditions, some related to common critiques of qualitative research methodology and some inherent to this study. One of the key limitations of this study is the issue of subjectivity and potential bias related to the researcher's past experiences working as a rural NP. Recognizing these limitations, coding schemes, coding documents, and transcripts were analyzed by committee members and other qualitative researchers. To reduce the limitation of potential bias during analysis, all participant names and practice sites were removed prior to coding interview transcripts.

A related limitation was the media used to conduct interviews. Few of the participants were familiar with on-line conferencing using Elluminate™. This led to two interviews being

conducted via telephone and three interviews being done without video data. Therefore, video data were not obtained for five interviews.

Summary

Interviews with 24 rural NPs were conducted, to explore the factors related to recruiting and retaining NPs in rural areas. Through constant comparison analysis, three concepts from Weinert and Long's (1987) rural nursing theory were revealed as pertinent to the rural NP: a) lack of autonomy, b) self-fulfillment, and c) outsider versus insider status. Deconstruction identified a) personal adaptation, b) social adaptation, and c) professional adaptation as qualities needed for role success and gratification.

CHAPTER 4

RESULTS

Introduction

The purpose of this qualitative study is to explore the factors related to recruiting and retaining NPs in rural areas. A better understanding of this phenomenon will contribute to understanding the NP's choice to practice and remain in a rural area. Results will inform NP educational programs and federal agencies involved in recruiting and retaining NPs in rural areas. In seeking to understand this phenomenon, the study addressed one research question: What factors are related to recruiting and retaining nurse practitioners to rural areas?

Description of Participants

Demographics were received from 29 NPs throughout the U.S (Table 2 and Appendix F). The majority of the NPs were 51-60 years of age (45%) and female (93%). They were from diverse racial/ethnic backgrounds: 83% White non-Hispanic, 14% Hispanic, and 3% Black/African American. The majority practiced previously in a rural area (65%) with many training in a rural setting (72%). Only six (21%) had an obligation to practice in a rural area with obligations to the NHSC (7%), their employers (3%), the local hospital (3%), or the state in which they reside (7%).

Results

Data were analyzed by constant comparison analysis which led to identifying categories and themes. Three of the six concepts from Weinert and Long's (1987) rural nursing theory, a) lack of anonymity, b) outsider versus insider, and c) self-reliance, were used as initial categories based on the pilot study. Categories and themes were then deconstructed. Patterns emerged revealing that NPs who had transitioned to rural practice experienced personal, social, and

Table 2

Demographics

Characteristic	N=29	Percentage
Age: 31-40	5	17
41-50	10	34
51-60	13	45
Over 61	1	3
Gender: Male	2	7
Female	27	93
Marital status: Married	24	83
Divorced	4	14
Widowed	1	3
Race/ethnic origin: White Hispanic	4	14
White Non-Hispanic	24	83
Black/African American	1	3
Number of children living with you: None	17	59
1	3	10
2	6	21
3	3	10
Years practicing as a nurse practitioner: Up to 5	11	38
8-10	9	31
12-15	8	27
Over 20	1	3
Practice location: Rural	19	65
Urban	7	24
Both	2	7
NP education included rural training: Yes	21	72
No	8	27
Obligation to practice in a rural area: Yes	6	21
No	23	79
Agency of obligation: NHSC	2	7
Employer	1	3
Hospital	1	3
State	2	7

professional adaptation, leading to role success and gratification.

Through content analysis, we discovered that nurse practitioners were affected by rural practice. Concepts from the rural nursing theory, a) lack of anonymity, b) outsider versus insider status, and c) self-reliance, were indentified through interviews with NPs in rural America.

Lack of Anonymity

Rural NPs experienced lack of anonymity which was seen as a burden. Some felt the burden of living in a small community, when patients approached them in public for healthcare. Several NPs had similar comments: "When it is a small town, people feel … a little bit more … more freedom … they call you on Saturday morning or call you Friday night at 10 o'clock and ask questions."

> I always send my husband to [get] the groceries, because I always get stuck in the vegetables department … between the vegetables and the fruit, and people ask me … "Oh I have this and this and this, look at this, my kid is sick, what should I do?" … It is all part of that community, you are one of the community, you … you cannot separate.

Others felt being in a small community offered them respect and security.

> So you know personally you feel very safe very secure, people are well aware of you, they watch out for you, it all kind of comes back to the respect, to the position that you have when they go to somebody, they kind of blend in to your day-to-day life … you have to want that, and I know some people that are very uncomfortable with that familiarity and kind of invasion of privacy … you kind of have to want to be part of the community.

Some established boundaries to maintain their anonymity, "I would give them the heads up and I will tell them that if I run into them in public, I won't act like I know them, and that allows them to keep their confidentiality."

Outsider versus Insider Status

Insider/outsider status addressed the time it took for an individual to be accepted as part of the community. Interestingly, these NPs were well accepted into the community; conversely, they were not accepted in the medical community. For example, one participant commented, "The welcome from the community was incredible, people offered all kinds of assistance and information … I felt very welcomed and never felt alone. Just immediately upon moving here, there was even a warm community welcome." Another subject shared, "I was diagnosed with cancer, unable to work for several months while I had treatment, and on my first day back to the clinic, patients started coming in to the waiting room without appointments. They were just there to welcome me back."

Lack of acceptance by the medical community included physicians and hospital administration. One NP commented, "I worked with a whole lot of physicians as a nurse for a lot of years with a lot of mutual respect, and then when I became a nurse practitioner, they wouldn't speak to me anymore." Another said, "The hospital where I work as an RN does not accept nurse practitioners very well, so there is a lot of fighting trying to get things done through the hospital that I need to get done."

Self-fulfillment

Self-fulfillment was achieved in both personal and professional aspects of the NP's life. Self-fulfillment was achieved personally by being available to their families. "I can see my daughter off to school in the morning, you know, make breakfast, send her off, and then go to work, and then I can be home in the evenings and not get home quite as late." Self-fulfillment was more prevalent in the subjects' professional lives as they transitioned into their NP roles. "Every day I learn something new … we receive patients from A to Z and with that comes an incredible fulfillment of what we are supposed to do, so it is hard, you know, people ask me

about being a nurse practitioner, and I say it is very fulfilling and we use every skill that we have."

> As a single provider practice, I'm there alone ... having a clinic full of patients while we manage an emergency situation. ... Those are the challenges, they are kind of fun and exciting challenges and it is very nice to be able to know that you can rise to those occasions and be well prepared for them.

Transition

Theme analysis and deconstruction revealed a model of NPs' transition to rural practice. Through personal, social, and professional adaptations, these NPs achieved role success and thus gratification (Figure 7). The NPs interviewed adapted to a rural practice in three different ways: a) personal, b) social, and c) professional.

Personal Adaptation. Some separated their personal and professional lives. Conversely, others adapted by blending their personal and professional lives. They were receptive to patients requesting medical advice outside the clinic.

> There's a lot of curbside consults, you know, people coming over to you in the small local grocery story and say, you know, "What do you think about this?" Wanting medical advice when they see me in public, or calling me at home. I even had a patient show up in my front door, and so I think that there is a little bit of an invasion of privacy.

