

Walden University

College of Management and Technology

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Eric Haupt

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2016

Abstract

Predictors for Florida Nurse Practitioners' Characterization of Organizational Climate

by

Eric F. Haupt

MA, Webster University, 1999

BS, Fayetteville State University, 1997

Doctoral Study Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Business Administration

Walden University

December 2016

Abstract

Healthcare managers are failing to meet the increasing demand for services while experiencing a growing shortage of healthcare workers. The restrictive scope of practice regulations and organizational barriers have a negative effect on the number and growth of nurse practitioners available to meet the required demand. Researchers have focused on the organizational climate of the nursing profession in general, yet there is an absence of research regarding the perceptions of the advanced registered nurse practitioners (ARNPs) in their local practice environment. The purpose of this study was to examine if ARNP role identification, autonomy, and collaboration were predictive of perceived organizational climate. Lewin's field theory formed the theoretical framework for the study. A sample of 187 ARNPs practicing in the state of Florida specializing in primary care completed the nurse practitioner–primary care organizational climate questionnaire administered via an online third party survey administration service. The results of the multiple linear regression analyses indicated the model as a whole was able to significantly predict organizational climate $F(3, 183) = 12.498, p = .001, R^2 = .681$. Role identification ($\beta = .346$) provided the most contribution to the model, followed by collaboration ($\beta = .296$) and autonomy ($\beta = .275$). The implications for social change could include providing Florida state policymakers and healthcare managers with the meaningful information needed to develop concrete strategies for optimizing and retaining the ARNP workforce. Improving nurse practitioner engagement could lead to improved patient results and safety.

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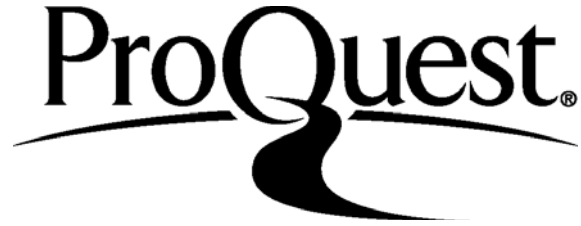
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Dedication

My dedication goes to my dear wife, Carla, whom I intensely love, for her support, patience, understanding, and love. I look forward to spending my life with you, chasing our dreams together. To my father, Richard Haupt, for instilling self-confidence in me at an early age and for reminding me that I could accomplish anything with hard work, discipline, and determination. I further dedicate this study to my children Brittney, Ashlyn, Madison, Garrett, and Sheridyn in the hope that this will inspire them to achieve their goals in life. I would also like to offer special thanks to my extended family of Roger and Julia Kauffman, Dr. C'Lamt Ho, Dr. Tom Seiler, and Kaela Hoffman for their support in the start and completion of this journey. Finally, I would like to dedicate this study to the memory of my mother, Gloria. Thank you for always loving me, being proud of me, and teaching me how to be a man.

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Section 1: Foundation of the Study

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, was the most comprehensive healthcare reform legislation in the United States since the Social Security Act of 1965 creation of Medicare and Medicaid (Lathrop & Hodnicki, 2014). The implementation of the PPACA expanded and broadened the availability of services to 32 million previously uninsured Americans (Congressional Budget Office, 2012). The PPACA further exacerbated the provider shortage problem in the United States (Pettersen et al., 2012).

Producing more doctors cannot overcome the impending physician shortages (Dill, Pankow, Erickson, & Shipman, 2013). Projected physician shortages coupled with changes called for by the PPACA have led to an increased reliance on physician assistants and nurse practitioners (Kirch, Henderson, & Dill, 2012). The growing nurse practitioner workforce represents a significant supply of primary care providers to meet the demand (Poghosyan, Nannini, Finkelstein, Mason, & Shaffer, 2013). The PPACA created challenges for organizations that may lack the preparation or processes to adapt and comply with the new requirements (Dagher & Farley, 2014).

The influx of previously uninsured Americans because of the PPACA served to exacerbate an already depleted healthcare workforce. The aging population further challenges the shortfall of providers to meet demand. Furthermore, primary care physicians are retiring or shifting to part-time work faster than their replacements can succeed them. Schwartz (2012) aptly described the phenomena as a bottleneck due to ballooning demand and vanishing supply. In the study, I examined the variables of role

identification, autonomy, and collaboration in nurse practitioner environments as they relate to the organizational climate.

Background of the Problem

State regulations restricting the scope of practice for nurse practitioners present a significant practical barrier to these clinicians' expanded roles (Dill et al., 2013).

Representatives of the Institute of Medicine (2010) conducted a study recommending that advanced registered nurse practitioners (ARNP) practice to the full scope of practice without restriction. The PPACA provides Florida ARNP an opportunity to address statutory restrictions and professional barriers that limit their ability to perform to the maximum extent of their education and training (Lathrop & Hodnicki, 2014).

Nurse practitioners represent a significant supply of professionals providing quality patient care (Poghosyan, Boyd, & Knutson, 2014). Confusion and disharmony exist, which contribute to role misunderstanding as various states, medical, and nursing organizations have different and at times adversarial statutes (Ryan & Ebbert, 2013). A restrictive organizational climate affects employee perceptions of their value and can lead to job dissatisfaction (Liu, Finkelstein, & Poghosyan, 2014).

Job dissatisfaction can lead to absenteeism and turnover, reducing the quality of patient care and causing a significant financial burden to short-staffed organizations (Poghosyan et al., 2013b; Wong & Laschinger, 2013). Satisfied employees are more productive, creative, and committed to their organizations (Markovits, Boer, & van Dick, 2014). Conducting this study may provide meaningful information to hospitals and

human resource managers about the need to develop concrete strategies for retaining the nursing workforce (Ramoo, Abdullah, & Piaw, 2013).

Problem Statement

Healthcare managers are failing to meet the increasing demand for services while experiencing a growing shortage of healthcare workers (Carryer & Yarwood, 2015). The estimated supply of providers will fall 20% short of demand by 2025 (Poghosyan et al., 2014). A restrictive scope of practice regulations and organizational barriers has a negative effect on the number and growth of nurse practitioners available to meet demand (Reagan & Salsberry, 2013). The general business problem is that some policy makers and managers in healthcare organizations lack awareness of their policies' potential effects on organizational climate. The specific business problem is that some managers in healthcare organizations do not understand the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate.

Purpose Statement

The purpose of the quantitative correlation study was to examine the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate. The independent variables are (a) role identification (X_1), (b) autonomy (X_2), and (c) collaboration (X_3). The dependent variable was organizational climate (Y_1). The targeted population consists of ARNPs practicing in the state of Florida. The implication for positive social change includes the potential to provide significant knowledge to influence policy, practice, and research to reduce healthcare costs and increase patient satisfaction and outcomes.

