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A Qualitative Study of Rural Nurse Practitioners' In Medically Underserved Clinics

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A QUALITATIVE STUDY OF RURAL NURSE PRACTITIONERS'
IN MEDICALLY UNDERSERVED CLINICS

A Scholarly Project Submitted to the Graduate School
in Partial Fulfillment of the Requirements
for the Degree of
Doctor of Nursing Practice

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IN MEDICALLY UNDERSERVED CLINICS

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A QUALITATIVE STUDY OF RURAL NURSE PRACTITIONERS' IN MEDICALLY UNDERSERVED CLINICS

An Abstract of the Scholarly Project by
Jama Jelaine Bogart

Retention of nurse practitioners is a serious problem in rural medically underserved areas. This study focused on the underserved areas in southeast Kansas, southwest Missouri, and northern Oklahoma. Approximately, three million persons reside in rural medically-underserved areas of the study area. Seventy-three percent of these adults have at least two or more complex chronic medical conditions and there are only 526 nurse practitioners to care for them. Rural providers face many challenges in caring for these individuals and experience anxiety and stress while caring for them. The purpose of this research study was to explore, analyze, and describe the phenomena of nurse practitioners practicing in rural underserved medical clinics. The research explored the nurse practitioners' attitudes and feelings related to their current position in the rural setting. The study included the concepts of professional isolation, stress or other factors that negatively affect job satisfaction and retention. A qualitative phenomenological design was used to allow the subjects to describe their lived experience of their day to day practices.

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Chapter I

Introduction

Description of Clinical Problem

In southeast Kansas, southwest Missouri, and northern Oklahoma, approximately 100% of all residents reside in a medically underserved area (NWLC, 2015). With close to three million residents and approximately 526 (AACM Annual Report, 2015) nurse practitioners (NPs) working in southeast Kansas, southwest Missouri, and northern Oklahoma this indicates there is a large population to be cared for and comparatively few providers. The nurse practitioner to patient ratio in southeast Kansas, southwest Missouri, and northern Oklahoma averages one NP per 2455 patients (AAMC Annual Report, 2015).

Residents of rural areas generally live farther from their nearest health-care provider, have fewer choices of health care providers, and have less access to specialty providers than their urban and suburban counterparts (RHHH, 2016). Rural areas is defined as population that may not contain more than 20,000 persons or more than 500 persons per square mile (USDA, 2016). Some rural areas the government has additionally defined as medically underserved are regions of the US that have “a relative or absolute deficiency of health care resources, including hospital beds, equipment and/or medical personnel” (HRSA, 2015).

Many factors challenge the provision of quality health care in rural medically underserved areas (MUAs), including isolation of primary care providers (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002), burnout (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002; Waddimba et al., 2005) and compassion fatigue (Sprang, Clark, Whitt-woosley, 2007; Waddimba et al., 2005). These factors affect recruitment and retention of medical providers in rural MUAs (Williams, 2012). Problems with recruitment and retention of medical providers in these areas naturally results in longer patient travel times to point of care services and higher patient to provider ratios (HRSA, n.d.). High nurse practitioner to patient ratios are especially problematic in rural MUAs because these areas have a proportionately higher number of economically and educationally disadvantaged persons and elderly with multiple, complex comorbidities (RHIH, 2016). The National Rural Health Association (2015) asserts that “economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural Americans in their struggle to lead a normal and healthy life” (pg. 1).

Significance

Approximately three million persons reside in rural medically-underserved areas (MUAs) in southeast Kansas, southwest Missouri, and northern Oklahoma, (Missouri Census, 2013; Oklahoma Census by County, 2012; Kansas Population by County, 2014). In these areas 73% of the adults have at least two complex chronic conditions requiring frequent and ongoing monitoring to achieve and maintain optimal health (CDCP, 2012). The number of nurse practitioners (NPs) working in rural geographic areas are

approximately 527 (AACM Annual Report, 2015). According to Bailey (2009) the distance between clinics who employ nurse practitioners ranges from 27 to 33 miles.

The distance between nurse practitioners limits opportunities for peer interaction (e.g. consultation, peer support) on site, while slow or unavailable internet access limits voice and video interaction online (Kutcher, 2014). Limited opportunities for consultation and peer support among NPs caring for persons with complex chronic conditions presents challenges to diagnosis and treatment (Bailey, 2009).

Challenges in diagnosis and treatment due to old equipment or lack of equipment can delay appropriate care and reduce work satisfaction among NPs (Bailey, 2009). Reduced work satisfaction increases the likelihood of burnout and compassion fatigue (Sprang, Clark, & Whitt-Woosley, 2007).

Longman, Passey, Singer, & Morgan (2013) have explored the relationship between professional isolation and compassion fatigue among physicians working in rural MUAs. Although, no studies have examined the relationship between professional isolation, difficulty with recruitment and retention, burnout and compassion fatigue among NPs working in rural MAUs. Williams (2012) linked professional isolation to difficulty recruiting and retaining primary care physicians in rural MUAs. Williams also linked difficulty recruiting and retaining physicians to higher provider-patient ratios, longer wait times for appointments, and longer travel times to point of care services. It seems reasonable that Williams' findings may be similar among professionally-isolated NPs.

Specific Aims/Purpose

The specific aims of this project are to:

- (1) Explore nurse practitioners' attitudes and feelings related to their current position in rural MUAs in southeast Kansas, southwest Missouri, and northern Oklahoma especially in relation to job satisfaction and retention.
- (2) Explore whether nurse practitioners in rural settings are experiencing professional isolation, stress or other factors that might negatively affect job satisfaction and retention.

Theoretical Framework

Orem's theory defines nursing as "the act of assisting others in the provision and management of self-care to maintain or improve human functioning at a high level of effectiveness" (Wayne, 2014, p. 3). The act of self-care is "to maintain life, health, and well-being" (Wayne, 2014, p. 3). Orem has six major assumptions:

- People should be self-reliant and responsible for their own care and others in their family needing care
- People are distinct individuals
- Nursing is a form of action-interaction between two or more persons
- Successfully meeting universal and development self-care requisites is an important component of primary care prevention and ill health
- A person's knowledge of potential health problems is necessary for promoting self-care behaviors
- Self-care and dependent care are behaviors learned within a socio-cultural context ("Nursing Theories," 2012, p. 2).

Orem's theory was used by this researcher to guide, support, provide an environment promoting personal development in relation to future demands, and to teach

others. Orem's self-care theory created a different way to look at the phenomenon of nurse practitioners' experience in the rural health clinics, support logical thought processes, and is generalizable to health care settings.

The researcher explored the phenomena relationship of professional isolation, burnout and compassion fatigue in the context of this scholarly project. The research explores the core of consciousness as experienced in the first person point of view by rural nurse practitioners. This theoretical perspective draws on the individuals making sense of the world in terms of meaning and classification they employ (Reeves, Albert, Kuper, & Hodges, 2008). Phenomena studies attempt to explore the individual's lived experience. Research completed in this way does not create a larger explanation but focuses on the provided data from individuals in a setting-specific phenomenological study.

Project

The purpose of this research study was to explore, analyze, and describe the phenomena of nurse practitioners practicing in rural underserved medical clinics. The researcher became immersed in the phenomenon under investigation and began to know the phenomenon as described by the participants. The researcher identified presuppositions, biases or assumptions held about practicing in a rural clinic and attempted to set them aside in an effort to keep what is already known separate from the lived experiences as described by the participants of this study.

The researcher created an opportunity for individual nurse practitioners practicing in rural settings to share their experiences related to the meaning of professional isolation,

burnout, and compassion fatigue. The sample consisted of six nurse practitioners in MUAs in southeast Kansas, southwest Missouri, and northern Oklahoma.

The researcher explored rural health professionals that care for populations of fewer than 10,000 persons living in the community surrounding the clinic area. Purposeful sampling was used to select individuals based on their knowledge, feelings and beliefs related to practicing in a rural setting. Purposeful sampling was chosen because, as Speziale and Carpenter (2003) assert, “the power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research” (p. 67).

Definition of Key terms/Variables

Key terms for this study are rural health, professional isolation, burnout, compassion fatigue and nurse practitioner. The following definitions were used to avoid misunderstanding and to clarify their use for this scholarly project.

Rural health: is the health care provided in a rural environment. Federal Office of Rural Health Policy (ORHP, n.d.) defines rural as located outside a Metropolitan Statistical Area (MSA), or located in a rural census tract of a MSA as determined under the Goldsmith Modification or the Rural Urban Commuting Areas (HRSA, n.d.). For this project, a rural environment is defined as rural areas of fewer than 10,000 persons living in an MUA surrounding a hospital or clinic. Lo

Professional isolations: is theoretically defined as a “lack of communication or interaction with colleagues, the relevant professional community, or related professional organization” (IES, 1993, para. 1). Bedward and Daniels (2005) described professional

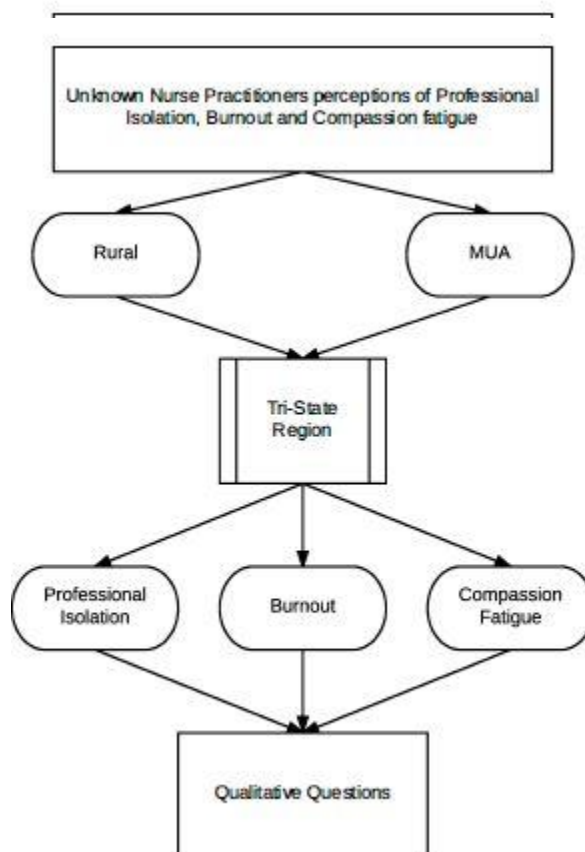
isolation as “feeling unsupported, lacking opportunities, not being recognized or praised for achievements” (p. 59). Other sources stated, rural providers feel job pressure, undervalues, and lack of peer support (Williams, 2012; Chapman et al., 2004). The definition the researcher used for this study was a lack of communication, feeling unsupported, lack of learning, lack of collaborative opportunities and lack of recognition/praise for achievements.