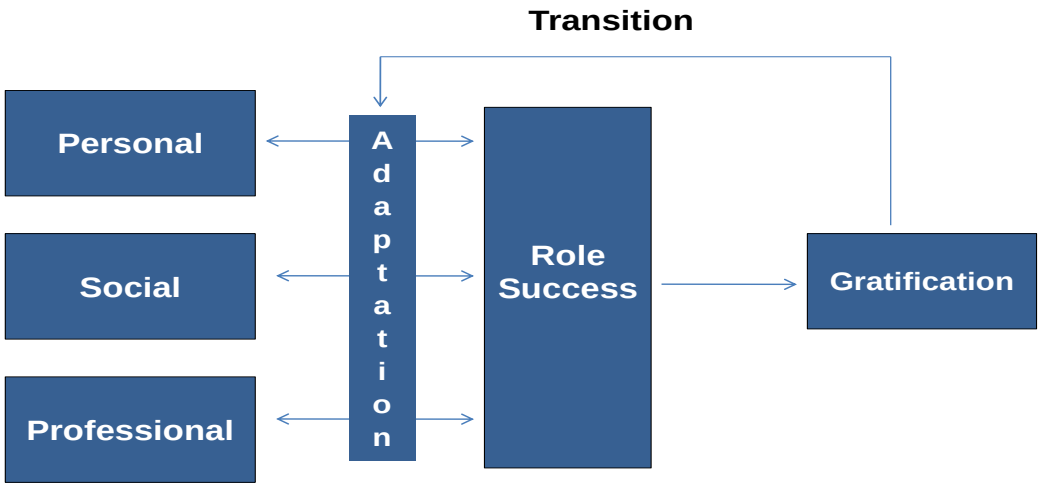

Figure 7. Transitional model.

Some adapted treatment modalities used to treat patients due to an understanding of rural community members. One NP stated, "I have a little bit more compassion for people in the situation that the people are in when they are having lost of jobs and they can't afford to take care of their diabetes or their high blood pressure or take care of their children's illnesses."

NPs adjusted not only to their patients' medical treatments, but also to their families' medical treatment. They discussed the impact being in a rural area had on ill family members, which meant they often had to care for their own children or seek long-distance care for a family member. One participant shared her thoughts, "It makes it a little bit easier … when my daughter has an illness, we don't have to stop and take her out from school and make an appointment for a nurse practitioner or a doctor. I can take care of her a little bit myself." And one woman whose

husband was chronically ill stated, “To get … him health care, it is about an hour and a half away from me, because he requires a certain type of care that we couldn’t get here.”

Social Adaptation. NPs were socially impacted by life in a rural community in three ways:

1. they adapted to and accepted a connection to the community;
2. they separated themselves from social situations; and
3. they became part of the community.

Some felt comfortable having connections with the community: “I know a lot of my patients outside of the clinic, or I know their families, or I know their friends … There’s a lot of connections that happen based on that.” Others expressed enjoyed having a connection with the community.

> My favorite thing about the rural practice is the connection with the community … you watch children grow up, you saw people you know get married and have babies, you would do their health care from birth and on forward, you have parents that went into the hospital that you cared for, it is just a tremendous knowledge of the community around you, especially when you are in an isolated area, that I don’t think you quite get in even slightly larger communities. You know, the community, you are part of the community.

However, establishing relationships with community members can be difficult. “The difficulty is seeing them in the community or having to deal with them in the community, you have a lot of guidelines for dual relationships that basically go out the window because when you are in a small community; it is very difficult.”

Due to difficulties with dual relationships, others separated themselves from social situations. “I would like to go to yoga with somebody or ask somebody to the movies or something, but I can’t, they are my patients.”

The NPs who accepted being part of the community felt embraced by community members.

> The welcome from the community was incredible, people offered all kinds of assistance and information and, you know, I felt very welcomed, and never felt alone. Just immediately upon moving here, there was even a warm community welcome. They would get together just to say hello and, again, I have never experienced that in larger practices.

One community supported the NP when she was ill.

> I was chronically ill in the last year and a half, and I bring that up only because of the response that I received from my patients was overwhelming. I was … unable to work for several months … and on my first day back to the clinic, patients started coming into the waiting room without appointments. They were just there to welcome me back. And I just, wow! You know? It was an amazing experience.

Professional Adaptation. The NPs adapted their practice to provide patient care and treatment modalities due to limited medical equipment and distance from urban areas. Patient care is "a little bit more difficult in a rural area because you don't have the equipment of hospitals … and your patients even have to travel sometimes to receive specialty care." When the patients did travel to the nearest hospital, the NP was unable to receive the patient's diagnostic results: "We miss out on opportunities with communication, for example, in the … age of digital radiology, if I send a patient into the nearest hospital for chest x-ray, I'm not going to see the results right away."

Rural community members had difficulty obtaining emergency services, and this impacts the NPs.

> It is so difficult to get services that people need, we are only equipped to do so much, and we are not an emergency room. I can do a type of emergency care along with splinting and suturing, that kind of thing, but then I'm dependent on emergency transportation getting to us quickly if I need to transfer someone.

These limitations caused these NPs to practice to their full scope of practice, since they "are usually the first stopping place for people that are experiencing emergencies, so you [the NP] are

kind of thrown into probably a larger scope from what we originally thought we would have just because we don't have the resources."

They found being a member of the community gave them an understanding of their patients:

> It is an added benefit … I have clients that come into the office and they are really miserable and everything is horrible, but I'll see them out in the community frequently laughing and having fun and interacting with people, so you do get to see that feedback that you might not get otherwise.

This improved understanding of the patients, both clinically and socially, assisted the NPs in the patient's treatment.

> Knowing patients, knowing people … not just from a clinical standpoint or from a clinical setting, but for other settings as well, and I think that is a big important thing, so you kind of know not just who people are but where they are coming from … you already kind of have some idea about what they … need to have done … to afford medication, what might be barriers to them being able to do what they need to do, so that can be a positive.

Familiarity with the community initiated treating patients outside the clinic, in "clinics without walls."

> I did more nursing on the boardwalk, in the homes, than every day at the clinic … the boardwalk was the main artery for the entire community, and so when I sat down at the post office with my blood pressure cuff, I saw everyone! They didn't want to come into the clinic, they felt a threat. When I did my protocol on the boardwalk routes, we found out a lot about the community … those boardwalks continue today because they are very therapeutic, but you are part of the community … when you go to the basketball game, you are the first one that, you know, you are the one that comes in with the sprain ankle on the floor, it becomes an extension of you.

Living in a small community as a healthcare provider tended to impact patient confidentiality. "I am not quite sure whether to acknowledge people when I'm out eating lunch, do they want me to say hi or do they don't want me to say hi, so I am very conscious about people's privacy." One NP stated he found it difficult to remember where he had heard confidential patient information. "It is hard to separate when I hear information, if I hear it in the

clinic behind closed doors or in public. What I heard in public is free to discuss, but what I hear in the clinic is confidential. Sometimes it is hard to remember."