Nature of the Study

I used a quantitative method for the study because of the need to examine the relationship between variables (Moxham, 2012). The primary interest of qualitative researchers is to explore and understand the participants' perceptions of an issue (Willig, 2013). The mixed method is applicable for researchers to provide a comprehensive understanding of a phenomenon from a combined interpretive and statistical perspective (Brannen & Moss, 2012). The purpose of the study was to examine the strength of the relationship between the independent variables and dependent variable. As such, the quantitative method was most appropriate because I required numerical data to analyze and address the research question.

I used a correlational design in the study. Quantitative research designs include descriptive, correlational, quasiexperimental, and experimental (Borbasi & Jackson, 2015). The researcher examines the interrelationship of variables without intervention in a correlational design (Polit & Beck, 2013). A descriptive design was not appropriate because it involves the general portrayal of an individual, group, or situation, and the frequency of occurrence (Polit & Beck, 2013). An experimental or quasiexperimental design is not appropriate because the independent variables of interest are not amenable to manipulation (Grove, Gray, & Burns, 2014).

Research Question

What is the strength of the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate?

Hypotheses

$H1_0$: There is not a statistically significant relationship between ARNPs' role identification and organizational climate.

$H1_a$: There is a statistically significant relationship between ARNPs' role identification and organizational climate.

$H2_0$: There is not a statistically significant relationship between ARNPs' autonomy and organizational climate.

$H2_a$: There is a statistically significant relationship between ARNPs' autonomy and organizational climate.

$H3_0$: There is not a statistically significant relationship between ARNPs' collaboration and organizational climate.

$H3_a$: There is a statistically significant relationship between ARNPs' collaboration and organizational climate.

Theoretical Framework

Lewin (1939) developed the field theory, which is also known as *topological psychology*. Researchers use field theory to understand the formation, motivation, and maintenance of social groupings (Burnes & Cooke, 2013). Lewin described the attitudes, feelings, and social processes of organizations as the *climate* (Ashkanasy & Dorris, 2015). Lewin concluded that the organizational climate linked to the organization's environment and is an important determinant of individual motivation and behavior (Burnes & Cooke, 2013). Organizational environment is a key factor that contributes to employee wellbeing (Randhawa & Kaur, 2014). As applied to the study, Lewin's field

theory implies that I expected the independent variables, assessed by the Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ), to measure a significant relationship between the ARNPs' motivation and the organizational climate (Poghosyan et al., 2013c).

Operational Definitions

The operational definitions listed in the section provide definitions for technical or unique words found in the study.

Advanced registered nurse practitioner (ARNP): An ARNP is a healthcare provider, licensed by the state. The educational path to becoming an ARNP in the United States is a master's degree from an approved nursing school program. A graduate candidate is required to pass the national council licensure examination or NCLEX-PN examination to obtain an ARNP license (U.S. Department of Labor, 2014).

Organizational climate: The organizational climate is a primary source that influences job attitudes to play a mediator role in explaining employee behavior (Randhawa & Kaur, 2014).

Patient Protection and Affordable Care Act (PPACA): The PPACA was federal legislation signed into law in 2010 that expands health insurance to approximately 32 million uninsured individuals. The PPACA requires reforms to health care delivery, the curtailment of health care costs, and an increase in the quality of care delivered (Congressional Budget Office, 2012).

Primary care provider: A primary care provider is a healthcare professional who helps in identifying, preventing, treating illness and disability (Rohrer, Angstman, Garrison, Pecina, & Maxson, 2013).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are possible factors accepted as true (Kirkwood & Price, 2013). These factors are difficult to control. The first assumption was that the study participants constitute a representative sample of Florida primary care nurse practitioners. The assumption was required to avoid the perception of a biased sample. The second assumption was that the respondents put personal biases aside and responded objectively to the survey (Meier & O'Toole, 2013). A participant's experience, values, and morals may differ from other individuals to complicate the findings.

An assumption was that participants understood each of the variables used in the study similarly. The effect of each variable and how each member perceives it could be different. The resulting misunderstanding could limit the validity of the study. The final assumption was that nurse practitioners desire a workplace environment of engagement. There must be a fit between the organization's climate and the nurse practitioner for engagement to occur. Engaged employees generate positive results for the organization and reduce absenteeism and turnover.

Limitations

Limitations are the influences that the researcher cannot control (Connelly, 2013). The participants received direction to set their personal biases aside and remain objective.

The experiences of nurse practitioners in Florida may not reflect the experiences of nurse practitioners from other states. The results of the study may not be generalizable because the data collection derives from a single source. Nurse practitioners who chose to participate may answer differently than those who chose not to participate (Poghosyan, Nannini, Stone, & Smaldone, 2013).

Some nurse practitioners may ignore the solicitation or postpone answering it, thus missing the survey deadline. It was possible that nurse practitioners did not check their work email because they did not have time during the day. The individual's email system of record may have flagged the solicitation as spam, so some of the nurse practitioners may have never received the survey. Participation in the study was voluntary. The concerns about confidentiality could impact participation rates.

Delimitations

Delimitations are choices made by the researcher and describe the boundaries set for the study (Paechter, 2013). The scope of the study was primary care nurse practitioners practicing in the state of Florida, regardless of the organization size, budget, or geographic location. The intent of the survey was to research and analyze the actions and approaches of healthcare managers as they identify ways to deal with the changes imposed by healthcare reform. Only nurse practitioners identifying as primary care providers participated in the study. The information collected from the study could create operational decision-making policies and practices for healthcare organizations. The experience or response of the nurse practitioners in other states may be different.

Significance of the Study

The intended audience for the study is healthcare business managers who have an interest in the quality of healthcare provided by their organization. Healthcare organizations around the globe will continue to face challenges related to nursing shortages and increased care demands (MacLean et al., 2014). Confusion and disharmony exist that contribute to role misunderstanding as various states, medical, and nursing organizations have different and at times adversarial statutes (Ryan & Ebbert, 2013). The findings and recommendations resulting from the study may provide a broader understanding of desired practice environments supporting the development of change initiatives to attract and retain nurse practitioners (McGlynn, Griffin, Donahue, & Fitzpatrick, 2012).

Poor organizational support affects employees' perceptions of their value and may lead to job dissatisfaction, turnover, and exacerbate nursing shortages (Liu et al., 2014). Dissatisfied employees could hinder the quality of care patients receive and cause a significant financial burden to organizations that find themselves short-staffed or in need of hiring or training new hires (Poghosyan et al., 2013b). The efficient utilization of the nurse practitioner workforce could contain costs and improve access to healthcare (Liu et al., 2014; Stange, 2014). The implication for positive social change includes the potential to provide significant knowledge to influence policy, practice, and research to reduce healthcare costs and increase patient satisfaction.