Burnout: is when an “employee has exhausted their physical and emotional capacity”. This often occurs as a result of “stressful job, lack of support and resources” (Sabo, 2011, p. 9)

Compassion fatigue: is a secondary traumatic stress reaction resulting from helping or desiring to help a person suffering from a traumatic event. The symptoms resemble that of post-traumatic stress disorder but it applies to the caregiver not the victim (Figley, 1995)

Nurse practitioners: is a registered nurse that has advanced training to “blend clinical expertise in diagnosing and treating health conditions with an added emphasis on disease prevention and health management” (“AANP,” 2016, p. 1).

Logic Model of the Proposed DNP Project



The logic model begins with a nurse practitioner's perception of her practice, in regard to professional isolation, burnout or compassion fatigue. This research asks the question; what are the nurse practitioners' perceptions of the areas in which they work, patients they serve, and opportunities that are in front of them. This research sought to discover the nurse practitioners' perceptions of their practice when asked a series of open ended questions.

Summary of Chapter

In summary, rural health providers are at a disadvantage due to their general location, limited resources, and lack of opportunities to collaborate and work with other providers. For this research project, the researcher attempted to discover a greater understanding of nurse practitioners' thoughts and attitudes while working in rural clinics. These discoveries may lead to ways to improve care in the rural MUA in the United States.

Through this qualitative research study, the researcher gained insight to the lived experience around MUA rural health and the effect it has on the nurse practitioner. The researcher gained insight on how nurse practitioners feel and think about working in rural areas by listening, hearing, and sharing experiences. It was anticipated that knowledge learned from this study might help prevent stress and occurrences of factors which make working in rural health care settings undesirable for many health care professionals. Enhanced understanding of the strain the rural nurse practitioners operates under may indicate ways to prevent professional isolation, stress and improve recruitment and retention therefore, helping to make rural health care a more desirable location for health care professionals.

Chapter II

Review of Literature

An integrated review of the literature provided information available from the last ten years. Topics researched included rural health care and factors related to providing services in this setting. In addition the review included information related to recruitment and retention of health care providers and the challenges and opportunities for offering targeted support to health care providers. Professional isolation and the role of isolation for health care providers in rural health settings along with an investigation of concepts of burnout and compassion fatigue was also explored in the review of the literature.

Rural Settings and Health Care Providers

Rural health care is important to the people of our country, but encouraging health care professionals to locate and serve in these areas is a difficult venture. Providers serving in the rural health medically underserved areas face many challenge in their career and personal life. The National Health Service Corp provides loan repayment program and scholarships for nurses, midlevel providers and physicians who are willing to work in medically underserved areas for a period of time. Health Resources and Services Administration have loan programs, scholarships, loan repayment and grants to encourage providers to relocate to these rural areas. Offering loan repayment and forgiveness is one way the government is attempting to assist in the recruiting efforts for

rural providers. Researchers have found these programs attract some providers to the rural areas but eventually the provider begins looking for other opportunities outside the rural area. Qualified providers to rural health care areas remain difficult to recruit..

The healthcare needs of individuals in rural areas have been documented to be different from those living in metropolitan and urban areas (Rural, 2008). There are many differences between living and working in a rural area as opposed to metropolitan areas. The differences influence “job satisfaction/retention rates” (Hegney et al., 2002, p. 33). “There is considerable evidence to suggest that the factors influencing job satisfaction/retention rates in rural and remote areas differ markedly from metropolitan areas” (Hegney et al., 2002, p. 33). Providers come to underserved health care areas with great intentions to continue their practice in the rural setting. But, as time passes there are several stressors that arise. Health care providers working in rural settings have identified several factors that contribute to their dissatisfaction with working in MUAs. These include working/living conditions, financial compensation, requirements to continue working in the clinic for a mandatory length of time, isolation from other professional health care providers along with personal and family issues (Williams, 2012).

The same factors that lead to work dissatisfaction often lead to provider burnout, compassion fatigue and feelings of professional isolation (Aylward, Gaudine & Bennett, 2011; Bedward & Daniels, 2005; Rohatinsky & Ferguson, 2013; Williams, 2012). Other studies suggested only burnout, and compassion fatigue lead to work dissatisfaction (Abendroth, 2011; Lombardo & Eyre, 2011; Long & Weinert, 1989; Sabo, 2011; Ward-Griffin, St-Amant, & Brown, 2011). Inadequate staffing of health care providers in rural

clinics naturally results in less opportunity for collaborative practice discussions between health care professionals. In addition, the rural health care provider may need to expand their professional role beyond their level of comfort and it may limit their ability to further their education. These factors have been identified as leading to professional isolation, burnout, and eventually compassion fatigue in physicians who work in medically underserved clinics.

Healthcare professionals view higher patient-to-provider ratios as especially problematic in rural MUAs. Often, these areas have a proportionally higher number of economic and educationally disadvantaged persons and clients with multiple complex comorbidities (NRHA, 2008) which increases time in the room with the patient in order to educate the patient and increase understanding and compliance in treatment. The National Rural Health Association asserted “economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas are barriers to rural Americans striving to lead a normal and healthy life” (NRHA, 2008, p.1).

Recruiting and Retention

Recruiting and retaining health care professionals in rural areas is difficult. The reasons identified in the literature for recruitment and retention difficulties of primary care physicians in rural areas were professional isolation, burnout, and compassion fatigue (Aylward, Gaudine & Bennett, 2011). According to Bedward and Daniels (2005), recruitment and retention problems were lessened if the provider had local ties to the area and a robust mentoring program existed which mentored the provider in the health care facility and in the community itself. Additional factors contributing to retention included

achievement of an active leadership role in the community, access to the internet and the means to gain continuing education. Aylward, Gaudine and Bennett (2011) noted that maintaining a good reputation and earning the confidence and trust of those residing in the community was important. A negative factor for retaining providers included the amount of time required to become involved in social and leadership activities within the community (Bedward & Daniels, 2005).

Rural Population

According to rural health determinants (2008), the United States population living in rural areas varies from 17% to 63% depending on the definition of “rural” that is used to define rural (Rural Health). According to the United States Census, there are approximately 3 million persons living in southeast Kansas, southwest Missouri, and northern Oklahoma and all live in medically underserved counties (USDHHS, n.d.).

Nurse Practitioners’ Practice

Family nurse practitioners (FNP) see a wide range of illness. A FNP is trained to diagnose and manage common medical conditions, chronic illnesses and a broad range of health care services. The FNP is often the patient’s primary care provider (AANP, 2015). On an average day, an FNP could see everything from a common cold to a patient experiencing a life-threatening event (Sabo, 2011). The average nurse practitioner sees three patients per hour (AANP, 2015). The estimated national provider-to-patient ratio is 21 to 1000, with rural health being the exception (AAMC, 2011). In the rural health clinic the provider never knows what type of patient may walk in their door. “A lack of physicians that care for families from birth to death in every medical aspect, the so-called

“medical home,” leads to a lack of good preventive care that results in more serious and more expensive medical problems down the road (CRA, 2009, p. 3).

Although “nearly 80% of rural counties are classified as Medically Underserved Areas,” (CRA, 2009, p. 3) these areas only get 9% of America’s physicians, and this number is decreasing. The decline in the number of family physicians and primary care physicians, the increase of women in the medical arena, lifestyle preference of younger physicians and the rising cost of education and student debt all negatively affect recruiting rural health providers (CRA, 2009). This group of physicians expect family time, personal time and do not want their career to interfere with their time (Thielfoldt & Scheef, 2004).

In a study of why nurses are leaving the rural areas the researcher identified the reasons as professional isolation, work overload, and personal reasons (Hegney et al., 2002). Links have been made between professional isolation and burnout, burnout and compassion fatigue, but there has not been a documented study including all three factors. However, professional isolation has a group of symptoms that may lead to burnout or compassion fatigue or both. A review of the literature indicated a connection between the three symptoms in the population of MUA rural health providers.

Professional Isolation

Globally, half of the world’s population lives in rural areas whereas only 38% of the nursing workforce is employed rurally; more specifically 10.8% of the registered nurses workforce and 17.5% of licensed practical nurses work in rural and remote areas (WHO, 2010). In 2010, the WHO called for increased mentorship in order to recruit and retain health care professionals to the rural areas. They believe that “rural health

professionals were more likely to remain in rural areas if they were connected through peer support networks, had relationships with both urban center and rural communities and had means to communicate electronically with others” (Coger & Plager, 2008, p. 36).

Professional isolation has been described as lack of support, lack of growth, lack of learning opportunities, and lack of recognition and praise for achievements (Bedward & Daniels, 2005). The prevalence of professional isolation in physicians and nurses ranged from 42% to 78% in medically underserved areas of rural health. These high statistics give validation to this dilemma (Aylward, Gaudine, & Bennett, 2011; Bedward & Daniels, 2005; Conger, Shaw, Congdon, Carter, Abbott, & Petchey, 2004).

Professional isolation is an important factor contributing to emotional and physical exhaustion. The emotional and physical toll reduces job satisfaction and leads to increased absenteeism, reduced productivity, and increased turnover among rural health providers (Abendroth, 2011). As professional isolation in the MUA rural health care progresses, it can be positive or negative (Williams, 2012). When professional isolation is not addressed, the negative effects could result in physical and emotional exhaustion, due to stressful job, lack of support and resource which relate to provider burnout (Sprang, Clark, & Whitt-Woosley, 2007). When professional isolation is positive it allows the provider to gain autonomy in practice (Tolbert, 2013). Several research articles have been written about professional isolation but only a few addressing rural health populations.