Gratification

Through personal, social, and professional adaptation, the NPs felt successful in their roles, and this led to gratification. They were happy to be practicing in areas where they grew up. "I was born and raised here in this particular community, I lived in my grandmother's house, actually it is kind of unique because I really have the opportunity to live in our community of origin." Many of the NPs felt a connection to the community: "I have always felt that I belong to the rural community and that I was part of the rural community." And, "I love it. I'm glad to be here and … I expect to be here mostly because this is where our family is." "I grew up in a small town in the rural area myself, I have a connection there, I guess, with the people that work in the rural area, and … I just like when people work very hard for what they get." "There really wouldn't be that much that would be able to drag me away from rural health. I think because of a combination of … things, my family … the type of practice. … I like family, communities and that sort of thing."

Along with being near their families, they stayed because of a "real sense of responsibility." Remaining in rural areas " … because of the patients, because of the people of the rural community, the farmers, the farm workers, the migrants, the farm workers and their families, those are the reasons why I stay."

The NPs felt they had a social responsibility to provide healthcare to the rural community: "If I'm not here, nobody is here, there wasn't a clinic here before." Some of them established their own clinics to benefit the residents of the community. One stated she

determined a need for healthcare services for the uninsured when a 16-year old Mexican girl came into the clinic with an 8-year old in her arms that had a syndrome.

> She had no insurance and from what I had noticed, she needed a prescription for the child until she could get to the specialty care that would keep her going for another week or so. But anyway, the physician that I was working with said, "We are not going to take care of her, she doesn't have any insurance." And I said, "Well, where would she go?" "Well, someplace where they take people without insurance." And I go, "But where would that be?" And he said, "I don't know, that is her problem," and it dropped there.

Some were driven by the need to care for rural residents: "It was almost a religious mission that somebody has to be here to take care of these people." Others had a vision of a new way to offer healthcare:

> We had this dream of this wellness center, where we could have this huge room for group therapy, yoga, athletic, kitchen, so we can teach mothers' nutrition facts … health education trying to bring ... a dental clinic, dental hygiene, antibiotics, extractions, and dental flossing … applying for grants to assist in their dream, we put in for seven million dollars in a grant.

One spoke of the need to educate the community:

> It took a lot of education … we started putting in these ads in the newspaper about what a nurse practitioner can do, and every week we had a, "Did you know that nurse practitioners can prescribe medicine?" … Then the next week, it was, "Did you know that a nurse practitioner …," and then the next week, "Did you know …" We had this did-you-know column for almost a year to try to make people to understand.

The desire to help others caused financial problems for some NPs. "I am barely making my overhead and I'm still not paying myself a salary after a year and a half, and so I still need to have outside employment, I'm still working two days a week." However, despite financial loss, the NPs were committed to making a difference. "I try to make my office visits as absolute reasonable as possible … I even make payment arrangements with patients so that they can pay for their well-woman exam over a period of months … because I strongly believe in … getting people and getting them seen."

NPs experienced professional gratification by spending time with their patients, by being involved in all aspects of patient care, by feeling needed, and by having autonomy in their practice.

> I'm able to really spend that time with my patients and get to know them very well, and offer them a lot of education, support, and counseling, so I feel that at the end of the visit that we have really covered all the important issues, their healthcare needs, family history, profile … I'm not pushed to see many patients in one day … I get to spend a little more with my patients and get to know them a little bit better.

Being able to be involved in all aspects of their patients' healthcare was challenging and rewarding for the NPs.

> I think it offers a lot … to nurse practitioners, especially if they want to be involved in all the aspects for patient care and not just a narrow range … it offers a lot of opportunities, it is growing and learning, and I've never seen that before, and I might never see it again, but I'm going to deal with it today and learn from it, and it is challenging and stimulating. I would be bored probably anywhere else.

All the participants felt knowing the patients not "just from a clinical standpoint or from a clinical setting, but from other settings as well" was important. "You kind of know not just who people are but where they are coming from, what they need to have done, you know, to afford medication, what might be barriers to them being able to do what they need to do, so that can be a positive."

With rural practice, NPs were able to work independently.

> It is fabulous, independent, every day I learn something new. I've dreamed of doing this, like I said, 30 years ago … we as nurse practitioners out here are the frontline, we receive patients from A to Z, and with that comes an incredible fulfillment of what we are supposed to do, so it is hard, you know, people ask me about being a nurse practitioner, and I say it is very fulfilling and we use every skill that we have.

Another NP also spoke about using her skills:

> I'm in the clinic, and I'm there alone. … there is a challenge with that as well in … managing an emergency situation, we are having a clinic full of patients while we manage an emergency situation. But so those are the challenges, they are kind of fun and

> exciting challenges, and it is very nice to be able to know that you can rise to those occasions and be well prepared for them.

NPs stated that they chose to stay in a rural area because they enjoyed their autonomy. "I really like the autonomy that I have, I like that feeling of relying on myself, knowing that I can rely on my education, my experience, my preparation, to provide good quality care." And, "I'm autonomous, I do what I please, you know, within the scope of practice, I don't have somebody like that doctor telling me that I cannot treat this person."

They were able to have a flexible schedule, oftentimes setting their own hours, which gave them time to care for their family.

In addition to a flexible schedule, many had a good income.

> I don't want to be, you know, extravagant in this response, but I do charge a lot of money, and I have been able to create an incredible schedule, and so I cluster my time so I may work 3 days in a row and have 10 days off, which is really nice and … the love of my life is working in the emergency room, and that is my greatest challenge right now as for someone who has been doing this for 30 years and being an emergency room nurse, you know, that's the life force, that is what feeds me professionally.

Summary

This chapter presented the results from 24 interviews with rural NPs throughout the U.S. Data from individual interviews revealed participants' perceptions of working in rural areas. The primary interview findings relating to recruitment and retention of NPs in rural areas identified development and maturity in these rural NPs as they experienced personal, social, and professional adaptation leading to role success and gratification.

CHAPTER 5

DISCUSSION

Introduction

The purpose of this qualitative study is to explore factors related to recruiting and retaining nurse practitioners in rural areas. An understanding of the perceptions gained by rural NPs through their individual experiences can assist in recruiting and retaining nurse practitioners to rural America. The question under study is: What factors are related to recruiting and retaining nurse practitioners to rural areas? This chapter presents a discussion of the data collection from semi-structured interviews.

Discussion

Prior to this study, a conceptual model was developed utilizing the most current literature. The model was adapted from the theory of cultural marginality and four of the six concepts of Weinert and Long's (1987) rural nursing theory (Figure 4). The model addressed the transition to rural NP practice. The results of this study demonstrate how NPs transitioned into their roles as rural NPs; however, the findings were primarily an expansion of the original model (Figure 8). NPs transitioned to their roles as rural providers through personal, social, and professional adaptation. Through these adaptations, the NPs became successful in their roles. With role success, the NPs experienced personal, social, and professional gratification.