A Review of the Professional and Academic Literature

The purpose of the review of professional and academic literature was to provide an empirical perspective on organizational climate, to identify the domains pertinent to ARNP practice, and to investigate existing policy relevant for ARNP practice in primary care settings (Poghosyan, Nannini, & Clarke, 2013). The literature review contains current research primarily from peer-reviewed journal articles, nonpeer-reviewed journal articles, seminal works, and scholarly books published within the past 5 years. The literature review includes research conducted in the areas of field theory, rival theories, role identification, autonomy, collaboration, and organizational climate within the healthcare industry.

Organization of the Review

The literature review contains five main sections (see Figure 1) including (a) theoretical framework, (b) role identification, (c) autonomy, (d) collaboration, and (e) organizational climate. In the first section, I discuss the (a) theoretical framework *field theory*, (b) rival theories, and (c) barriers to practice. The second section contains a discussion of the independent variable *role identification* and (a) role awareness, (b) contributions, (c) care coordination, and (d) organizational placement. In the third section, I discuss the *autonomy* independent variable and (a) policies, (b) decision-making, (c) patient care, and (d) scope of practice. The fourth section contains a discussion of the independent variable *collaboration* and (a) communication, (b) support, (c) trust/rapport, (d) respect, (e) collegiality, and (f) teamwork. I address the dependent variable *organizational climate* in the final section.

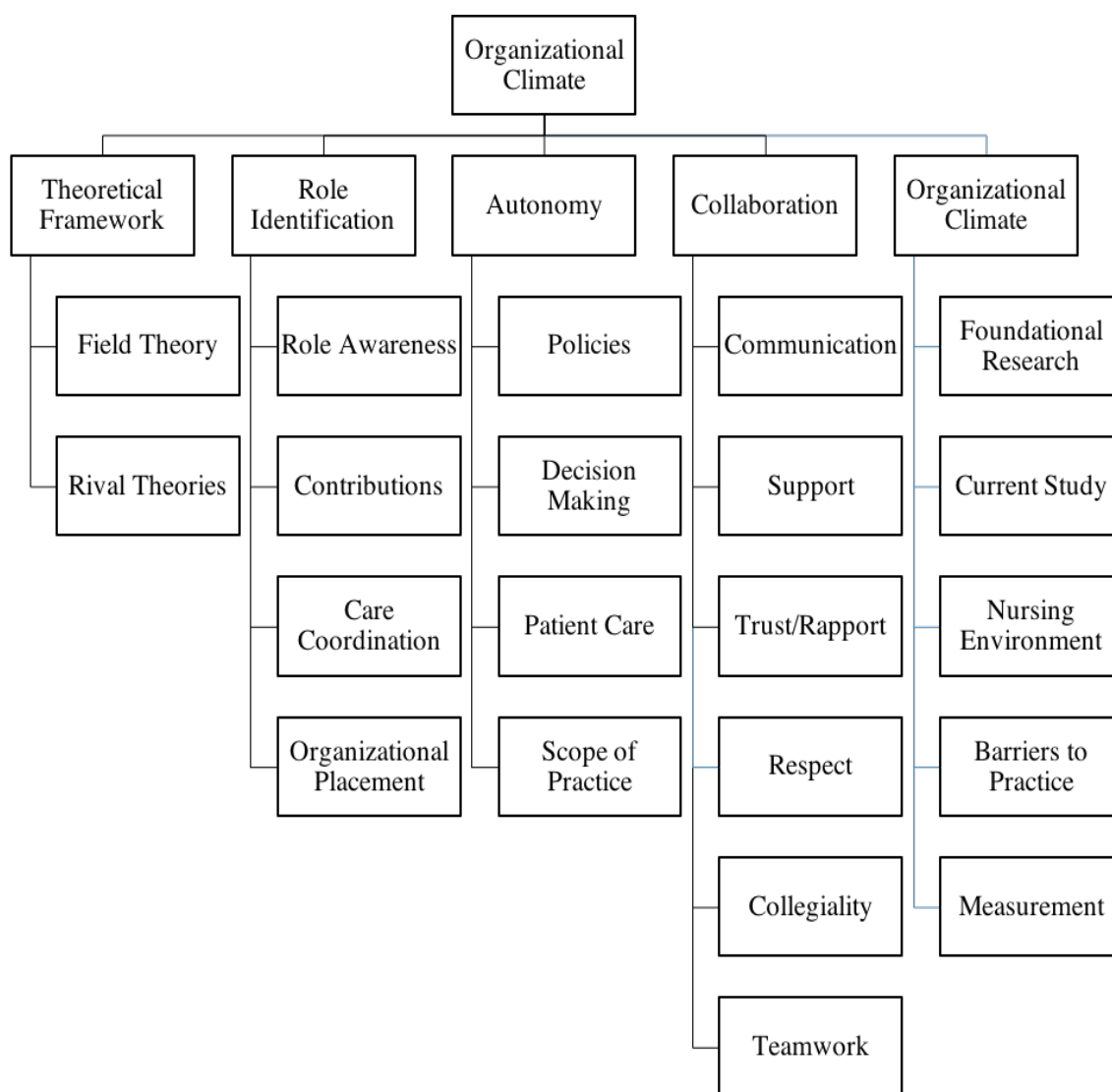


Figure 1. Organization of the literature review.

Strategy for Searching the Literature

I conducted an extensive search of organizational climate and ARNP practice in primary care settings using Google Scholar, ProQuest, EBSCO, PsychINFO, ABI/Inform Complete, Business Source Complete, and Academic Search Complete databases, and several other psychological, sociological, healthcare policy, and nursing databases. I used the following search terms in the initial search: *nurse practitioner* plus any of the

following keywords, *organization, nurse practitioners, climate, work environment, practice environment, collaboration, culture, scope of practice, and primary care*. I used combinations of these keywords to arrive at a suitable number of references for analysis.

Compliance

I assessed each of the retrieved articles for relevance to support the requirement for at least 85% of the total sources within 5 years of expected graduation in 2016. I validated the peer-reviewed status of the sources using Ulrich's Periodical Dictionary to ensure at least 85% peer-review of the total sources with a minimum of 60 peer-reviewed sources in the literature review. I validated the peer-reviewed status of the books by ensuring consideration of the books by expert reviewers responsible for assessing sections of the entries and searching for reviews of the book in scholarly journals that provided detailed evaluations. I presented 202 resources, with 91% of these resources published in the last 5 years (2012-2016), and 97% of these resources peer reviewed (see Table 1).

Table 1

Synopsis of Literature Review Sources

Source of content	Outside of 5 year range (2011 and earlier)	Within 5 year range (2012 – 2016)	Total of all sources
Peer-reviewed sources	16	180	196
Nonpeer-reviewed sources	2	4	6
Total	18	184	202

The intent of the quantitative correlation study was to examine the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate. The central research question is as follows: What is the extent of the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate? In Alternative Hypothesis 1 ($H1_a$), I presented that a statistically significant relationship exists between role identification and the organizational climate. The nurse practitioners' role identification influences the organization's climate.