Health care systems in rural areas around the globe are encountering major challenges (Alward, Gaudine, & Bennett, 2011). Aylward, Gaudine, and Bennet

discussed the “limited perspective of the rural health managers” (2011, p. 1). One of the challenges of these populations is the nursing shortage. There are three major impact points: an aging population with increased health demands, communities spread hundreds of miles apart, and the outmigration of young professionals which has caused a strain on health care professionals working in rural areas and the population they serve. These areas have also experienced some career hardships. The low potential for career satisfaction for rural nurses is another problem with provider satisfaction (Abendroth, 2011). It might be thought that the high demand for nurses, would draw nurses to the rural areas. However, the problem often lies in significant others or spouses being able to find employment due to the lack of employment opportunities in the rural area.

In a study completed in 2008, Penz, Stewart, D’Arcy, and Morgan (2008) examined job satisfaction of individuals, and workplace and community characteristics that may contribute to job satisfaction in rural health settings. Some of the factors that affected job satisfaction include having adequate up-to-date equipment, good scheduling, and less demanding workloads. The researchers concluded job satisfaction was higher when the provider lived in a rural community that they were comfortable in (Penz, Stewart, D’Arcy, & Morgan , 2008). The Association of Registered Nurses of Newfoundland and Labrador released a paper on staffing issues which found that adequate staffing levels to insure patient satisfaction helped with retention and recruitment in the rural areas. The author quoted Dyson’s 2002 paper that mentioned lack of basic services in these rural areas, transportation options and geographic isolation as problems in seeking health care professionals. Additional factors cited by sources referenced in the article included allocation of resources, geographical isolation, full time employment, available

technology, adequate staffing, good leadership, interdisciplinary teams, education opportunities, adequate orientation, having rural connections, and salary.

MacLeod, Browne, and Liepert (1998) discussed challenges of adequate medical resources and geographic isolation as issues causing problems with recruitment and retention of professionals. The researchers stated in some areas the nurse is the only medical professional available and therefore takes on multiple roles. Another source states, “geographic distance, aging population and high turnover rates in staffing [lead] to inconsistent care” (Newhouse, 2005, pg. 353). Although this study suggested that administrators should improve access to care and use alternative approaches to health care provisions in rural areas due to unique characteristics, the article did not go on to discuss the details of these interventions (Newhouse, 2005).

Newhouse (2005) found when the spouse of a nurse must leave the area for employment the nurse also leaves the area and seeks other employment. Health care professionals are easier to recruit and retain if they have family connections in the rural area where they work (Newhouse, 2005). Another factor found in the results was that the “isolative nature of rural communities, lack of resources and services have been a major challenge” (Newhouse, 2005 p. 352). The difficulty of maintaining professional anonymity and confidentiality in small rural communities also affects the choices of professionals causing ethical dilemmas and role strain (Newhouse, 2005). Factors that have been found to have a positive effect on rural nurse recruitment and retention in this study include having “rural connections, patient workloads, professional development opportunities, adequate orientation, and salaries” (Newhouse, 2005, p. 9) There were some additional factors that came up in this study that were not identified in other studies; these

include “spousal employment, sense of belonging, social networking, attitude of younger nurse and the beauty of rural areas” (Newhouse, 2005, p. 9).

A study by Aylward, Gaudine, & Bennett (2011) described the experience of rural Newfoundland healthcare managers. The barriers identified after repeatedly reviewing the interviews with health care managers are undesirable aspects of rural life, personal factors, lack of nursing services, and limiting nature of rural nursing structure. The three facilitating factors included connection to the community, supportive work environment, and rural benefits.

Both Newhouse and Aylward solely looked at the nurse manager perspective with neither study obtaining the nursing professionals’ perspectives. Newhouse’s recommendations for further research included: a larger study in many areas of rural health, obtain perceptives of the nurses in rural health areas, study of multiple generational nurses and their experience in rural health, and educating rural health nurses on the multispecialist role for this culture and needs of the community (Newhouse, 2005).

A study by Rohatinsky and Ferguson’s (2013) focused on managers’ perceptions of the roles in creating mentoring culture with specific findings in the rural areas. One of the categories that emerged from the data was rural mentorship. Rohatinsky and Ferguson (2013) looked at six health care regions in one Canadian province each having urban and rural locations. All managers that volunteered for the survey were front line managers having direct responsibility for their units.

The challenges found by Rohatinsky and Ferguson (2013) with supporting employee mentoring in rural areas are that managers have inadequate resources, limited staff, and difficulties recruiting and retaining new nurses. According to these authors,

nurse managers admit they don't commit to mentorship, they see it as a tool for recruiting and retention, therefore, they do not put a strong process in place. The managers have limited applicants so they really have few choices in who they hire. The managers do not feel they have adequate resources to have a mentorship program and feel it is beyond their ability to establish without senior leadership on board. Many times the employee works in isolation or minimal staffing of a different discipline making it difficult to pair up two of the same discipline for mentoring. Managers in the study discussed time-limited contracts, and the fact that most of these people leave when the contract is complete. The nurse managers felt the programs for permanent housing, developing relationships with other staff members, and establishing community networks to encourage new staff to stay in rural areas were extremely important. "Nurse managers also discussed providing mentoring programs in larger areas but the new nurses were resistant due to being uncomfortable on the highway, driving in a larger cities, attending workshops alone, lacking of funding to pay for mileage, hotel accommodations, meal and finding replacement staff to work the shift with the potential mentor attending the workshop" (Rohatinsky & Ferguson, 2013, p. 4).

Support strategies ideas came from the rural health managers, such as smaller staffing allowing new employees to get to know their colleagues and develop relationships, and allowing the new nurse to feel supported with the knowledge of where to go with problems. Rural managers felt the lack of physicians in the rural environment has potential for nurses to feel isolated and have increased responsibility. Once a new nurse became comfortable being alone, they continued to have a resource to call if needed for question or support. These nurse managers stated mentoring did not stop with the work environment it

continued with the community, they feel it is important to socialize new staff members into the community to help them build roots to the community. Socializing included introducing them to community activities, providing school options, inviting them to community events and social events within the community. If they hire internationally educated nurses it is very important to help them gain socialization to the community, because of cultural differences, and linking them to their internationally educated nurses near by (Rohatinsky & Ferguson, 2013). Another suggestion is that mentorship workshops be available by videoconference or in person with facilitator coming to the rural facility, having other rural areas come together which eliminates several of the travel concerns of the manager and the nurse. Rohatinsky and Ferguson (2013) assert that “in order to successfully recruit and retain health care employees in rural areas innovative mentorship initiatives are needed to ensure quality work environments” (p. 155). Based on Rohatinsky and Ferguson (2013) professional isolations can be combated with professional socialization, collaborative relationships and fostering positive rural outcomes for the underserved population.

A research project completed by Conger and Plager (2008) looked at advanced nursing practice in rural areas and explored connectedness versus disconnectedness. Connectedness elements included “development of a support network, relationships with urban health care centers, connections with local communities, and support through electronic means” (Conger & Plager, 2008, p. 24). “Rural disconnectedness resulted from lack of relationships with other health care providers lack of mentors and support staff, and the absence of electronic support” (Conger & Plager, 2008, p. 24). Conger and Plager (2008) previously identified that “factors such as isolation from other health care

professionals, lack of anonymity, and perhaps most important of all, the outsider status of the professional who enters the new community with little understanding of rural issues all lead to difficulties in both attracting health care professionals to rural areas and even more importantly retaining them in these practices” (Conger & Plager, 2008, p. 24).

Conger and Plager (2008) found that a majority of graduates were employed in rural practice. Of the 30 graduates, 87% of them practiced in the rural areas. Eight of the nurse practitioners worked in areas of fewer than 99,999, eighteen worked in rural/frontier areas, and four in metropolitan areas (Conger & Plager, 2008). The sense of connectedness came from journal clubs with other professionals, the presence of other health professionals, support persons and services, telecommunication with urban hospitals (telemedicine, fax, phone), and internet (Conger & Plager, 2008, p. 28). Rural disconnectedness came from isolation, inability to attend professional meetings (no back up, distance too far), breakdown in communication (lack of electricity, client has no phone), lack of other health providers, poor or non existent internet connection, and garbled communication with urban hospitals (Conger & Plager, 2008, p. 32).

A study by Hagney et al. (2002) looked at reasons why nurses resigned from positions in rural areas and found the lack of confidence in skills needed to practice in these areas, issues with professional isolation and culture shock were all reasons for resignation. Another study in 2007 by Penz et al., identified barriers including distance from educational institutions, inadequate staffing to allow nurses to attend conferences, unrealistic expectations for nurses working in isolation, plus the nurse being responsible for travel, lodging, continuing education event and lack of employer support provided for lack of retention in rural areas.

In Williams' (2012) integrative review of the literature, it was apparent that the "focus was professional isolation from a rural health perspective" (Williams, 2012, p. 6). Several themes became obvious such as characteristics and implication of rural professional isolation. The rural medical professionals dominated the literature from North America, and Australia (Williams, 2012). "Inherent in the nature of rural professional isolation is the notion of being distanced from some aspect of the profession either from peers, technology, larger centers, or education" (Williams, 2012, p. 6). Another relevant description of professional isolation is the idea of working alone; characterized by sole or solo practitioners, working in smaller teams, or working in non urban locations" (Williams, 2012, p. 6). The fallout from professional isolation can be positive or negative. Generally, it is found as negative in recruiting, retaining, and competence. William (2012) defined rural professional isolation as follows, "rural professional isolation as lack of some element necessary to complete the professional role, such as peer-support, mentorship, proctorship, continuing education, or technology, coupled with the practitioner's perception that the necessary element was missing in his or her professional life (p. 7).