Rural Nursing Theory

In the original conceptual model for this study, four of the six concepts from the rural nursing theory were thought to affect the transition to the role of a rural NP. This study identified three concepts of the rural nursing theory as pertinent, a) lack of anonymity, b) outsider versus

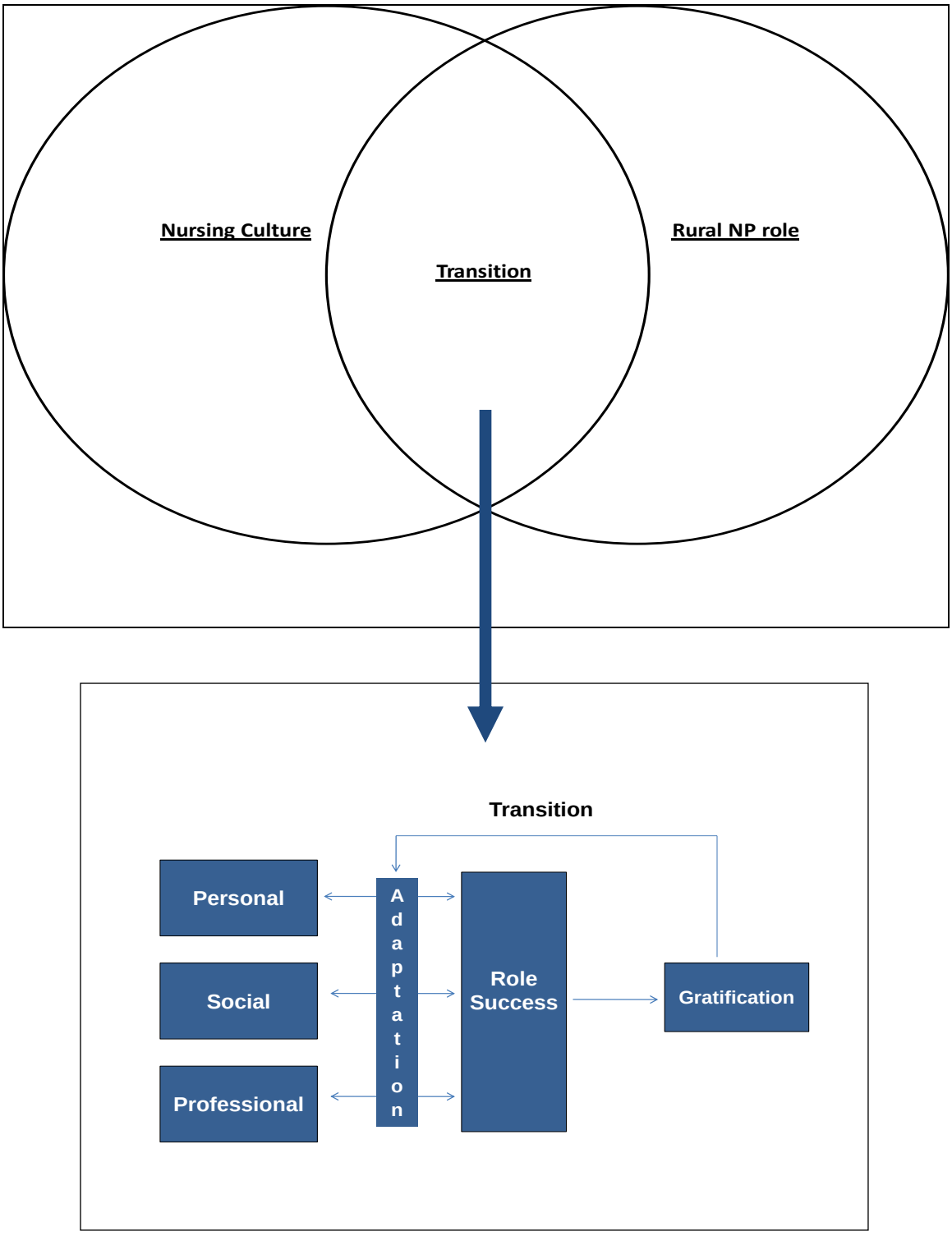

Figure 8. Revision of Transition from Original Conceptual Model.

insider status, and c) self-reliance. However, they were demonstrated differently, representing a growth in maturity in the role played by rural NPs.

Lack of anonymity. Lack of anonymity is defined by Lee (1988) as "taking care of clients who are known through associations other than the nurse/client relationship" (p. 76). According to Raph and Buehler (2006), lack of anonymity is common in rural communities, where community members have a lack of privacy at both the personal and professional level. In the past, NPs found lack of anonymity to be an annoyance (Raph & Buehler). In this study, the NPs did not find lack of anonymity to be an annoyance, but viewed it as part of being an effective healthcare provider. By immersing and assimilating themselves in the rural community, they became comfortable with rural life (Scharff, 2006).

Outsider versus Insider Status. This research shows that NPs are well accepted by rural community members. Making connections within the community is one way that NPs gain community acceptance and become trusted community members (Conger & Plager, 2008). Previous studies also found NPs were well accepted into rural communities. The perception of the NP as an insider or an outsider seems to have had little effect on their acceptance by the community members (Findholt, 2006).

However, these NPs were not always welcomed by the existing medical community. Previous studies found that rural physicians sometimes were resistant to the presence of NPs (Lawler & Valand, 1988; Lindeke, Bly, and Wilcox, 2001). The study conducted by Lindeke, Bly, and Wilcox examined the perceived barriers to rural NP practice. They determined lack of public knowledge of the NP role and resistance from physicians as barriers to rural NPs.

Previous studies concurred with this study's findings that NPs have difficulty gaining acceptance from physicians and hospital administrators (Lindeke, Grabau, & Jukkala, 2004). In

Lindeke et al.'s study, they concluded that NPs experienced barriers to rural practice due to a lack of understanding by healthcare professionals and administrators.

Lack of acceptance by the medical community can lead to a feeling of being disconnected from other providers. Conger and Plager (2008) listed various elements which led to rural connectedness, including, a) the development of support networks, b) relationships with healthcare centers, and c) connections with local communities. It was important for NPs in this study to develop support networks, that came from a) other healthcare providers in their community, from b) providers in urban settings, and from c) previous colleagues.

Self-reliance. Hanson, Jenkins, and Ryan (1990) stated that NPs demonstrate self-reliance by demonstrating autonomy, and that autonomous practice stimulates personal and professional growth of the NPs. The NPs in this study are able to function alone and make independent decisions related to patient healthcare and their clinical practice.

Transitional Factors

The NPs interviewed transitioned to their role as rural providers through personal, social, and professional adaptation. Through adaptation, they achieve role success leading to gratification. By taking personal actions, they adapted to a rural community; some learn to separate their personal and professional lives by setting boundaries, others learn to blend personal and professional lives by becoming a part of the community

The NPs raised in rural areas adapted to a rural practice due to their understanding of rural society. They enjoy being able to return to their community of origin and take pleasure in living near their families and friends. They believe it is their social responsibility to care for rural residents and to provide healthcare to rural communities.

The NPs who are comfortable establishing connections with the residents become part of the community. As community members, they adapt to the social climate of the community, eventually recognizing and appreciating the residents' lifestyles, living situations, and beliefs. With this understanding, they provided holistic patient care. Through modifications in patient treatment modalities, they successfully treat patients regardless of their insurance or financial status, lifestyles, or beliefs.