In Alternative Hypothesis 2 ($H2_a$), I presented that a statistically significant relationship exists between autonomy and the organizational climate. The nurse practitioners' perception of autonomy influences the organization's climate. In Alternative Hypothesis 3 ($H3_a$), I presented that a statistically significant relationship exists between collaboration and the organizational climate. The nurse practitioners' perception of collaboration influences the organization's climate. I defined and related the independent variables and the dependent variable to the theoretical framework of Lewin's field theory.

Theoretical Framework

Scholars and practitioners continue to focus on organizational research that seeks to improve organizational effectiveness (Schneider & Barbera, 2014). The study of organizational climate emerged from the psychological concern for understanding situational influences on behavior (Ehrhart, Schneider, & Macey, 2014). The first organizational use of the term *climate* appeared in the 1930s and was associated with Lewin, Lippitt, and White (1939), who studied how the social climate engendered by a

work group's leader affected the behavior of group members (Ashkanasy & Dorris, 2015; Glisson & Williams, 2015). Lewin and colleagues used the term *climate* to capture the psychological impact of the work environment on employees' sense of well-being, motivation, behavior, and performance (Barrick, Mount, & Li, 2013).

I chose field theory to ground the study. Lewin (1936) conducted research on *typological psychology* as a means to understand individual behavior and later as a method to analyze and change group behavior (Burnes & Cooke, 2013). Lewin originally developed *field theory* to understand the formation, motivation, and preservation of social groups. It is possible for researchers and practitioners using field theory to understand the forces that maintain current behavior and to identify the forces required to modify or change behavior (Burnes & Cooke, 2013). Field theory was an appropriate theoretical framework for the study.

Field theory. Lewin's seminal work derived from field theory in physics, arguing that a life space encompasses the coexisting facts in an individual or group situation (as cited in Burnes & Cooke, 2013). It is possible to predict, understand, and apply the psychological forces required to influence individual and group behavior at a given point in time (Zimbardo & Boyd, 2015). Gestalt psychology influenced Lewin's field theory. Gestalt psychology challenged the dominant structuralist and behaviorist psychology, which maintained that human beings are the sum of their parts (Lewin, 1951).

Gestalt psychologists maintained that behavioral change is a learning process that incorporates individual perceptions, expectations, though patterns, insights, and outlooks (Burnes & Cooke, 2013). The gestalt perspective places an emphasis on the external

stimuli and the perception set by the individual. Gestalt psychologists believed that the interdependent and dynamic individual parts are different from the sum of their parts (Burnes & Cooke, 2013). Lewin (1951) argued that behavior involves the totality of coexisting and interdependent forces that determine the life space.

The following characteristics underpin Lewin's field theory: (a) constructive method, (b) dynamic approach, (c) psychological approach, (d) analysis of the whole situation, (e) behavior as a function of life space, and (f) mathematical representation (Lewin, 1951). The constructive nature of the theory allows for a relationship with other theories or systems. Lewin (1951) believed that an individual's social life is dynamic where change occurs. It is possible to analyze the life space forces to understand, predict, and change behavior. Lewin's psychological perspective is that an individual's or group's life space is a result of their perception of reality rather than an observer's objective viewpoint.

Life space. Lewin (1951) believed that all psychological events are a product of the life space and that the entire environment requires consideration rather than focusing on one or two elements. The present life space is a function of the field at the time that it occurs and not as a cause of something in the past or future. Lewin's concern for scientific discipline and rigor of the psychological situation drove him toward a mathematical representation of field theory. The numerical representation comes from Lewin's philosophy of science and the use of the mathematical procedure to determine a relationship between psychological laws and individual and group behavior (as cited in Burnes & Cooke, 2013).

Lewin's (1951) concept of life space represents the total psychological environment of an individual's or group's subjective experience. The individual or groups behavioral field is represented by the expression $B = f(p, e)$. The behavior B is a function of the interaction between the individual or group p and their environment e (Lewin, 1936). Field theory represents a way for researchers and practitioners to understand and appreciate the totality and complexity of the forces in a given life space to modify or change behavior (Burnes & Cooke, 2013). Lewin (1951) maintained that field theory represented a continuous learning process and that individuals and groups reflecting on the forces that affect their lives could achieve behavior change.

Lewin's pursuit of complex mathematics to measure the strength of psychological forces and to calculate the effect that changing one or more forces within a life space have drawn the greatest criticism (Kadar & Shaw, 2000). Lewin replaced the gestalt-based field theory and topological life spaces with a mathematical representation that lead to the rejection of the theory (Burnes & Cooke, 2013). Lewin's pursuit of rigor in his field theory based on mathematics served to undermine its relevance. The issue was achieving a suitable balance: Too far down the path to rigor and the research can lose relevance, too far down the relevance path, the research can lose methodological soundness (Shultz, 2010). I used Lewin's original conception of field theory based on conventional topology and Gestalt psychology for the study.

Rival Theories

Upon reviewing the literature, several theoretical frameworks appeared that could support the study. The first theoretical framework for consideration was Herzberg's

(1959) two-factor theory (Herzberg, Mausner, & Snyderman, 1959). The second theoretical framework for review was Kanter's (1976) theory of structural power as supported by employee performance. The final theoretical framework for analysis was Haslam's (2001) social identity theory as supported by interpersonal behavior influences (Turner & Haslam, 2014).

Two factor theory. Interesting work, challenge, and increasing responsibility motivate employees. Herzberg (1959) developed the motivation-hygiene theory, also known as the two-factor theory (Herzberg et al., 1959). Herzberg found that job satisfaction factors were different from factors that cause job dissatisfaction. Herzberg identified the satisfiers as motivators and the dissatisfiers as hygiene factors. The intrinsic factors are the actual motivators that fulfill an individual's need for psychological growth such as the work, achievement, advancement, recognition, and growth. The extrinsic factors lead to job dissatisfaction if not met, such as salary, working conditions, and job security. Job satisfaction does not result from existing hygiene factors (Hertzberg et al., 1959).

Theory of structural power. Kanter's 1976 theory of structural power suggests that organizational climate can either promote or impede employee performance regardless of individual tendency. Organizational structures impact employee work behavior more than inherent personal characteristics (Kanter, 1976). Organizational structures serve an important role in shaping behavior and relationships. Organizations can empower employees by providing access to information, support, and resources or

fail to enhance employee performance, which results in productivity issues and adverse outcomes (Poghosyan et al., 2015).