Chronic nursing shortage in rural health areas has troubled rural communities for years. Similar to other studies, Williams (2012) also found that professional isolation is associated with recruitment and retention in the rural settings. According to William (2011) even with knowledge concerning professional isolation, little information has actually been published on the topic. In 1989, an article authored by Long and Weinert mentioned professional isolation from a rural prospective. Long and Weinert (1989) listed three characteristics that rural care givers possessed; "lack of anonymity, isolation

from professional peers, and a sense of role diffusion” (p.120). Long and Weinert’s findings correlated with Williams’s findings (2012) that professional isolation is viewed negatively, there is a lack of resources and access to other persons, and sometimes other desirable things in rural areas. “For the most part professional isolation was portrayed in a negative sense ; lack of some needed resources or a distance from some needed person, place or thing (Williams, 2012, p. 5) . According to Bedward and Daniels (2005), the social context of feeling unsupported included lacking opportunity, not being recognized, and not being praised for achievements. Several sources described professional isolation as being under job pressure, feeling undervalued, or being distanced from peer support (Bedward & Daniels, 2005; Long & Weinert, 1989; Williams, 2015). This is in contrast to Conger and Plager (2008) who believed professional isolation was simply lacking communication with others. Evidence from other studies identified issues with recruitment and retention related to professional isolation (Conger & Plager, 2008; Rohatinsky & Ferguson 2013).

Burnout

Sprang, Clark, and Whitt-Woosley (2007) associate lack of support, resources and exhaustion of physical and emotional capacity with burnout. Moreover, exhaustion of physical and emotional resources was described as part of burnout which was more prevalent among rural providers (Sprang et al., 2007). “Limited resources, geographical isolation, professional isolation, rural MUAs, complex chronic conditions created a ‘perfect storm’ for burnout risks among rural clinicians” (Sprang et al., 2007, p. 273). Evidence from Sprang et al. (2007) study supports a relationship between the job duties, burdens, and stressors of rural work which appear to generate burnout. Sprang et al.

(2007) indicated however that the development of empathy and engagement with patients may increase vulnerability to burnout of providers in rural areas. Several studies (Aylward, Gaudine & Bennett, 2011; Abendroth, 2011; Bedward & Daniels, 2005; Lombardo & Eyre, 2011; Long & Weinert, 1989; Rohatinsky & Ferguson, 2013; Sabo, 2011; Ward-Griffin, St-Amant, & Brown, 2011; Williams, 2012), reported that providers working in rural MUAs, compared to their urban counterparts, have increased job duties, burdens and stressors which increased the risk of burnout. Although the symptoms of burnout and compassion fatigue overlap, compassion fatigue is not specifically cited as a consequence of the increased demands placed on providers in rural MUAs. It is reasonable to speculate the same demands that contribute to burnout also would contribute to compassion fatigue. However, the direction of causal influence is unclear and may be bidirectional. For example, burnout may prevent provider engagement and development of empathy with the patient which increases the risk of development of compassion fatigue. Burnout sometimes has more to do with employees' expectations of themselves or personal circumstances. People who are truly burned out lose the ability to empathize with the person they serve but can safely complete patient care (Sprang et al., 2007).

Burnout was defined by Sabo (2011) as “a syndrome of emotional exhaustion, depersonalization, and reduced accomplishments that can occur among individuals who do people work for some time” (p. 2). Abendroth, Lombardo, and Eyre believe that “three personality trait contribute to burnout: type A personalities, coping styles including escape-avoidance, problem solving, confrontation, and traits known as the big

five neuroticism, extroversion, openness to experience, agreeableness, conscientiousness” (as cited in Sabo, 2011, p. 2).

Burnout is sometimes influenced by the nurses’ work-related attitude, in the way they care for their patients and their personal standard of care for their patients. The nurses’ values and belief in how others should care for their patients increases the potential for burnout. Sabo (2011) discussed how the work-related and organizational characteristics produce job stress and client-related stress. Many theories have been proposed to explain burnout, but the research increasingly supports the idea that burnout arises out of a mismatch between the person and the job (Abendroth, 2011). There are six issues that supporting this notion: work overload, lack of control, lack of reward, lack of community, lack of fairness and value conflict (Sabo, 2011).

Studies on burnout found that it is especially prevalent among helping professionals and higher with mental health professionals (Sprang, Clark, & Whitt-Woosley, 2007). A number of factors have been identified that increase or decrease the risk of burnout: age decreases the risk, female sex seems to increase the risk, higher education increased the risk for burnout, specialized trauma training decreases the risk for burnout. Organizational factors such as supportive work environment, adequate supervision, autonomy, control and access to sufficient resources resulted in more positive outcomes (Sprang et al., 2007). Sprang, Clark, & Whitt-Woosley believed that personal history of trauma, gender-specific vulnerability, and repeated exposure to occupational trauma cause the health professional to be at greater risk for burnout. This study did indicate that specialized trauma training might provide some protection against occupational exposure to trauma. Sprang, Clark, and Whitt-Woosley (2007) indicated

that people who worked “in rural locations were more likely to suffer burnout than those in highly metropolitan locations” (p. 273). The researchers reported that “limited resources, geographical isolation, few colleagues, and highly demanding caseloads create a ‘perfect storm’ for burnout among rural clinicians” (Sprang et al., 2007, p. 273). The rural providers should be educated about risk and protective factors, and be provided resources to aid in prevention, in order to reduce the level of burnout in rural providers.

According to Waddimba, Seribani, Nieves, Krupa, May & Jenkins (2005), “American physicians are more burned out than other physicians and more of them are symptomatic” (p. 2). Medical practice in rural/underserved settings intensifies “risk for burnout due to stressors such as geographic or organizational isolation, lower remuneration, resource constraints and more distressing patient –provider interactions” (Waddimba et al., 2005, p. 2). This investigation looked at less time consuming screening tools to assess at-risk providers. Using the Professional Quality of Life tool (ProQOL E-IV), a scale for measuring compassion fatigue, compassion satisfaction and burnout, the researchers did a series of cross tab analyses to examine the relationship between demographics and the three ProQOL subscales of compassion fatigue, compassion satisfaction and burnout. Burnout and compassion fatigue share many physical symptoms and relational disturbances but the degree of the symptoms worsen with compassion fatigue. They both have psychological symptoms but compassion fatigue has increased distress. Burnout and compassion fatigue have cognitive symptoms but compassion fatigue causes a shift in cognitive function (Sabo, 2011). The health care provider is emotionally pushed beyond their limits and are unable to deal with any additional work stress and shift more into compassion fatigue.

Burnout was found to be the most frequent issue of helping professionals in general; this was not only prevalent in rural areas but in all areas. Because health care professionals have the desire to take care of others, they often times put others before themselves. Frequently, they do not get recognized for the hours and the work they do, resulting in feeling undervalued and having a poor sense of accomplishment. Often times burnout is a result of too much time put into caring for others and too little time caring for oneself.

Compassion Fatigue

Figley (1995) defines compassion fatigue as a secondary traumatic stress reaction resulting from helping or desiring to help a person suffering from a traumatic event. MUA rural health providers care for everything from simple diagnosis to major trauma with the same tools, which often causes major physical and emotional stress and distress. Therefore, when looking at the symptoms, they resemble that of post-traumatic stress disorder but it applies to the caregiver not the victim. Although the writings of Figley (2005) are often critiqued by Sabo (2011) for his lack in addressing the nurse's ability to halt compassion fatigue, their combined research of compassion fatigue show that approximately 13% of the psychiatric health care professionals and emergency room personnel from their studies suffer from compassion fatigue. When health care professionals suffer from compassion fatigue, they become insensitive to the needs of the patients and are unable to complete the care needed by their patients (Sabo, 2011). The literature shows that "compassion fatigue is an off shoot of burnout it reflects the adverse psychosocial experienced by these providers" (Sabo, 2011, p. 3). Compassion fatigue has been described as the "natural consequent behaviors and emotional resulting from

knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help, a traumatized or suffering person” (Figley, 1995, p. 7).

Nurses had to work hard to become professional nurses and they look forward to the profession being rewarding and fulfilling. Sometimes, however, “caring for the needs of others leads to severe stress in all areas of nursing” (Abendroth, 2011, p. 1). Johnson (1992) wrote “a nurse described the phenomenon of compassion fatigue as a unique form of burnout that affects people in caregiving professions” (as cited in Sabo, 2011, p. 9). The caregiver is in a state of persistent arousal and anxiety as a result of this secondary trauma. Some of the behaviors that are noted are difficulty falling or staying asleep, irritability, outbursts of anger, feeling overwhelmed, being unable to effect positive change and exaggerated startle response. In the long run they lose their ability to be empathic toward the patients; the impact is sudden, and acute. Some work areas such as “intensive care, mental health, pediatrics, and oncology are more vulnerable to work related stress” (Sabo, 2011, p. 1). Sabo feels the key factor in compassion fatigue is inability to provide empathy in a therapeutic relationship. Lombardo and Eyre (2011) emphasize how compassion fatigue can affect job satisfaction and care providers’ health, resulting in decreased productivity and increased turnover; they remind us that nurses comprise the largest group of health care providers in the country (Lombardo & Eyre, 2011). Another group of nurses that are at high risk for compassion fatigue are the nurse-daughters caring for the elderly parents. The lack of resources, along with increased family expectation, contribute to compassion fatigue in this population. This role never

allows the nurse to step out of the caregiver role (Ward-Griffin, St-Amant, & Brown, 2011).

The term compassion fatigue has been described as the “natural consequent behaviors and emotional resulting from knowing about a traumatizing event experienced by a significant other, the stress resulting from helping or knowing about a traumatizing or suffering person” (Figley, 1995, p. 7). Some researchers have suggested that this phenomenon is connected to the therapeutic relationship between the health care provider and patient, in relation to the traumatic or suffering experience of the patient triggering a response on the multiple levels in the provider (Sabo, 2011). Figley (2002) suggests, that individuals who display high levels of empathy and empathic response to a patient’s pain and suffering, or traumatic experience, are more vulnerable to experiencing compassion fatigue.

Figley (2002) describes compassion fatigue as a series of cascading events beginning with exposure to a patient’s pain, suffering, and traumatic event, resulting in empathic concern and empathic ability on the part of the provider that may end in stress. The stress then increases with ongoing exposure, memories that produce the emotional responses, and unexpected disruption in their life. This is a linear theory that does not work well with humans because it “failed to clearly articulate the conceptualization of empathy of which this model is based” (Sabo, 2011, p. 3). This model also “fails to account for the benefits that nurses may derive from their relationships with patients or how the therapeutic relationships may potentially serve to protect the nurse from experiencing compassion fatigue” (Sabo, 2011, p. 3).