Familiarity with community members can lead to dual relationships. Dual relationships can encompass both positive and negative effects. In this study, some NPs feel it is good to know about their patients as it guides them in how to approach and care for them. Previous studies examining the effects of the doctor/patient relationship have determined the frequency of patient visits increases the physician's understanding of the patient and his/her social situation (Stewart, 1979). A close patient/provider relationship contributes to patient satisfaction and healthcare compliance (Stewart).

Due to distances from urban areas, rural NPs may be the only healthcare provider available. Being the only provider leads to autonomous practice. Role autonomy is an important factor for these NPs who choose to remain in a rural community. Role autonomy has been identified for decades as being important in role satisfaction and a key reason for selecting and remaining in a practice site (Lawler & Valand, 1988).

It is through adaptation, role success, and gratification that NPs in this study made the transition to rural practice. For some NPs, this transition is easier because they grew up or were trained in a rural area. With previous exposure to the distinctive aspects of a rural community, the NP can transition to rural practice.

Dual Relationships

Multiple relationships in rural practice are inevitable due to: (a) the limited number of rural practitioners, (b) limited access to healthcare, (c) characteristics of rural communities, and (d) characteristics of the nurse practitioner. “Such relationships are almost impossible to avoid when there is no choice but to shop at the client’s store or when one’s children are in school with and even friends with the client’s children (Brownlee, 1996, p. 499).

The interdependent relationships existing among rural community members create multiple relationships (Brownlee, 1996). Rural residents are privy to a lot of information about other members of their community. Local businesses are not just places to purchase goods and receive services; they are also places where one hears about what is new in the community (Campbell & Gordon, 2003).

Avoiding dual relationships is unrealistic for a rural provider. “The rural provider often possesses an intimate knowledge of extended members of families and their interconnection with other families, family reputations, patient’s places of work, the cars they drive, their places of worship, interest, and their vices” (Coyle 1999, p. 202). This is especially true for the many primary care providers who manage both physical and mental illnesses. There has been an increase in the number of patients who have received treatment for depression from their primary care provider (Olfson, Marcus, Druss, Elinsin, Tanielian, & Pincus, 2002).

Maintaining dual relationships with patients contradicts the views of many mental health professionals. To impede dual relationships, these professionals established some professional boundaries, feeling that this would promote trust with patients and provide a structure for therapeutic work (Simon & Williams, 1999). Treatment boundaries include: a) patient

separateness, b) confidentiality, c) prohibiting personal relationships with patients, d) therapist anonymity, and e) self-disclosure (Simon & Williams).

Dual relationships faced by mental health providers in rural areas also affected the NPs interviewed. Multiple relationships in rural communities are almost certainly a result of the needs and characteristics of both provider and community. In this relationship, the NPs gained community acceptance and become trusted community members. It is important, of course, that these NPs maintain multiple relationships and community involvement to decrease distrust and to increase approachability (Schank & Skovholt, 1997). Disengagement from the community by the provider may lead to a sense of rejection, lack of trust, and produce a less than productive clinical environment (Nelson, Pomerantz, Howard, & Bushy (2006).

Practicing in a rural area generally means living and working in the community and being a "part of the community," a situation which creates both benefits and problems with patient care. Confidentiality can be a problem in a small community. One of the NPs interviewed stated she was reluctant to enter potentially stigmatizing comments in a chart because the patient's relative or friend may be a member of the healthcare team. Therefore, for example, she may choose to "diagnose" a patient with irritability when it is actually a more serious psychiatric illness, knowing her notation will be in the patient's medical record for other members of the healthcare team to see. Confidentiality can also be a problem when friends and acquaintances of the patients are in the waiting room (Nelson et al., 2006).

Social Entrepreneurship

NPs often become social entrepreneurs when they establish rural clinics to care for the underserved rural populations. Social entrepreneurship differs from commercial entrepreneurship. Commercial entrepreneurship focuses primarily on economic returns, while social entrepreneurship focuses on social returns (Austin, Stevenson, & Wei-Skillern, 2006). Many social entrepreneurs possess qualities and behaviors associated with the business entrepreneur, but they operate in the community and are more concerned with caring and helping than with "making money" (Thompson, 2002). The social entrepreneur targets underserved, neglected, or highly disadvantaged populations who lack financial means or political clout (Martin & Osberg, 2007). The social element of social entrepreneurship, while based on ethical motives and moral responsibility, can also include personal fulfillment.

There are differing definitions for social entrepreneurship. One group defines social entrepreneurship as not-for-profit initiatives in search of alternative funding strategies. A second group refers to it as a socially responsible practice of commercial businesses. A third group understands social entrepreneurship to be a means to alleviating social problems and to initiating social reform (Mair & Marti, 2006).

Social entrepreneurs and their endeavors are driven by social goals, a desire to benefit society with an aim to increasing the social value and wellbeing of a community (Peredo & McLean, 2006). The NPs in this study have a desire to offer healthcare to rural residents despite the patient's inability to pay for healthcare services. They offer healthcare to a population who otherwise would go untreated.

Social entrepreneurs listen to the voice of the community. They identify a need and then have the ability to picture a solution to the problem. Once they have developed a solution, they

secure the necessary resources needed to enact their plan. They will overcome obstacles to establish their venture (Thompson, 2002). NPs in this study identified the problem of limited access to healthcare for rural underserved residents. They have established clinics to offer healthcare to the uninsured who were denied care from other providers due to an inability to pay. Many offered this support at their own sacrifice, stating that, even after being in practice for over a year; they were unable to provide themselves an income and were working additional jobs or being supported by family members.

Due to limited financial resources, social entrepreneurs (including NPs) spend a significant portion of their time cobbling together numerous grants to meet day-to-day operating expenses (Austin, Stevenson, & Wei-Skillern, 2006). To assist in the funding to establish their clinics, the NPs interviewed applied for grants and federal funding.

Implications for Nurse Practitioner

Education Programs

While some have argued about what features cause rural practice to be unique, others suggest rural practice should be considered a specialty practice (Bushy & Leipert, 2005). Interviews with rural NPs throughout the U.S. have shown the differences between urban and rural practice. Due to these differences, it is imperative that NP students be given an appreciation for the uniqueness and benefits of working in a rural setting (Yonge, 2007). Rural nursing requires additional skills and modifications, and NP students need to develop the skills necessary to care for individuals in the rural context, including a) limited access to healthcare, b) fewer resources, and c) distance to specialties. Students can learn about the uniqueness of rural areas through changes in didactic and clinical components of NP education programs. Including rural theory and practice perspectives, inviting rural practitioners as guest lectures, and exposing

students to rural areas through clinical placement could increase student familiarity with and confidence to work in a rural setting (Yonge, 2007). Through an understanding of rural characteristics, NPs will be prepared to practice in rural areas and will be encouraged to choose a rural position after graduation.

According to Edwards, Smith, Courtney, Finlayson, and Chapman (2004) and Smith, Edwards, Courtney, and Finlayson (2001), the students who choose rural clinical placement shared common characteristics, a) a rural background, b) the number of years they previously lived in a rural community, c) previous employment in a rural community, and d) financial and family considerations.