Social identity theory. Haslam's 2001 social identity theory suggests that the perceived social group identity influences interpersonal behavior (as cited in Maxwell, Baillie, Rickard, & McLaren, 2013). Individuals identify with a particular group and view others through the in-group lens. Individuals share viewpoints with the in-group and deal with an out-group member based on the group relationship (Maxwell et al., 2013). Individuals have multiple identities simultaneously and competing demands that determine the relative influence on workplace structures (Turner & Haslam, 2014). The result is that competing priorities are constant, and that change is not a single event (Maxwell et al., 2013).

Role Identification

The U.S. healthcare system is reacting to a confluence of issues ranging from a growth of chronically ill and elderly patient populations (Morgan, Abbott, McNeil, & Fisher, 2012; U.S. Department of Health and Human Services, 2012). Increases in healthcare spending, concerns about workforce adequacy, and a persistent lag in quality healthcare represent business critical discussions for the healthcare industry (Iglehart, 2013; Naylor & Kurtzman, 2010). It is important to understand the environmental attributes that demonstrate the nurse practitioner role as care providers, validate their contributions to care, and support the nurse practitioner professional identity (DesRoches et al., 2013; Martin et al., 2013). The nurse practitioner professional visibility is an

important organizational climate domain in primary care settings that requires study (Poghosyan et al., 2013a).

Role awareness. The nursing profession suffers from the traditional influence of values and cultural and social norms on gender and professional status (Hoeve, Jansen, & Rootbol, 2014). Nurse practitioners view themselves as well-trained healthcare professionals. The public perceives nursing as a low-status profession that does not require academic qualifications, lacks professional autonomy, and remains subordinate to physicians (Desborough, Forrest, & Parker, 2012; Pirret, Neville, & La Grow, 2015). The traditional views of nurses include a predominantly feminine and domestic activity in a supporting role to physicians and occupying a subordinate decision-making and delegating position (Hoeve et al., 2014).

It is time to counteract the effects of nurse stereotyping, improve the public image of the profession (Hoeve et al., 2014), and focus on increasing primary care capacity by redefining the role of each of the available healthcare providers. Bodenheimer and Smith (2013) argued the mislabeling of the workforce shortage crisis as a physician shortfall when a more accurate characterization of the issue is a demand-capacity mismatch. Primary care organizations could significantly increase their ability to meet the demand by redefining the role of nonphysician team members and use the patients themselves (Graves et al., 2016).

Each of the U.S. states mandates a graduate degree in advanced practice nursing, passing a national exam, and gaining state licensure for entry into the profession. Nurse practitioners provide healthcare primarily focused on the patient as a whole, through

patient counseling and education of health promotion and disease prevention (Chattopadhyay, Zangaro, & White, 2015). The advanced training of the nurse practitioner workforce allows them to diagnose patients, order and interpret tests, write prescriptions, and provide acute and chronic illness treatment (Stange, 2014). Nurse practitioners also provide patient history intake and demonstrate healthcare efficiencies by saving doctor time, patient wait times, decreasing the incidence rates of disease, and reducing expensive hospitalizations (Chattopadhyay et al., 2015; Stange, 2014).

The nurse practitioner workforce represents a potential solution to the demographic, economic, and political health care issues facing policymakers, the public, and other stakeholders (Barnes, 2015; Buerhaus, DesRoches, Dittus, & Donelan, 2015; National Governors Association, 2012). Managers and policy makers could reallocate clinical responsibilities (Bodenheimer & Smith, 2013) and relax restrictive scope of practice regulations (Lowe, Plummer, & Boyd, 2013) without significant changes in legal statutes. The nurse practitioners' professional identities result from the values and beliefs that guide their thinking, actions, and interactions (Hoeve et al., 2014).

Contributions. There are challenges associated with identifying and understanding the contributions of the nurse practitioner role in the delivery of primary care services (Lowe et al., 2013; Roots & MacDonald, 2014). Primary care is the provision of integrated, accessible health care services that covers a broad majority of personal health care needs including health promotion, disease prevention, and public health functions (Mackey, Hatcher, Happell, & Cleary, 2013). The classification issues undermine the professional identity of nurse practitioners and other multidisciplinary

providers that make valuable contributions to primary care (Poghosyan, Lucero, Rauch, & Berkowitz, 2012).

The nurse practitioners' distinct knowledge and skills demonstrate the quality of patient care improvements and reduce healthcare costs (Hooker, Brock, & Cook, 2015; O'Grady, Hanson, Lugo, & Hodnicki, 2012). A clarification of definition and understanding of the nurse practitioner role remain elusive, which results in their continued underutilization or not fully realized role in primary care practice (Kooienga & Carryer, 2015). The nursing profession can improve its public image by gaining professional autonomy, increasing interprofessional learning and peer consultation, and job rotation (Carryer & Yarwood, 2015).

Previous descriptions for nurse practitioners include midlevel providers, physician extenders, and nonphysician providers (Poghosyan et al., 2012). The descriptions do not accurately represent the nurse practitioner professional identity and further serve to marginalize their expertise as less than physicians do (Poghosyan et al., 2012). The lack of information about the nurse practitioner knowledge, skills, and expertise contributes to the mischaracterization of their capability and impedes the development of their professional identity (Naylor & Kurtzman, 2010).

DesRoches et al. (2013) and Newhouse et al. (2012) examined the provision of primary care among physicians and nurse practitioners and demonstrated that patient outcomes including mortality rates, satisfaction, and physical, emotional, and social functioning were equivalent. A body of evidence exists that nurse practitioners diagnostic reasoning are equal to physicians, the cost of care is lower, and they provide equal or

better care than physicians when compared with equivalent services (Morgan et al., 2012). The fact that the nurse practitioner education process is faster than their physician counterparts are while providing comparable quality in many dimensions of patient care supports the interest in expanding the workforce (Buerhaus et al., 2015).

A review of the literature demonstrated a shortage of research that describes or explains the impact of the nurse practitioner role implementation or cost-effectiveness in primary care practices within the organization or health care system (Naylor & Kurtzman, 2010). Few studies have examined the results of the nurse practitioner integration on the physician, primary care practice, the community, and the utilization by the patients of the practice (Roots & MacDonald, 2014). The sparse research conducted focuses on the nurse practitioner roles involving hospitalization, long-term care, and transitioning patients vice the three decades of demonstrated cost-effectiveness of the nurse practitioner role (Hooker et al., 2015).

Dill et al. (2013) conducted a study indicating a patient preference for a nurse practitioner related to access, the speed of care, lower cost, and greater accessibility (Dill et al., 2013). Additional reasons for the nurse practitioner preference include quality issues, ease of communication, positive experiences, and the perception of more personalized and compassionate care (Dill et al., 2013). Expansion of the nurse practitioner role may benefit the population facing the greatest healthcare access barriers resulting from the PPACA implementation (Budd, Wolf, & Haas, 2015; Reagan & Salsberry, 2013). The successful implementation of the ACA could increase the

prominence of nurse practitioners in meeting the healthcare needs of Americans that have traditionally had the greatest challenge accessing care (Budd et al., 2015; Stange, 2015).