Valent (2002) hypothesized “compassion fatigue may emerge as a result of unsuccessful, maladaptive psychological and social stress responses of rescue-caretaking, these responses include sense of burden, depletion and self-concern, resentment, neglect and rejection” (Valent, 2002, p. 26). Because in the rural health clinic the provider and nurse may be the only two health care providers for a rural area, this may increase the stress due to the inability to debrief a stressful situation.

A study by Abendroth and Flannery (2006) found self-sacrificing and caring for patients more than themselves, put nurses at higher risk for compassion fatigue than other occupations. More research is needed to fully explore self-sacrificing behavior as a contributing factor for increased risk of compassion fatigue.

Another avenue of compassion fatigue is when the provider is also caring for elderly parents. Ward-Griffin et al, (2011) argue “being both a nurse and a daughter leads to the blurring of boundaries between professional and personal care work, which ultimately predisposed these caregivers to compassion fatigue” (p. 1). This is generally due to lack of personal and professional resources, increased family expectations, preoccupation with parents, erosion of professional and personal boundaries, and adverse health condition of the nurse. Ward-Griffin (2011) identifies groups of nurses that are more vulnerable to compassion fatigue; pediatrics, intensive care, mental health, and end of life care.

This study of Ward-Griffin (2011) identified specifically double-duty nurses report ‘living on the edge’ (p. 1). The goal of the study was to “develop recommendations for health care providers and decision makers to enhance the health and well-being of nurses and other health professionals who care for elderly relatives” (Ward-

Griffin et al., 2011, p. 4). From this study, three findings were prevalent: the nurse's lack of a personal and professional line, the characteristic of being preoccupied and absorbed with parents, and consequences-erosion of boundaries and relationships.

Generally nurses enter the profession to help others and provide high quality empathic care for patients. This high level of empathy can be to their detriment, resulting in compassion fatigue. Lombardo and Eyre (2011) described compassion fatigue as “a combination of physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress” (p. 1). Figley (1995) went on to say that compassion fatigue (secondary trauma stress) is experienced by those who repeatedly help others in distress resulting in inadequate self-care behaviors and increased self-sacrificing in the helper role. Figley and Sabo describe this as post traumatic stress disorder, but the provider was not the one who experienced the actual trauma (Figley, 1995; Sabo, 2011). Some of the symptoms of burnout and compassion fatigue are similar, but the distinguishing factors include onset of symptoms and the effect upon the caregiver's role (Lombardo & Eyre, 2011, p. 3). Burnout is found to be more “progressive, but compassion fatigue is acute in onset, and may swiftly result in over involvement in patient care” (Lombardo & Eyre, 2011, p. 3). Several authors have noted that “burnout could increase the possibility of developing compassion fatigue” (Abendroth & Flannery, 2006; Abendroth, 2011; Figley, 2002; Lombardo & Eyre, 2011; Valent, 2002). The article by Lombardo and Eyre was the only article that discussed interventions for compassion fatigue.

Health care is a rewarding as well as a difficult and risky career. Health care professionals suffer with compassion fatigue when they become the secondary victims to

trauma and pain they see repeatedly in their career. Because of this, they become unable to function in their professional capacity. They have symptomatology similar to post traumatic stress disorder and require intervention and treatment.

Chapter III

Methodology

This chapter discusses the design of the scholarly research project to be completed by this researcher. The “primary interest” of the qualitative phenomenological model “is to accurately describe the lived experiences of the research subjects” (Terry, 2015, p.106). This “approach proposes that a person’s reality is influenced by the world in which he or she lives to such an extent that his or her choices are confined by the specific conditions of his or her daily existence” (Terry, 2015, p. 107). The researchers belief, the qualitative data may provide a general understanding of the phenomenon with the goal to identify whether professional isolation, burnout and compassion fatigue are perceived by nurse practitioners in the rural clinics.

Project Design

The study focused on the individual lived experiences of rural nurse practitioners and relied on in-depth interviews with rural nurse practitioners to capture their experiences in their own words. It was important to know how these nurses define their situations in order to develop effective interventions to support and retain nurse practitioners who practice in rural community settings. Data was collected from personal interviews with nurse practitioners in rural MUAs. The study spanned three states in

order to provide a more general idea of rural nurse practitioners' lived experiences affecting care for rural populations.

The use of qualitative research allowed the researcher to gather subjective data that was unique to the individual and allowed for self-expression of thoughts and feelings without the risk of judgement of one's opinion (Terry, 2015). The relationship of the researcher with the subjects "places a great deal of reliance on the knowledge and reliability of the researcher" (Terry, 2015 p. 104). The researcher encouraged the nurse practitioners to speak their thoughts, feelings and opinions without judgement or repercussions. The nurse practitioners were asked a series of questions; the only additional questions were those asked to clarify information or explore an issue (Terry, 2015).

Sample/Target Population:

The researcher recruited subjects who would provide rich cases and would enlighten understanding of practicing in rural medically-underserved clinics, from the nurse practitioner's view. The sample was used to generate a detailed description of the phenomena and enhance the generalizability of the findings (Marshall & Rossman, 2011). The sample included MUA rural nurse practitioners in a practice where for the majority of the time were the only provider.

The sample was English-speaking nurse practitioners who do not currently practice in an urban or metropolitan area, who have been practicing in MUA rural health clinics for at least one year, in southeast Kansas, southwest Missouri, and northern Oklahoma. The subjects selected for the interviews were rural health care nurse practitioners practicing in medically underserved rural health areas with a population of

10,000 or less. Two nurse practitioners' were interviewed from each state with the possibility of an additional interview, should it have been deemed necessary to achieve data saturation. Regardless of identification method, each nurse practitioner was screened for the inclusion criteria. Potential nurse practitioners were contacted by phone and queried about participation in the study, and their willingness to participate in a one-hour interview within the next two weeks. The researcher allowed the nurse practitioner to choose a location that was quiet and free of interruptions during the interview to accommodate the need to audio tape the interview.

The interview was a transaction, reciprocal in nature between the researcher and the participants. The researcher guided the discussion using open-ended questions, with occasional clarifying questions to facilitate the process. The researcher gave complete concentration during the interview process to improve the accuracy, trustworthiness and authenticity of the data. However, the researcher remembered to remain centered on the data, listen attentively, avoid interrogating participants and treat participants with respect and sincere interest in the shared experience. Data collection was continued until the researcher believed saturation had been achieved, with no additional themes or essences having emerged from the interviews with participants.

Inclusion & Exclusion Criteria

The subjects were chosen with the following inclusion criteria: nurse practitioners working in MUA rural health in southeast Kansas, southwest Missouri, and northern Oklahoma. The populations the nurse practitioners serve must be less than 10,000.

There are two exclusion criteria. First, the nurse practitioner was excluded if they work both in a rural health care area and a metropolitan/urban area simultaneously,

and second, the nurse practitioner was excluded if they had practiced for less than one year.

Data Collection Procedure

The data collection method used in qualitative studies is individual interviews in which the participants respond to open-ended questions and the investigator observes their responses (Moran, Burson, & Conrad, 2014, p. 335). Individual interviews (Appendix I) were scheduled at the NP's convenience and were completed in the time allotted for the interviews. The open-ended questions were developed so each question reflected the specific aims and purpose of the project. Each interview was audio taped to capture the thoughts and feelings of the NP on their lived experiences in the rural health clinic. The researcher "[verified] the data during the data collection process to affirm the interpretation of data" (Moran, Burson, & Conrad, 2014, p. 341), by asking clarifying questions during the interviews. The researcher documented in field notes any non-verbal cues during the interview, and these cues were included in the transcript. The audio tapes was transcribed verbatim with the non-verbal communication in parentheses. The transcriptions was completed by a voice recognition transcription system, then checked for accuracy by comparing the written transcriptions and audio tapes.

Consent

The emergent design of qualitative research requires a process to obtain informed consent (Terry, 2015). According to Munhall, (1988) qualitative research is conducted in an ever-changing field, informed consent is an ongoing process. Participants were informed they could withdraw from the study at any time.

The subjects were assured all responses were confidential and the interview tape was labeled with interview numbers to ensure confidentiality. All data was collected and maintained in a secure method; audio tapes was locked in a fire proof box and transported in such to the transcription device and back to the researcher. The audio tapes were transcribed to a jump drive that was password protected and was also placed in the fire proof box. The data will be kept in the fireproof locked box for six months after the project is completed and then will be destroyed.

Protection of Human Subjects

The researcher received approval to complete the study from the Irene Ransom Bradley School of Nursing and the Pittsburg State University Human Subjects committees. There was no contact with potential participants until approval was received from these committees. Participants were made aware that the data collected may be read by other researchers to establish the confirmability of the research findings in the context of data analysis. With completion of the study, the data will be destroyed by the researcher.

After approval from Pittsburg State University IRB committee, the participants were called and ask to participate in a one-hour audio taped interview to discuss the lived experience as a MUA rural nurse practitioner. Prior to interview the researcher asked participants to sign a consent to participate and allow audio taping of the interview. They were informed their participation was completely voluntary and they could withdrawal from the project at any time (See Appendix A).

Tools/Instruments Described and Linked to Measures and Objectives

An interview template served as a standard outline for the beginning of each interview (See Appendix B). The template began with demographic information: age of nurse practitioners, gender, years worked in rural health, state and area of practice setting, approximate population the nurse practitioners serve, followed by a series of questions.

The researcher designed each question to reflect the specific aims and purpose of the project. The specific aims of this project were to:

- (1) Explore nurse practitioners' attitudes and feelings related to their current position in rural MUAs in southeast Kansas, southwest Missouri, and northern Oklahoma especially in relation to job satisfaction and retention.
- (2) Explore whether nurse practitioners in rural settings are experiencing professional isolation, stress or other factors that might negatively affect job satisfaction and retention, burnout and compassion fatigue.

This researcher's goal was gather qualitative data that would add to the understanding of the lived experiences of nurse practitioners practicing in rural underserved medical clinics.