Previous research has shown that having a rural background was positively associated with future employment in a rural community. Along with a rural background, the number of years an individual previously lived and worked in a rural community impact their decision to accept a clinical placement in a rural community. Finally, financial and family considerations influence clinical placement. Students who needed to work while completing their education often chose a clinical placement near their place of employment. While this was often in an urban area, others chose rural settings to be near family.

Edwards et al. (2004) also observed that rural clinical placement improved the clinical skills needed for rural practice because it offered students with no previous rural experience an appreciation of the rural practice environment, as well as an introduction to available practice sites. Additionally, rural placement helped students to gain the necessary knowledge to be effective rural providers.

An understanding of rural communities can also be provided by student mentors who ensure that students are part of both the social community and the professional community.

Mills, Francis, and Bonner (2005) defined the difference between mentoring and preceptoring, stating that mentoring included exposing the student to knowledge outside the immediate work area. This is important in rural areas, as knowledge related to the distinctive factors of rural areas gives the student an understanding that rural practice extends past the clinic walls. Rural providers need to have an understanding of public health, health development, and community development.

Links between rural roots established during childhood and a desire to practice in a rural location reinforce the need to recruit NP students from rural areas. Increased access to educational programs can minimize the student's commute from remote areas (long-distance, computer classes) and offer opportunities for professional advancement (Kippenbrook, Stacy, & Gilbert-Palmer, 2004). Through the use of current technology, students can remain in rural settings and care for rural residents while taking courses toward NP practice.

Implications for Government Agencies

NHSC

The NHSC is actively involved in recruiting nurse practitioners to rural practice, and offer tuition assistance for NP students. NHSC offers a variety of programs to NPs who are willing to practice in a rural community. They offer scholarships that pay for tuition, fees, and books, as well as a monthly stipend for living expenses. In exchange for this financial support, the student commits to practice in a rural community for a length of time. The NHSC also offers a loan repayment plan, which assumes educational loans in exchange for a commitment to practice in a rural area. The difference between the two plans is that with the loan repayment program, the students choose where they want to practice and then apply for funding.

The NHSC recently reinstated the Student Experiences and Rotations in Community Health (SEARCH) program. The SEARCH program assists students in rural areas during part of their formal education. This assistance includes financial support for the expenses they occur. This is a wonderful opportunity for students to become familiar with the unique aspects of a rural community. Often, students are offered a position at the clinical site where they completed their SEARCH. By reinstating the SEARCH program, the NHSC expressed its commitment to recruit healthcare providers to the rural areas. Previous research has demonstrated that individuals from a rural area (or trained in a rural area) are more apt to return to a rural area to practice (Bushy & Leipert, 2005). Thus, it is imperative that programs be initiated to support these research findings.

AHECs

Nurse practitioners who accept positions in rural settings most often have a rural background, have participated in a rural training program, or have a desire to serve a rural community. Numerous NPs return to their community of origin after completing their education. This reinforces the need for community outreach programs, such as AHEC, to recruit NPs from rural areas. Students entering NP programs with an understanding of rural areas and the health needs of their community are more likely to return to their hometown. Thus, through the help of AHECs, rural areas can grow their own healthcare providers from rural residents that have an understanding and commitment to rural communities and rural community members.

Recruitment

The results of this study are congruent with previous studies concerning the recruiting of NPs to rural areas. Prominent reasons for accepting a position in a rural setting include, a) a rural background, b) participation in a rural training program, and c) a desire to serve rural community needs.

Many of the NPs interviewed for this study spoke of their excitement in returning to their community of origin. This reinforces the need for community outreach programs to recruit NPs from rural areas such as AHEC. Students who enter NP programs with an understanding of rural areas and the health needs of their community are more likely to return to their hometown. Completion of a rural practicum has also been associated with accepting a position in a rural practice. In this study, 72% of the NPs completed at least one practicum in a rural setting. This finding supports the importance of rural training as an effective strategy in recruiting NPs to rural areas.

Retention

The results of this study are comparable with previous studies (Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hart, Salsberg, Phillips, & Lishner, 2002). NPs remained in rural settings due to, a) a desire to serve the community's health needs, b) a financial aid obligation, and c) a desire to return to their hometown.

Most of the NPs in this study grew up in rural settings, returning to their hometown community to offer healthcare to individuals they knew. Familiarity with the community afforded them the opportunity to become a part of the community. Through an understanding of the community, they easily adapted to the unique aspects of a rural setting; this ease of adaptation was a factor leading to role success. Role success fosters gratification. The NPs found

gratification in hometown practice and in providing care for rural patients who might otherwise not receive healthcare. They enjoyed spending time with their patients, both in a clinical setting and in the community's social life, adding to their understanding of all aspects of their patients' lives. Through an understanding of their patients, they were able to offer holistic healthcare. These findings are congruent with a study conducted by Sullivan, who determined that the rewards of a job and a high level of job satisfaction led to retention (1978).

Recommendations

1. This qualitative study identified the adaptation of NPs as they transitioned to their roles as rural NPs. Future research should be conducted via survey to determine if these findings can be generalized to the rural NP population.

2. Most NPs who choose rural practice are either from a rural area or have completed a least one clinical practicum in a rural setting. It is understandable that NPs from rural areas will adapt to a rural practice due to previous rural experience. However, does completing a clinical rotation in a rural area offer enough information on rural life for the NP to transition to rural practice? Or is it the underlying personality of the individual that makes them succeed as a rural provider? I recommend a study be conducted utilizing the Myers-Briggs Type Indicator to determine if there is a difference in the personalities of NPs who choose rural practice versus urban practice.

3. Finally, research needs to be conducted into the effects of adding rural didactic and clinical content to NP curriculum. To assist with curriculum changes and the research cost, NP educational programs can apply for program grants.

Summary

This chapter offered discussion related to the findings from interviews with 29 rural NPs throughout the U.S. The transition of NPs to their role as rural providers was explored, including the functions of dual relationships and social entrepreneurship. Implications for NP education programs and government agencies to assist in recruitment and retention were presented, and recommendations for future research were presented.

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APPENDICES

APPENDIX A

FLYER - FACTORS RELATED TO THE RECUITMENT AND RETENTION OF NURSE PRACTITIONERS IN RURAL AREAS

RURAL NURSE PRACTITIONERS NEEDED FOR INTERVIEWS

DISSERTATION RESEARCH: FACTORS RELATED TO THE RECRUITMENT AND RETENTION OF NURSE PRACTITIONERS IN RURAL AREAS

Dayle Sharp, RN, FNP-bc, PhDc
Director of the Family Nurse Practitioner Concentration at the University of Texas at El Paso
NHSC Ambassador

For the past several decades, rural America has experienced significant health disparities. Changes in the demographics of rural America have led to a large number of individuals out of work due to the shifting of industries leading to a large number of unemployed or underemployed residents who are uninsured or underinsured.

Parallel to the changes in demographics there are a limited amount of primary care providers in rural areas. Consequently, rural America is facing reduced and unequal access to healthcare. A possible solution is to increase the number of nurse practitioners in rural areas. Nurse practitioners currently offer effective primary care, however only 40% practice in rural settings. Thus, the recruitment and retention of nurse practitioners in rural America will help to decrease rural health disparities.