Care coordination. In a study conducted by Donelan et al. (2013), 74.9% of the nurse practitioners surveyed indicated that they were able to practice within the full extent of their education and training (Donelan, DesRoches, Dittus, & Buerhaus, 2013). In a similar study conducted by Chattopadhyay and colleagues, 84% of nurse practitioners surveyed agreed that they practice fully of the state's scope of practice regulations, and 89% agreed on the full utilization of their skills (Chattopadhyay et al., 2015). The nurse practitioners that did not believe they were able to practice fully of their education and training cited state restrictions, hospital regulations, and the work setting, as factors limiting their scope of practice (Donelan et al., 2013).

The cost-effectiveness of nurse practitioner integration is less well studied, with the majority of research associated with physician substitution versus the nurse practitioners' complimentary role in the conduct of primary care (DesRoches et al., 2013). Physicians described the increased responsibility and liability for tasks that team members with far less training are not able to perform (Sinsky et al., 2013). The requirement to carry out the work personally and current reimbursement policies force the physicians to maintain the old work to supplement their income (Bodenheimer & Smith, 2013). There is little incentive to redistribute the work to nonphysicians who increase operating costs but do not produce revenue (Stange, 2014).

Physicians and nurse practitioners do not agree on their delivery roles in primary care practice (DesRoches et al., 2013; Hoeve et al., 2014). Nurse practitioners and

physician assistants outnumber primary practice physicians and are the principal providers of healthcare to many communities (Stange, 2014). Supply growth continues in spite of cross-state variation in scope of practice regulations, with some states permitting independent practice while others are mandating physician oversight (Stange, 2014). The idea of subordination to the medical profession is a factor that influences the self-concept and professional identity of nurse practitioners and leads to high levels of dissatisfaction with their career status (Hoeve et al., 2014).

Hiring physicians and medical directors have the expectation that new nurse practitioners are quickly able to provide patient care (Sargent & Olmedo, 2013). Significant occupational restrictions may limit the extent to which expansions in the number of providers have translated into meaningful changes in health care outcomes (Stange, 2014). Sargent and Olmedo (2013) conducted a study describing that new nurse practitioner graduates have feelings of inadequacy in assuming clinical responsibilities, unclear expectations for the orientation period, lack of support by team members, and role isolation. Many studies demonstrate that the nurse practitioner public image does not always match their professional image (Hoeve et al., 2014).

Nurse practitioners lack the depiction as independent professionals and the public, and organizational stakeholders are not aware of the theory-based, scientific, and scholarly nature of their preparation (Hoeve et al., 2014). The expectation mismatch can be a source of frustration for collaborating physicians and novice nurse practitioners (Sargent & Olmedo, 2013). The findings of the study support a dedicated consultation

and mentorship program for the nurse practitioners first year suggesting that their perceived competence and confidence increase over time (Sargent & Olmedo, 2013).

Organizational placement. Expanding the nurse practitioner workforce demonstrates their contribution to a collaborative and team-based practice environment in opposition to competing with physicians as an economical substitute (Buerhaus et al., 2015; DesRoches et al., 2013). The contrary perspectives of physicians expressing a desire for collaboration yet hiring new doctors reflected remnants of long-standing educational isolation, professional socialization, and the intent to protect their profession (Buerhaus et al., 2015). In the examination of independent practice, time spent in patient care, sense of value, and respect from their healthcare peers, 92% of the nurse practitioners surveyed reported *satisfied to very satisfied* (Chattopadhyay et al., 2015).

Nurse practitioners function in both independent and collaborative practice arrangements in large and small public and private practices (Naylor & Kurtzman, 2010). The results of the various studies described the implementation of nurse practitioners in the delivery of primary care could lead to substantial cost savings if implemented in other states (Lowe et al., 2013). The absence of definitive economic analyses places a priority on distinguishing the nurse practitioner contribution to high-value primary care (Buerhaus et al., 2015; Stange, 2014). These findings validated the need to optimize the integration of nurse practitioners into their organizations (Sargent & Olmedo, 2013).

Real innovation integrates a critical approach toward traditional thinking and operating and then taking a calculated risk to abandon these practices as the basis of real change that supports human health and quality of life (Kagan, 2013). Current healthcare

reform strategies emphasize the need for increased access to primary care, an emphasis on health promotion and disease prevention, and multidisciplinary care (Roots & MacDonald, 2014). The reform agenda and the provisions of the PPACA reinvigorate the case for nurse practitioners to expand their participation in primary care organizations. Nurse practitioners that have full scope of practice authority could improve the efficiency of service delivery by treating patients, ordering labs, and writing prescriptions without physician approval (Chattopadhyay et al., 2015).

The successful implementation of the nurse practitioner roles as a professional group requires discussion to develop a standardized approach to the education, competence, and scope of practice to extend their advanced practice roles (Kooienga & Carryer, 2015). The result of such a discussion could support development strategies to achieve a public image that reflects their scholarship and professional attributes (Hoeve et al., 2014). Nurse practitioners struggle to make their contributions visible. The establishment of consistent scope of practice regulations from state to state could serve a significant role in clarifying the nurse practitioner professional identity for managers, healthcare leaders, and patients (Poghosyan et al., 2012).

The process involved in allowing nurse practitioners to extend their practice responsibilities are burdensome and create barriers (Iglehart, 2013; Institute of Medicine, 2012). It is critical for nurse practitioners to identify their contributions, quantify their practice, and recognize their associated clinical outcomes in implementing their role. It was difficult to demonstrate the value that the nurse practitioner role adds to primary care practice without further research. Senior executives and physician support is crucial to

the establishment of nurse practitioner roles, especially in the early stages of implementation (Lowe et al., 2013).

It is reasonable to expect the continued evolution in the professional identification and role of the nurse practitioner and further the altering of the physicians' roles to include other primary care team professionals (Buerhaus et al., 2015; Stange, 2014). Nurse practitioner discontentment result in employee turnover and recruitment and orientation issues that are costly to the organization (Sargent & Olmedo, 2012). The support of managers and policy makers is essential to the process of ensuring the understanding and integration of the roles of each health care provider into the organization toward the efficient and quality patient care to meet the increasing demand requirement. These same managers and policymakers need to address the autonomy issue as it applies to the nurse practitioner role within their organizations (Poghosyan et al., 2012).