Treatment of Data/Outcomes

This study was a phenomenological qualitative study. The data gathered during the nurse practitioner interviews were transcribed by a voice recognition system and then analyzed by the researcher. Field notes and observation data were analyzed by the researcher. The data was segmented into small units after thoroughly reviewing the transcriptions. Each segment was coded and given a name based on categories and subcategories. This method assisted to reduce the data, identify themes, arrange themes

into similar groupings, to summarize, and compile groups of information. These groups help the researcher to put data into thematic groups (Terry, 2015).

Limitations

Limitations included the time available for the researcher to complete the research study, being a novice qualitative researcher, and the ability to convert emotions and stressor responses into usable data. The study was limited by all interviews taking place with nurse practitioners in this specific identified geographic area.

Chapter IV

Results and Discussion

The objective of this qualitative phenomenological study was to examine the lived experiences of the nurse practitioners related to their current position in rural MUAs in southeast Kansas, southwest Missouri, and northern Oklahoma especially in relation to professional isolation, stress, job satisfaction and retention. By way of content analysis of the data, four themes emerged that influence the experience and retention of nurse practitioners in the MUA. These four themes are 1) inability to deliver appropriate and necessary care; 2) work related anxiety; 3) frustration with administrative support; and 4) autonomy and job satisfaction.

Six respondents agreed to the interview; of these subjects five were female and one male. Ages ranged from 28 to 60 with the average age being 48 years of age. There were two respondents from each study area. All respondents worked in a solo practice with only phone assistance if needed. Years of rural health care experience ranged from one year to twelve years; many of the respondents have worked rural health their entire nursing career, but for the study the focus was on the years worked as a nurse practitioner.

Theme 1: Inability to Deliver Appropriate and Necessary Care

The inability to deliver appropriate and necessary care them was the most common in all interviews. This theme emerged in seven of the eleven research questions. Specialty care was the common thread in all the interviews. The researcher belief there is a twofold problem: first “getting a specialist that is willing to accept the patient in a reasonable amount of time”, and second securing “transportation for the patient to attend the appointment”. Many of the “rural patients do not come for care until it is beyond what a nurse practitioner is able to do”, so “helping the patient understand the need of a specialty care is also difficult at times” due to their “lack of education and understanding”. The provider must keep in mind Orem’s theory of “self-care and dependent care are behaviors learned within a socio-cultural context” (“Nursing Theories,” 2012, p. 2). Respondents find themselves “[doing] some things that normally you would refer to a specialist” or “quite frankly... [doing things] that are beyond my skill set,” in order to care for the patient. The other issues are the fact the patients either do not have access to transportation or cannot afford to pay for transportation. There are a few Medicaid transports but this system is backed up and it is difficult to get transportation without a week or two lead time. If the provider is lucky to get an appointment with a specialist for the patient in the same week, these transportation services will not help the provider with the transportation. Therefore, finding the patient a ride to the specialist is also an access problem.

The next issue under this theme is getting diagnostic imaging in a timely fashion. There are several issues preventing the access to diagnostic imaging. These include having personnel to do the x-ray in office, having the equipment needed, and getting the

patient to a facility if a specialized imaging is needed. Clinics for the most part hire nurses in the rural clinics; they do not have the volume to have a diagnostic imaging person, so the nurse must learn to do in office x-rays. One respondent respond, “my staff often have not completed training for x-ray, and I often do not have the time to stop and do the x-ray myself”. According to those interviewed, there is a significant learning curve to this and getting a nurse trained takes several months. Having personnel in the office to do x-rays helps the office run well and gets the diagnostic results to the provider in a more timely manner. Although many rural health clinics have simple x-rays, there are times when the patient needs more extensive tests. Often there are issues with getting prior insurance authorizations for a procedure and setting up payment arrangements. In addition, some remote hospitals only have MRI or CT scans 1-2 times a month, consequently the patient has to wait or make a longer trip to get the imaging done.

Lab testing is another issue in the rural clinics. Blood can be drawn in the clinic, but then it must be transported back to the hospital or the lab. Many times this is a day or two delay for laboratory testing. Respondent states, “I wish we could have immediate lab results or at least within the same day.” The delay in getting tests results often effects diagnosis and treatment of a medical condition. Respondents find it frustrating that they cannot get the information they need to promptly care for their patients. If the patient is asked to go to the hospital for something the providers deems emergency lab, again the transportation and money come up as issues.

Theme 2: Work Related Anxiety

This theme focused on the respondents’ feelings about the work environment, job factors may increase or decrease stress, aspects of job or life outside the work setting that

causes or decreases stress, motivating factors to change jobs, and negative impact for retention. Everyone is quite aware that having a career comes with an expected level of stress. According to the respondents, the idea of being frustrated, overwhelmed, stressed and anxious were the most frequently mentioned.

Access to care was the most mentioned problem. However, the respondents talk about the anxiety they felt when they were unable to get the appropriate care for the patients. One respondent said, “it eats me up, I worry, it consumes my thoughts when I cannot get my patients the care they need”. Another respondent said “I felt like a failure.” These thoughts and feelings are also what one might hear when the health care provider is experiencing burnout. It was noted that the respondents had to be directly asked about stress before they really shared anything about how the work in rural MUA affected them. According to Orem’s theory this is a concern, and important for the well-being of the health care provider. Orem’s theory states, “a person’s knowledge of potential health problems is necessary for promoting self-care behaviors” (“Nursing Theories,” 2012, p. 2).

When the subjects talked about feeling frustration, irritation or infuriated it was in part due to the patients they serve and in part due to the difficulty getting the care the patient needs. One respondent talked about becoming “frustrated”, because “instead of purchasing a four-dollar prescription for medication the patient returned with the same medical issue and having a new large tattoo and a full pack of cigarettes” in his pocket. Others shared similar stories when talking of their patients. Others referred to frustration in “getting the patient to understand how important it was for them to see a specialist”. In both situations the respondent called it frustration. Compliance with treatment is an issue

with all patient populations, but it is exceptionally difficult with the rural population due to low educational levels, and the generally poor population. Some of the respondents could not determine if the problem was that the “patient did not understand” or “really did not pay attention” or “was I unclear” to them when the respondent was educating them on their medical issues.

The average nurse practitioner sees “three patients in one hour” (AANP, 2015, p. 1) in an 8-hour day that would be 24 patients. “Overwhelmed” was the way two of the respondents described days at work in really busy clinics or extremely busy clinic days often seeing 30-40 patients in a day. Respondents discussed the majority of these patients were “walk-ins”; consequently they “did not know their history” and “trying to read histories when you are so busy is difficult at best”. The sheer volume of patients with different problems was more than they felt they could comprehend and make good judgements. These are similar to the thoughts and feelings that were discussed when reading about professional isolation. Four out of six interviewed stated, “feeling overwhelmed would motivate them to leave and be a negative impact on retention”.

Stress was mentioned by all six respondents at some point in their interview. In every instance it had to do with patients, their care and everyday clinic functioning. One respondent shared a story about the schedule. The respondent has tried to “explain to the receptionist that she is the one in control of the schedule”. The receptionist in charge of the schedule can cause “everyone in the back to have a stressful or stress free day depending on how she schedules” the patients for that day. The perception of the respondent, was the “scheduler does not think when scheduling; she just fills slots”.

Others feel being a provider is just stressful because they are caring for someone's life and the responsibility is stressful in itself.

Anxiety was explained in several ways by the respondents, but four of the six interviewed reported they take stress home on a regular basis. However, none of the six respondents felt the stress and anxiety at work caused issues at home. A respondent explained, "when there was a busy day the next morning I would have to get up at 4 or 5 am in order to get his charting done from the day before", but he denied this action caused home related issues. A respondent described the feelings of "nervousness, worry, unease, and keeps me awake at night". These feelings were described by four out of six respondents when talking about job factors increasing or decreasing stress. In general, some anxiety is good, but is concerning when a respondent states, "it is consuming my thoughts." They report feeling so overwhelmed they just "sat blankly in a chair at home until bedtime." Two respondents stated, "lying in bed and not being able to sleep" because they worried they missed something or misdiagnosed a patient that day. In all instances, they discussed how this anxiety was constantly on their minds and how it kept them on edge. These thoughts, feelings and behaviors also describe burnout as it is defined in the literature review for this study. Two of the respondents have good support systems to help them work through the issues, two had extended family they use as support and the other two do not have a good support system so must rely on the work community to reduce stress. Two of the six reported that stress would be a motivating factor to leave if they were to leave MUA rural health clinic.

Theme 3: Frustration with Administrative Support

Administration plays a role in the daily management of the practices in which respondents are employed. The level of involvement with the administrators in this study directly reflects to the number of years the respondents have practiced. The more years of practice the respondent had, the more their frustration increases with the administration. Respondents who are newer to their role experienced less frustration. Three of the six respondents feel they are supported by their administrators and expressed no frustration. One respondent boasted, “I see the administrator one time a year when planning the budget otherwise the administrator is never seen again.” Others have never met their administrator and deal only with the office managers. This researcher suspects their feelings of support will change as the respondents become more familiar with the regulation and a better grasp of their position as a provider. Increased administrative support is one factor that is a positive factor for job satisfaction and NP retention.

This author’s belief often administrators in the rural areas are large city hospital administrators nearing retirement and want to downsize their job so they seek a position in a rural hospital. The problem with this is the rural health regulations are different than the regulations of the for profit or not for profit hospitals in the city. The rural hospitals and clinics have their own set of rules from Centers for Medicare and Medicaid Services (CMS). Unless the administrator takes the time to learn these rules, it is a constant battle to manage the practice and follow the CMS rural health rules and regulations. This is one area of frustration with the respondents. “They [administrators] don’t know what they are doing and make it difficult” according to one respondent. According to the respondents, they push for quantity instead of quality, although in the rural clinics the population does

not come for medical care. Often the NP's must spend time taking care of many issues when the patient visits the clinic. One angry respondent said of his administrator, "all he thinks about is numbers, he does not care about how well I care for my patients, or that they are my regular patients." The general consensus of the respondents, administrators are about money and numbers. When they have nothing else to say to them, they encourage the respondents to increase their volumes and bring up their numbers. But, the truth is the hospitals get reimbursed by the government when the rural health clinic does not cover all the cost. This researcher believes when the administrator told one respondent "they must get their patient volumes up" without giving them additional resources, it would lead the respondents to question if administration truly expected an increase in patient numbers.