If you are interested please contact:
Dayle Sharp at dbsharp@utep.edu

I am conducting a study to explore factors related to the transition of nurse practitioners to rural areas. An understanding of the transition rural NPs experience will assist in the recruitment and retention of nurse practitioners to rural areas. Results from this study will enhance the understanding of factors related to nurse practitioners accepting and remaining in positions in rural America.

I invite you to participate in this important study to help identify interventions which can be utilized to increase access to health care for rural Americans.

APPENDIX B

INFORMED CONSENT FORM

APPENDIX B

INFORMED CONSENT FORM

University of Texas at El Paso (UTEP) Institutional Review Board
Informed Consent Form for Research Involving Human Subjects

Protocol Title: Factors Related to Recruitment and Retention of Nurse Practitioners in Rural Areas

Principal Investigator: Dayle Boynton Sharp

UTEP College of Health Science

1. Introduction

You are being asked to take part voluntarily in the research project described below. Please take your time making a decision and feel free to discuss it with your friends and family. Before agreeing to take part in this research study, it is important that you read the consent form that describes the study. Please ask the study researcher or the study staff to explain any words or information that you do not clearly understand.

This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas at El Paso protocol number 115865-2.

2. Why is this study being done?

You have been asked to take part in a research study of the factors related to recruiting and retaining nurse practitioners in rural areas. The purpose of the study is to gather information related to the reasons you have decided to work in a rural setting and the reasons you have decided to remain in a rural community. Experiences might include where you grew up, your educational background and aspects of the community you work and reside in. Results will help to identify changes that can be made in Nurse Practitioner education related to rural practice.

Approximately 25 subjects will be enrolling in this study at UTEP.

You are being asked to be in the study because you currently practice as a nurse practitioner in a rural area where you also reside.

If you decide to enroll in this study, your interview will last between 1 to 2 hours.

3. What is involved in the study?

The investigator or a representative will explain the purpose of the study to you before you agree to participate. If you agree to take part in this study, the researcher will conduct an interview with you at a mutually agreed upon time that will last from 1 to 2 hours. During the interview:

1) You will be asked some general demographic questions about your education and years as a practicing nurse practitioner. Answers will be archived so your answers will be transcribed accurately and completely. The investigator may also take notes during the interview.
2) All information and your answers will be kept completely confidential. No names will be included in the final report. Data will be reported in aggregate form.
3) The primary investigator and person hired to transcribe the interview recordings will have access to the archives. The recordings will be stored in a locked closet in the primary investigator's office. The recordings will be destroyed one year after the completion of the investigator's dissertation. The transcription of the recordings will be analyzed for themes which will help educators identify changes that can be implemented in nurse practitioner education. Transcripts will be destroyed after completion of the study.

4. What are the risks and discomforts of the study?

There is a possibility that you may become distressed while talking about your position. If the questions are uncomfortable for you to answer, you do not have to answer them. The researcher will stop the interview if you become uncomfortable, and offer to reschedule for another time, or you can decline to participate any further.

5. What will happen if I am injured in this study?

The University of Texas at El Paso and its affiliates do not offer to pay for or cover the cost of medical treatment for research related illness or injury. No funds have been set aside to pay or reimburse you in the event of such injury or illness. You will not give up any of your legal rights by signing this consent form. You should report any such injury to the UTEP Institutional Review Board (IRB) at 915-747-8841 or irb.orsp@utep.edu.

6. Are there benefits to taking part in this study?

There will be no direct benefits to you for taking part in this study.

7. What other options are there?

You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.

8. Who is paying for this study?

Dayle Sharp will be responsible for the funding to conduct this study.

9. What are my costs?

There are no direct costs. You will be responsible for the cost of internet access for the interview and any other incidental expenses.

10. Will I be paid to participate in this study?

You will not be paid for taking part in this research study. You will receive a webcam for the interview and your personal use.

11. What if I want to withdraw or am asked to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you do not take part in the study, there will be no penalty.

If you choose to take part, you have the right to stop at any time. However, we encourage you to talk to a member of the research group so that they know why you are leaving the study. If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them.

The researcher may decide to stop your participation without your permission, if she thinks that being in the study may cause harm, or if you become distressed while talking about your position. If the questions are uncomfortable for you to answer, you do not have to answer them. The researcher will stop the interview if you become uncomfortable, and offer to reschedule for another time, or you can decline to participate any further.

12. Who do I call if I have questions or problems?

You may ask any questions you have. If you have questions or concerns about your participation as a research subject, please contact the UTEP Institutional Review Board (IRB) at 915-747-8841 or irb.orsp@utep.edu.

13. What about confidentiality?

You will not be personally identified in any reports or publications that may result from this study. Any personal information about you that is gathered during this study will remain confidential to every extent of the law. A special number will be used to identify you in the study and only the investigator will know your name.

Every effort will be made to keep your information confidential. Your personal information may be disclosed if required by law. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include, but are not necessarily limited to:

a. The sponsor or an agent for the sponsor
b. Department of Health and Human Services
c. UTEP Institutional Review Board

Because of the need to release information to these parties, absolute confidentiality cannot be

guaranteed. The results of this research study may be presented at meetings or in publications; however, your identity will not be disclosed in those presentations.

All records will be stored in a locked closet in the primary investigator's office. The recordings will be destroyed one year after the completion of the investigator's dissertation. The transcript of the recordings will be analyzed for themes which will help educators identify changes that can be implemented in Nurse Practitioner education.

14. Authorization Statement

I have read each page of this paper about the study. I know that being in this study is voluntary and I choose to be in this study. I know I can stop being in this study without penalty. I will get a copy of this consent form now and can get information on results of the study later if I wish.

Participant Name: _____ Date: _____

Participant Signature: _____ Time: _____

Witnessed by:

Print name: _____ Date: _____

Signature: _____ Time: _____

Consent for Audio- and Video-Recordings and Archiving

I agree to be audio- and video-recorded during my interview in this study. I am aware the recording will be archived by the researcher.

Participant Name: _____ Date: _____

Participant Signature: _____ Time: _____

Witnessed by:

Print name: _____ Date: _____

Signature: _____ Time: _____

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Age:
____ 20 to 30 years
____ 31 to 40 years
____ 41 to 50 years
____ 51 to 60 years
____ Over 61 years

Gender: ____ Male ____ Female

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed

Race or ethnic origin:
____ White Hispanic
____ White Non-Hispanic
____ Black or African American
____ American Indian or Alaska Native
____ Native Hawaiian or other Pacific Islander

Number of children living with you _____

Length of time you have practiced as a Nurse Practitioner _____

Location(s) of previous practice_____ (rural, urban)

Did your NP education include training in rural areas? _____

If yes, how much time did you spend in a rural area during your training? _____

Do you have an obligation to practice in a rural area? _____

If yes, how long is your obligation? _____

Who is your obligation with? _____

APPENDIX D

SEMI-STRUCTURED INTERVIEW GUIDE

APPENDIX D

SEMI-STRUCTURED INTERVIEW GUIDE

Tell me about being a nurse practitioner in your current position?