Autonomy

As the role of the nurse practitioner matures, autonomy continues to be a primary professional concern as the roles, and scope of practice issues, evolve (Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011). Autonomy is a dimension of organizational climate based on the individual factors of responsibility, independence, and initiative (Campbell, Dunnette, Lawler, & Weick, 1970). Keenan (1999) defined autonomy as the considered, independent judgment to affect the desired outcome. Keenan (1999) further described the attributes of autonomy as independence, decision-making authority, knowledge, judgment, and self-determination. Research should explore autonomy and

clearly define the concept as a dimension of organizational climate for the nurse practitioner workforce (Poghosyan et al., 2013a).

Policies. The American Medical Association and the American Academy of Family Physicians opposed the Institute of Medicine recommendation describing the physicians' extensive education versus that of the nurse practitioners as the basis for not being a viable substitution (Pittman & Williams, 2012). Nonnurse practitioner supervisors who lack an understanding of their knowledge and experience lead to poorly defined roles, scope of practice issues, and shared governance concerns (Metzger & Rivers, 2014). The U.S. Federal Trade Commission supports the expansion of nurse practitioner scope of practice emphasizing that an increase in competition would serve the interests of healthcare consumers and that it would not adversely impact the quality of care (Pittman & Williams, 2012).

Managers and policy makers should consider a variety of approaches to expand nurse practitioner opportunities particularly in areas where a provider shortage is already documented or projected to worsen (Green, Savin, & Lu, 2013; Yee, Boukus, Cross, & Samuel, 2013). Adequate access to care is a major management and policy concern that requires focus mainly since the expectation of the nurse practitioner workforce to double by 2025 (Auerbach, 2012). The various U.S. state practices that limit nurse practitioner scope of practice should match less-restrictive states and expand the potential capacity of their healthcare organizations to meet increasing patient demand (IOM, 2012).

The nurse practitioner role continues to evolve in the healthcare system, yet independent practice challenges the development of the scope of practice legislation

(Poghosyan et al., 2013b). The greatest challenge to nurse practitioner autonomy remains the restrictive scope of practice regulation by the state governments (Kuo, Loresto, Rounds, & Goodwin, 2013). There is significant state variation in the scope of practice regulation (Pearson, 2012) that prevents nurse practitioners from practicing by their experience and educational preparation. The influence of organizational climate should take into account the federal, state, and third party payer contexts in determining nurse practitioners' abilities to practice independently (Peterson, Cai, Moore, & Bazemore, 2013; Poghosyan et al., 2013c).

Nurse practitioners would benefit from political representation to influence at the state and national level as they negotiate workplace contracts and geographic areas to establish careers and households (Judd & Keleher, 2013). Nurse practitioners are the most likely healthcare provider to locate with the large underserved populations, which is the explicit rationale for the nurse practitioner role in health delivery systems (Esperat, Hanson-Turton, Richardson, Tyree Debisette, & Rupinta, 2012). The underserved populations include high uninsurance and poverty rates that require the greatest increase in primary care providers to meet the demand resulting from the PPACA implementation (Huang & Finegold, 2013).

The Pearson Report (2012) provides an annual overview of the state-by-state nurse practitioner legislation based on three levels of scope of practice restriction, (a) no restrictions, (b) intermediate or certain limitations, and (c) most restrictive practice. The most restrictive practice states require a physician presence to diagnose, treat, and prescribe. Seven of the ten states predicted to require the greatest increase of primary care

providers have restrictive scope of practice environments for nurse practitioners (Huang & Finegold, 2013). State legislatures should feel pressure to broaden nurse practitioner scope of practice laws because of the significant increase in demand (IOM, 2012).

Decision making. The ability to make decisions in clinical practice is the most frequently identified factor associated with nurse practitioner autonomy and further job satisfaction (Pron, 2013). Identifying strengths and obstacles in the environment are essential as organizations attempt to recruit more nurses into advanced practice (Ryan & Ebbert, 2013). Healthcare organizations with restrictive organizational climates affect nurse practitioners' abilities to exercise their clinical judgment, exert independence, and employ initiative (Poghosyan et al., 2013c) and further distress the number and growth of providers to meet demand (Peterson et al., 2013).

The primary sources of nurse practitioner dissatisfaction result from restrictive organizational policies and practices and a lack of supervisor recognition (Metzger & Rivers, 2014). The lack of attention and not being considered a professional peer results in a lack of nurse practitioner job satisfaction (Pasarón, 2013). Employees rely on their supervisors to provide feedback regarding competency, organizational resources, professional development, and organizational integration (Metzger & Rivers, 2014). Job satisfaction correlates with retention, recruitment, and quality patient care, yet a universal measure for the attribute does not exist (Pasarón, 2013).

Pasarón (2013) described the importance of understanding the nurse practitioner interplay of job satisfaction factors within their organizational climate of a) partnership/collegiality, b) professional, social and community interaction, c)

challenge/autonomy, d) professional growth, e) time, and f) benefits. The lack of employer information causes issues associated with nurse practitioner job dissatisfaction that includes burnout, depression, sleep disturbance, hypertension, physical stress, and emotional role limitations (Metzger & Rivers, 2014). Autonomy in professional actualization allows nurse practitioners to practice fully of their training and education (Maylone et al., 2011).

Patient care. The nurse practitioner education and certification requirements were nationally standardized in the 1990s (Reagan & Salsberry, 2013) to gain acceptance from their medical peers. The Balanced Budget Act of 1997, Medicare Part B provisions eliminated restrictions on the settings and practices of nurse practitioners and allowed direct Medicare reimbursement at 85% of the doctor fee rate (Medpac, 2012). The mandated reimbursement rates and restrictive scope of practice regulations serve as barriers and noncompetitive factors that influence the market (Reagan & Salsberry, 2013). Nurse practitioners may not be able to enter the market without the sponsorship and collaboration of a physician (Reagan & Salsberry, 2013).

The use of economic theory predicted that the reduced reimbursement and restrictive scope of practice regulations inhibit the implementation of nurse practitioners in market equilibrium compared to the same markets without restriction (Reagan & Salsberry, 2013; Stange, 2014). States with a greater ratio of medical providers to patients have lower expenditures and disease-specific mortality (Kuo et al., 2013). Many of the barriers that nurse practitioners face result from physician concerns for patient safety, provider competence, and the possible economic effect of increased competition (Pittman

& Williams, 2012). Doctors fear that their income could decline because of expanding nurse practitioner scope of practice (Stange, 2014).

According to the Bureau of Labor Statistic wage data, there was a lack of evidence that supported an expanding nurse practitioner scope of practice would reduce a physician's earnings (Pittman & Williams, 2012). Mixed evidence exists on the effect that a less restrictive nurse practitioner environment would have on physician income (Stange, 2014). The healthcare costs, use of resources, and health outcomes are similar between nurse practitioners and doctors while patient satisfaction is the same or better with nurse-led care (Kuo et al., 2013; Martínez-González et al., 2014). The supply and demand zero sum concern resulted from the assumption that nurse practitioners received less pay for their services, payers would seek to substitute nurse practitioners for physicians leading to a reduction in income and influence (Pittman & Williams, 2012).