The respondents had one major theme when talking about administrative support; they wanted and expected action on the issues they reported to their administrators. Five of the six said when they have an item that needs fixed it is very slow to happen, if the request was not ignored entirely by the administrator. One respondent said, "I feel like the red headed step child", when asked to have something done. Another said, "out of sight out of mind." Four of the respondents talked about needing lab equipment, diagnostic tools, or something in the building fixed. They informed the interviewer that from the time they reported until the problem was fixed it took 2-6 months for the problem to be resolved, unless it is survey time. One respondent told a story about the x-ray machine being down for 6 months, and then "magically being fixed the day the surveyors arrived". Clearly, with administrative support many of these issues might quickly be resolved resulting in decrease the stress of the NP's. In Orem's theory,

“nursing is a form of action interaction between two or more persons: ("Nursing Theories," 2012, p. 2), therefore using assertive communication with the administrators expressing needs and expectations may reduce some of these stressors.

In many clinics, NPs are the only provider in the clinic. Often, they are checked on throughout the month to see that things are running well. They felt even though they are expected to keep things running smoothly, they are not appreciated by administration and not kept informed about decisions having to do with the clinic. One respondent told a story about a new physician coming into the clinic for orientation and the respondent had to call the administrator to verify that the physician was in fact to be there for an orientation.

The need to hire and train staff from the nurses up to the physicians is also important to the NPs. Very few staff members in the rural health clinics know the general policies. According to the respondents, they are told to read the policies, but they never do. Those interviewed believed if the clinics were adequately staffed they could take time off without feeling guilty about leaving the clinic short staffed and patient care would not suffer. The respondents have a sense of obligation to see that their clinic is run efficiently and smoothly, even when they are not there to oversee it. They feel strongly that each and every staff member needs to know and practice the clinic policies as well as rural health policies as set up by CMS.

The respondents indicated the administration plays an important part in retention and satisfaction. Several sources stated that praise and recognition increases retention and job satisfaction. What the administrator may need to remember is nurse practitioners are not physicians and group praise needs to include them. For example, when the

administrator writes a newsletter appreciating the physicians, who are only in the clinic one day a week, for the hard work they do in rural clinics without acknowledging the NP's work, they reported feeling unappreciated.

Theme 4: Autonomy and Job Satisfaction

Respondents interviewed felt because they were serving in a medically underserved area, they were helping to improve the access to basic medical care for their patients close to home. They reported, “[this job] it feels like this is my calling,” this “is where I want to be,” and, “I love what I do”. One respondent told a story of having seen 20 patients in the morning and 20 patients in the afternoon and feeling guilty she had to stop taking patients because she could no longer concentrate on the patients; her head was spinning. Another respondent stated, “I have a hard time accepting that I cannot be all for everyone.”

A respondent stated, “Rural area allows me the opportunity to be the patient's primary care provider”. “One of the positives is I see the same people over and over which gives me a little more understanding in to their personalities, background and their ability to understand, lets me know what I can and can't expect of them. According to one respondent the rural provider has “a lot more hats to wear.” Two respondents said, “Positives are you get to help the people that need you the most.”

Although the respondents felt they were undercompensated financially, citing lack of time off and poor education reimbursement, the idea of changing jobs was not being considered. Of the six subjects interviewed, none of them plan to leave in the near future, one is leaving in three years when her husband retires so they can relocate to Florida to be near her children. None reported wanting to leave because of the compensation or

benefit. However, all were aware they would possibly be better off elsewhere. If a respondent can relocate 90 miles and make \$23,000 dollars more a year, one must wonder what is keeping them in rural health.

All the respondents from this study have lived in rural areas all their life. They like “caring for friends and neighbors,” and they like the fact the pharmacist knows them by their first name. They enjoy the rural life and have no desire to move away from the area. Each of them enjoyed having a less than 10-minute drive to their clinics, although they admit that at times having “people stop by my house with medical problems” or “stopping me in the grocery store to show me a rash” becomes anxiety provoking. However, they did not see this as a cause to leave the rural area. Having a job the respondent likes, and caring for friends and neighbors is a positive retention factor.

Six out of six subjects liked the autonomy they have working in a rural clinic in solo practice. Each one felt they would “lose the opportunity to practice independently if they were to work in a metropolitan area or an urban area.” Several felt leaving a rural area would affect their diagnostic skills and reduce their skill base. One respondent reported, “working in a rural area you have to be flexible, able to perform more skills, and be more creative than in larger places.” Each respondent felt they were a more independent, well-rounded nurse practitioner from working in the rural MUA. “Working rural allows me to keep my nursing skills up, in a smaller place where you have to do more things, you are more flexible, and able to do more skills.” A respondent stated, “job satisfaction comes from the ability to perform more skills and work independently”. The respondents believe this makes them, a more well-rounded nurse practitioner. “There is a

lot of satisfaction in helping people and coming up with treatment plans, managing, and monitor their diseases.”

Respondents reporting they liked the fact they have to rely mainly on themselves. They all have a collaborative physician, but at times they feel they need to research and look for a solution to their clinical issues. One respondent explained, the most satisfying part of her job was when she was able to figure out what was causing the medical issues in her patient. Then, when she got that patient to the correct specialist, she found it rewarding that the specialist “took their time to call me and tell me what a great work up I had done”. She stated, “That is true job satisfaction.” Another respondent defined her job satisfaction as when she “walked into the emergency room and a patient said, ‘that is my NP she is better than any doctor, she listens’.” For the most part, the respondents feel that patients are recognizing and appreciating them for the skill set they have and can offer them.

Summary

After analysis of the data from the individual interviews, four final themes were identified by this researcher. These themes emerged from the interviews and data obtained from six family nurse practitioners’ real life experiences.

Chapter V

Conclusion and Recommendations

The purpose of the phenomenological qualitative study was to explore the lived experience of nurse practitioners practicing in rural health clinics in medical underserved areas. This chapter provides implications for nursing, strengths and limitations, and recommendation of future research. Data collection was guided by two goals.

1. Explore nurse practitioners' attitudes and feelings related to their current position in rural MUAs in southeast Kansas, southwest Missouri, and northern Oklahoma especially in relation to job satisfaction and retention.
2. Explore whether nurse practitioners in rural settings are experiencing professional isolation, stress or other factors that might negatively affect job satisfaction and retention.

Nursing Implications

Rural health administration and providers need to investigate different care delivery systems that increase patient access to care. Inability to deliver appropriate and necessary care was the focus of the first theme. The nurse practitioners were very concerned they could not get the medical specialties for their patients that were needed. At times, this caused the nurses to step out of their comfortable scope of practice and do research in order to provide this care in their clinic. This issue was compounded by

difficult patients understanding the need for specialty care, having the money to pay for care, and having access to transportation for the specialty care, all of which is supported by the literature. Conger and Plager (2008) found a sense of isolation came from inability to get patients referred to needed specialties. Newhouse (2005) suggested administrators should improve the ability to deliver appropriate and necessary care by the use of alternative approaches to health care, due to the unique characteristics in rural health.

Nurse practitioners need a means to reduce the stress in their work environment, including access to working equipment, assistance with referrals, arranging transportation, prior authorization, and improved compensation. Work-related anxiety was the second theme. Stress and anxiety comes to the MUA rural health clinics in many ways, according to Sprang, Clark, and Whitt-Woosley (2007), who cite a sense of isolation due to emotional and physical exhaustion, lack of support and resources, and strain on the professional role. The researcher's believes that nurse practitioners experience stress because they often practice alone in clinics. They seem to have similar personality types and tend to have a drive for success. The respondents alluded to the fact that if they are not successful, this increases their stress. With large amounts of stress, it is difficult to focus, and three of the subjects talk of this very thing. During the data gathering, the nurse practitioners discussed worry, nervousness, anxiety and inability to sleep. One discussed anger and inability to control her anger with her staff. According to Waddunba et al. (2005), medical practice in rural medically underserved areas intensifies the probability of burnout due to physical distance, low compensation, limited resources and distressing patient-provider relations. Stress and emotional disturbance was a theme all participants discussed. Using Orem's theory, nurse

practitioners need to have “knowledge of potential health problems for promoting self-care behaviors” (“Nursing Theories,” 2012, p. 2) in themselves. The respondents from this study did not acknowledge their stress or discuss it until they were directly asked, which could mean they were unwilling or unable to put into words how they were feeling until it was discussed. Each person has their own acceptable stress level, but taking care of some of the daily issues may reduce their stress. For example, having the equipment regularly maintained and reducing the breakdowns could have a positive effect on NP’s stress levels. Bailey (2009) states, stress comes from delays in trying to diagnosis or treat a patient due to old or unavailable equipment. Keeping the computer connection and equipment in good working order for communication and access to information quickly may also reduce stress on NPs. Stress for the working NP’s may also be reduced by getting access to specific specialities by having them visit rural areas or by using telemedicine. According to Conger & Plager, (2008) the sense of connectedness came from the presence of “other health professionals, support persons and services, telecommunication with urban hospitals, and internet” (p. 28). In all these ways, stress can be reduced and retention improved.

Nurse practitioners need to model self-care and independent behavior-focused care within the patient’s socio-cultural context (“Nursing Theories,” 2012) by teaching and educating patients on disease prevention, disease process, and treatment and by practicing strategies for self-care themselves. By using Orem’s theory, the providers understand all patients are distinct individuals (“Nursing Theories,” 2012) with their own levels of education, desire and financial opportunity.

Data from the research study indicates administrators need to listen and take action to assist nurse practitioners in running the clinic smoothly and reducing the stress the NPs feel. Frustration with administrative support was present in most interviews. The primary outcome the nurse practitioners wanted from their administration was action. They felt when they asked for equipment to be repaired, action should be taken without having to wait months. Orem's theory suggests that "nursing is a form of action and interaction between two people" ("Nursing Theories," 2012, p. 2) so the need for direct and open communication and set expectations may help in reducing stress from slow response to requests.