Prompts: What is it like to be a provider in the community?
What keeps you in your current position?
How is your life impacted by being a nurse practitioner in the community?
How is your personal and private life impacted?
Tell me about your transition to your current position.

APPENDIX E

IRB APPROVAL

IRBNet ID: 115865-2 USER PROFILE LOGOUT

IRBNet

Welcome to IRBNet
Dayle Sharp

My Projects
Create New Project
My Reminders (7)

Project Administration
Project Overview
Designer
Share this Project
Sign this Package
Submit this Package
Delete this Package
Send Project Mail
Project History
Messages & Alerts (7)

Project Overview

[115865-2] Factors Related to the Recruitment and Retention of Nurse Practitioners in Rural Areas

You have Full access to this project. (Edit)

Research Institution University of Texas at El Paso, El Paso, TX
Title Factors Related to the Recruitment and Retention of Nurse Practitioners in Rural Areas
Principal Investigator Sharp, Dayle, MSN, PhD(c)
Status Approved
Lock Status Locked
Keywords Nurse Prarctitioner, Rural Practice, Recruitment, Retention

The documents for this project can be accessed from the Designer.

Submitted to:
University of Texas at El Paso IRB 10/06/2009 Approved 10/15/2009. Review details.

The previous package (115865-1) has a status of Approved.

Shared with the following IRBNet users

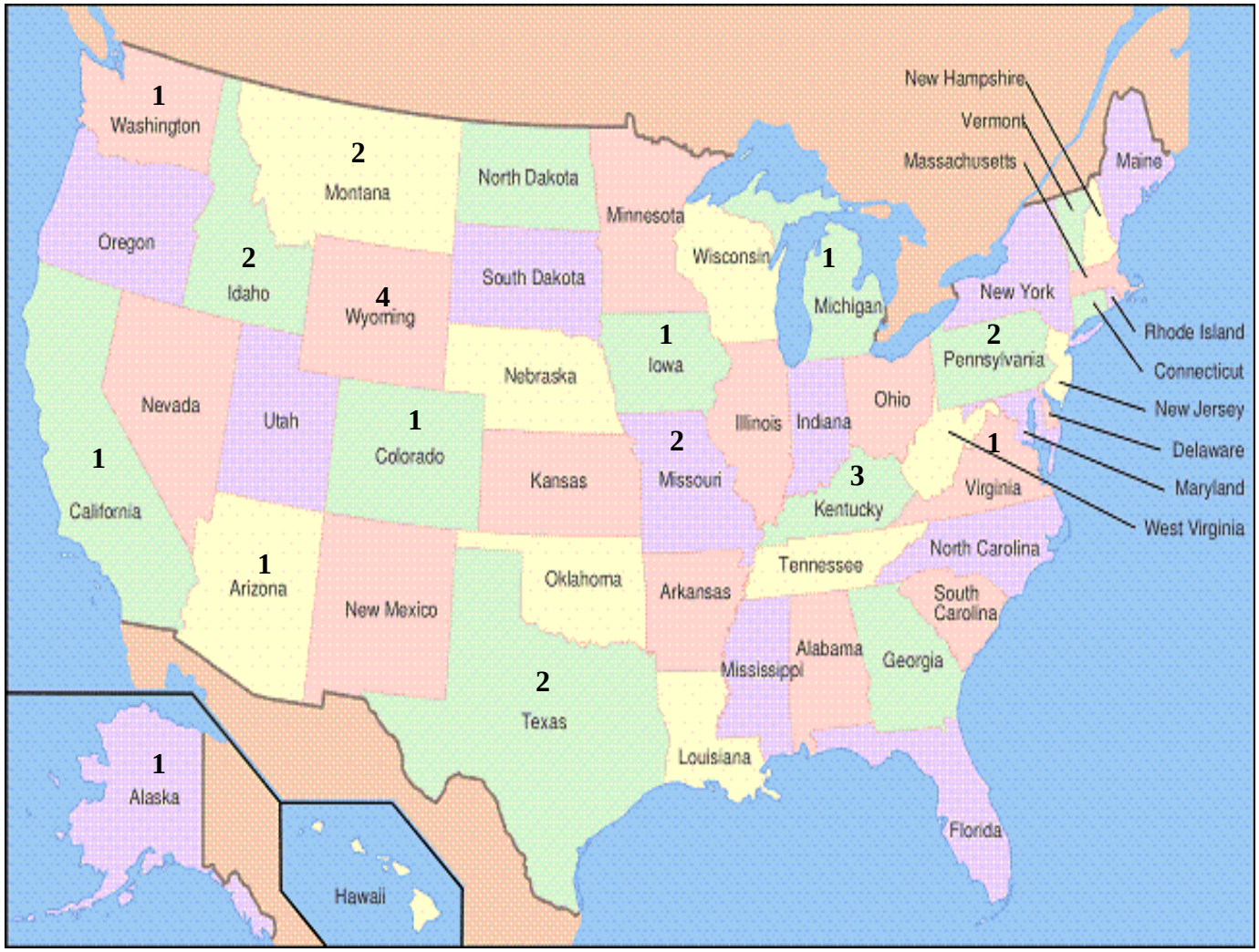
IRBNet User	Organization	Access Type
Charon Pierson	University of Texas at El Paso, El Paso, TX	Full
Dayle Sharp	University of Texas at El Paso, El Paso, TX	Full
Kris Robinson	University of Texas at El Paso, El Paso, TX	Full
Francisco Soto Mas	University of Texas at El Paso, El Paso, TX	Full
Diane Monsivais	University of Texas at El Paso, El Paso, TX	Full

APPENDIX F

MAP OF RURAL LOCATIONS

APPENDIX F

MAP OF RURAL LOCATIONS



CURRICULUM VITA

Dayle Boynton Sharp was born in Bourne, Massachusetts. The fourth daughter of Irving Leslie Boynton and Jane Crandell Joubert, she graduated from Alvirne High School, Hudson, New Hampshire. She completed her Bachelor's of nursing degree in the spring of 1992 from The University of New Hampshire. While completing her bachelor's degree she participated in two summer externships one at Wentworth-Douglass Hospital in Dover, NH and the other at Georgetown University Hospital in Washington, DC. In 1997, she returned to school to advance her career, entering Idaho State University to become a family nurse practitioner. During her master's education she received a National Health Service Corp (NHSC) scholarship. While in the NHSC she participated in the Student/Resident Experiences and Rotations in Community Health (SEARCH) program in rural Idaho. After receiving her master's degree she accepted a position as a nurse practitioner at the site she conducted her SEARCH program. After working in rural Idaho she relocated to El Paso in 2001 to work at the Kellogg Clinics caring for the underserved living in colonias along the U.S./Mexico border. Part of her position as a site manager and nurse practitioner included educating students from multiple disciplines from both the University of Texas at El Paso and Texas Tech University. Through this experience she found she enjoyed teaching later accepting a position as a faculty member at the University of Texas at El Paso. In the fall of 2005, she entered the Graduate School at the University of Texas at El Paso.

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