The nurse practitioners feel having adequate staffing would help them feel supported. Newfoundland and Labrador (2005) released a paper that reporting, adequate staffing levels ensure patient satisfaction and helped with retention and recruitment in rural areas. Adequate staffing would allow nurse practitioners and other staff to take time off and attend educational conferences to keep up on the latest knowledge.

This researcher believes improvement in the orientation and training of all employees in rural health clinics would decrease stress, improve communications and increase satisfaction. Working in rural health is a challenge, but when working many miles from assistance and having staff that do not have knowledge of policies and procedures and rural health regulation, it becomes much more difficult. Rural disconnectedness came from isolation, inability to attend professional meetings, breakdown in communication, lack of qualified health providers, poor or non-existent internet connection, and garbled communication with urban hospitals (Conger & Plager, 2008). Participants in the study indicated staff who were unable to accomplish their

required tasks at the clinic added stress for the nurse practitioners. The providers would like the staff to know policies and procedures, be able to perform all their duties, and keep their charting current. Dyson (2002) discussed the need for allocation of resources for good leadership, adequate staffing, educational opportunities and adequate orientation in these rural areas.

Autonomy and job satisfaction are qualities rural nurses are proud to possess. Organizational factors such as supportive work environment, adequate supervision, autonomy, control and access to sufficient resources resulted in more positive outcomes (Sprang et al., 2007). The NP's feel being a primary nurse practitioner is their calling and they strive to do as much as possible for their patients. Although they feel undercompensated by money, time off and educational opportunities, they have no intention of leaving the rural MUA, which parallels the research done by Newhouse (2005) stating, "rural connections, patient workloads, professional development opportunities, adequate orientation and salaries"(p.9) increases retention. Those interviewed stated, they enjoyed caring for friends and neighbors and plan to continue. Autonomy was very important to the rural MUA nurse practitioner. Several of those interviewed indicated the importance of this attribute.

In addition, they felt true job satisfaction when their patients recognized them as medical professionals. The nurse practitioners indicated their pride lay in the service they provide in caring for their patients. They enjoyed the autonomy, which research by Tolbert (2013) found to be positive for retaining nurse practitioners.

The nurse practitioners interviewed are strong individuals and for the most part work independently, but with the day after day grind it is important for them to know

someone is watching and appreciating what they are doing, as a clinic group and as a provider. Therefore, it is important that administration look at ways to praise and recognize the NP's work. Bedward and Daniels (2005) reported that providers need to be "recognized or praised for achievements" (p.59). This does not require daily communication but positive communication of a regular basis may help with retention of NPs.

There is an immense amount of work needing to be done to help nurse practitioners in medically underserved areas to retain their personnel. All three areas in this study are 100% rural and 100% medically underserved. In order to provide medical care equality throughout the United States, steps will need to be taken to improve the conditions in rural health. Orem's self care theory is an excellent guide to "maintain life, heal and well-being" (Wayne, 2014, p. 3). This theory is used in part to guide patient care as well as the self care of the nurse practitioner.

Nurse practitioners in the MUA rural health clinics felt they were improving the access to care in the rural health clinical experience. However, it is important that laws that restricting the practice of nurse practitioners be reviewed and revised to allow NP's to practice at the full scope of their education (AANP, 2015). The NPs liked the fact their education and clinical experience made them more well-rounded in their practice than their counterparts in the larger cities.

Strengths and Limitations of Study

The phenomenological qualitative study was an effective method to explore the lived experience of nurse practitioners practicing in rural health clinics in medical underserved areas. This study design allowed the nurse practitioners to express their

experiences, thoughts and feelings about working in a MUA rural health clinic. This free expression allowed the nurse practitioner to provide valuable information that might not have been expressed in another format. The accommodation and willingness to participate in an interview about rural health lived experience was a strength. All participants were allowed to choose a setting in which they were comfortable to respond to the interviewer's questions. Interviews were done in a private atmosphere allowing the participant to feel comfortable to share thoughts and feelings.

Limitation included small sample size. Six nurses were interviewed, two from each geographic area. Although this number is acceptable for qualitative research. The researcher did not feel complete saturation of the lived experiences was obtained with only the six interviews. The participants were all very close in age with five of the participants being 48 years of age and older. All participants have always worked and lived in a rural community. All participants lived within a 100 mile radius.

Another limitation is the time available for the researcher to complete the research study. Data collection was limited to a two-week time period. Additional data collection after initial analysis was not possible due to the two-week time restraint.

Recommendations for Future Research

Future research to address the struggles NP's experience in the MUA rural clinic needs to be ongoing. First, research should be conducted to study inability to deliver appropriate and necessary care, work-related anxiety, frustration with administrative support, and autonomy and job satisfaction of nurse practitioners. Within each of these themes, there are many areas that need to be explored in the future.

Second, future search should explore ways to improve access to care of persons living in the MUA, taking an in-depth look at the number of specialists and the best way to provide specialty care in the remote areas. A third recommendation for further research would be to study the cost and modes of transportation in the rural areas.

A fourth recommendation might include comparing the emotional state of providers caring for patient in metropolitan and urban areas with those practicing in the rural areas. Researchers should consider completing a quantitative study and compare to a qualitative study to see if providers know the emotional toil they are under working in MUA rural health clinics.

A fifth area for further research would be to look at the administrative style of metropolitan administrative officer versus rural administrative officers. This would investigate if the administrators are changing their leadership style in compared to the person and area they are working with.

Lastly, a study comparing rural health nurses to nurse practitioners working in urban and metropolitan areas. This study would discover if the retention issues were just in rural areas or an issue for nurse practitioners in general.

Conclusion

Seventy three percent of the adults in the United States have at least two or more complex chronic conditions requiring frequent and ongoing monitoring to achieve and maintain optimal health (CDCP, 2012). Many of these patients are in the rural areas and are cared for by a nurse practitioner. The need for rural clinic nurse practitioners is great

but with the difficulties in recruiting and retaining nurse practitioners, it is not easy to keep these clinics staffed with qualified nurse practitioners.

Nurse practitioners in this study felt the keys to helping and retaining nurse practitioners in the MUA would require a great deal of work. The nurse practitioners identified the need to deliver appropriate and necessary care for their patients and actually get them to their specialty appointments, laboratories for blood work or for diagnostic imaging. Another issue verbalized by the nurse practitioners was work-related anxiety that comes first with providing medical care to a patient but also doing so with less staff, equipment or poor quality equipment, experiencing physical exhaustion, lack of support and resources, and strain on the professional role. Reduction of frustration with administrative support to address equipment failures or repairs, building issues, provide some emotional support, increased communication, increase in benefits and salary, provide some praise and recognition. The autonomy and job satisfaction the nurse practitioners enjoyed by working in the rural MUA needs to be acknowledged.

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APPENDICES

Appendix A

**Pittsburg State University
Informed Consent for Research**

Project Title: A Qualitative Study of Rural Nurse Practitioners' In Medically Underserved Clinics

Approval Date of Project:

Expiration Date of Project: 5-1-2017

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Purpose of the Research:

The purpose of this project is to gather qualitative data that can be used to understand the lived experiences of nurse practitioners practicing in rural underserved medical clinics.

Procedures or methods to be used:

If you agree to participate in this study, your participation will last approximately one hour. This will involve:

- An interview of predetermined questions.
- The interview will be audio recorded and transcribed by a transcriptionist
- Your identity will be kept confidential by using a state plus a number code.

- The audio tape will be kept in a fire proof secure box during analysis process and destroyed when research is completed.
- The transcriptions of recording from each interview will be maintained in a secure file with the researcher for 6 months then destroyed.

Alternatives:

Participation in this study is voluntary.

Length of Study:

Study participation will be a one-hour long interview.

Risks Anticipated:

No known risks or discomforts are anticipated from this research study.

Benefits Anticipated:

No known benefits are anticipated from this research to the participant or researcher.

Extent of Confidentiality:

The researcher will protect your information as required by law. Your name will not be associated in anyway with the information collected about you or with the research findings from this study. The researcher will use a state and number combination to identify the audio tape instead of a name. Transcript will be shared with the scholarly project committee members by way of Pittsburg State University secure file transfer system /the researcher will not share information about you with anyone not specified above unless required by law or unless you give permission.

Terms of Participation:

I understand this interview is part of a research project. I am participating totally voluntarily. I am agreeing to participate in a one hour taped interview. I also understand if I chose to withdrawal at any time I may do so without explanation, penalty or loss of benefits or academic standing to which I may otherwise be entitled.

I verify that my signature below indicated that I have read and understand this consent form, any questions have been answered and willingly agree to participate in this study under the terms described and that my signature acknowledges that I have received a signed and date copy of this consent form.

Participant Name: _____

Participant Signature: _____ Date: _____

Appendix B

- 1) Tell me about the type of work you do at the rural clinic.
- 2) What impact do you think working in a rural clinic has had on your nursing practice?
- 3) In working at the rural clinic, do you ever experience situations where you don't have the personnel, tools or equipment needed to handle the situation? Follow up if needed: Tell me about those situations.
- 4) What do you think would be different about working in a metropolitan/urban area versus rural clinic?
Follow-up if needed: How do you think that would affect your practice?
Follow-up if needed: When you need someone to talk to about an issue related to your work how easy is it to find someone who can help you with technical information, emotional support or other types of support?
- 5) Now, I'd like to ask you about your feelings related to practicing in a rural medically underserved area. From your perspective, what are the positives and negatives of this type of nursing practice?
- 6) How do nurse practitioners in similar practices feel about working in rural health care?
- 7) Now, I'd like to ask you to reflect on job factors of your professional life that either increase or reduce stress. How does stress impact your feelings about your job every day?
Follow-up: What aspects of your job or your life outside your job do you feel contribute most to your (high or low) stress level?
Follow-up: How could your administration help reduce/prevent the stress associated with your current position?
- 8) What reasons have your peers given when leaving your MUA rural health practice?
- 9) How likely are you to leave your current position?
Follow up: If you are likely to leave what are the issues motivating this?
- 10) Thinking about the future of rural health, factors do you think will have the biggest negative impact on retention of nurse practitioners in your type of practice? What factors could potentially have the biggest positive effect?
- 11) Is there anything you want to tell me that you have not been ask about?