Scope of practice. Representatives of the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine conducted a two-year study in 2008, responding to the need to assess and transform the nursing profession (Institute of Medicine, 2012; National Governors Association, 2012). The purpose of the study was to provide an action-oriented blueprint for the future of nursing (Institute of Medicine, 2012). The restrictive scope of practice laws and strict payer policies limit nurse practitioner employment to physician practices and hospitals rather than independent practices (Maylone et al., 2011). Yee et al. (2013) described that payer policies have a greater impact on nurse practitioner practice than the restrictive scope of practice laws. Maylone

et al. (2011) demonstrated that the level of state scope of practice restrictions correlates to the degree of autonomy granted to the nurse practitioners through payer policies.

The incident to payment designation limits the nurse practitioners' autonomy and minimizes their role as primary care providers (Poghosyan et al., 2012). The incident to a physician is the common practice in healthcare organizations that allows full reimbursement for services provided by a nurse practitioner as long as a doctor is on the premises (Poghosyan et al., 2013c). The Medicare reimbursement policies represent significant barriers for nurse practitioners making it difficult to practice without a collaborating physician (Maylone et al., 2011). The lack of direct payment or lower payment rates for similar services discourages nurse practitioners from establishing an independent practice (Poghosyan et al., 2013c).

A nurse practitioner should diagnose and treat without physician supervision and prescribe either without a doctor or with a signed physician collaborative agreement or the state board of nursing approval for consideration as an independent provider (Pearson, 2012; Pittman & Williams, 2012). Numerous healthcare organizations utilize nurse practitioners to meet the demand for services and decrease health disparities (Pettersen et al., 2012). Incorporating nurse practitioners is known to improve job satisfaction, the quality of health care, decreases medical errors, and addresses cost containment (Pasarón, 2013; Ryan & Ebbert, 2013).

The state of Florida mandates physician and nurse practitioner collaboration practice agreements. The state of Florida does not allow nurse practitioner prescriptive authority for controlled substances (Pearson, 2012). Florida further does not allow nurse

practitioners admission privileges and reimbursement is incident to a physician (Pearson, 2012; Peterson et al., 2013). These barriers and others prevent the full employment of the nurse practitioners in Florida (Pearson, 2012). The nurse practitioners lack autonomy, supportive reimbursement policies, and scope of practice legislation that inhibit their ability to practice within the full scope of their training, education, and experience (Poghosyan et al., 2012).

Addressing the factors that hinder nurse practitioner autonomy may lead to job satisfaction, increase retention, encourage tenure, and support the entry of new professionals (Pasarón, 2013; Ryan & Ebbert, 2013). The psychological empowerment of employees can further improve productivity and job performance, lower absenteeism and increase job retention (Metzger & Rivers, 2014). The importance of nurse practitioner independent practice can have additional factors, which include an effect on collaboration, public perception, organizational constraints, and support of other healthcare colleagues (Maylone et al., 2011). The successful treatment of the autonomy issues of scope of practice variance and reimbursement policies could enhance nurse practitioner and physician collaboration, increase job satisfaction and quality patient care in future healthcare practice (Poghosyan et al., 2012).

Collaboration

State legislation that is supportive of nurse practitioner scope of practice had a substantial effect on the deployment of nurse practitioners over the previous two decades (Kuo et al., 2013). It is important to pursue effective teamwork and collaboration to deliver quality patient care as the healthcare industry continues to increase in complexity

and specialization of skills (Erickson, 2013; Weller, Boyd, & Cumin, 2014). New nursing roles and understanding the role implementation are critical for teamwork and collaboration as healthcare organizations evolve their processes to meet the demand for care (Bodenheimer & Smith, 2013; Erickson, 2013).

Communication. Collaboration among healthcare providers is a core attribute of the organizational climate and an essential component in providing quality care (Bridges, 2014; Poghosyan et al., 2013a). The research of the literature identified mutual respect, trust, communication (Kilpatrick, 2013), and shared mental models as critical conditions required for collaboration (Schadewaldt, McInnes, Hiller, & Gardner, 2013).

Multidisciplinary health care teams rely on communication and teamwork to deliver efficient and safe patient care (Everett et al., 2013; Weller et al., 2014). The multidisciplinary teams include all levels of the treatment pyramid including aides, nurses, physician assistants, therapists, social workers, and attending physicians (Bodenheimer & Smith, 2013).

The success of these multidisciplinary teams depends on their understanding and accommodation of each disciplines' unique roles and practice requirements (Pathman, Konrad, & Hooker, 2014; Schadewaldt et al., 2013). Researcher inquiries into multidisciplinary teams described improved outcomes, patient and employee satisfaction, and limited adverse events (Epstein, 2014). Increasing evidence suggests that nurse practitioners improve quality care and efficiency when implemented into the primary care team (Everett et al., 2013; Kilpatrick, 2013). Patients were willing to accept nurse

practitioners as their care providers after nearly half a century in the workforce (Dill et al., 2013).

A systematic review of the dimensions of teamwork described the emergent behavioral processes of communication and the affective states of respect within the workplace (Valentine et al., 2015). Enhanced cooperation is shown to improve communication between the different levels of healthcare workers, which have reduced morbidity and mortality outcomes, decreased the length of stay, and resulted in greater patient satisfaction (Epstein, 2014; Kilpatrick, 2013). Interdisciplinary decision making and communication facilitate the individual skills and knowledge of each healthcare provider and compliment practice styles and expertise (Bridges, 2014; Roots & MacDonald, 2014).

Support. Nurse practitioners and physicians often experience disagreement regarding autonomous nursing practice and role identification, which may affect teamwork (Schadewaldt et al., 2013; Sinsky et al., 2013). Nurse practitioners manage less complex patients in primary care as compared to their physician counterparts with a similar patient and encounter characteristics (Morgan, Everett, & Hing, 2015). A systematic review of nurse practitioner outcomes in different contexts found that nurse practitioners provide safe and efficient patient care (Kilpatrick, 2013; Weller et al., 2014). Nurse practitioners work fewer hours, see fewer patients, and earn lower incomes than physicians earn (Donelan et al., 2013). Supporting and strengthening relationships between doctors and nurses is shown to foster high-quality patient care (Bridges, 2014).

There is a need for a clearer conceptualization of collaboration for nurse practitioners to guide their practice and facilitate teamwork (Bodenheimer & Smith, 2013). Understanding collaboration within the context of nurse practitioner-physician collaborative practice is significant because each application within different clinical, management and reimbursement situations may cause misinterpretation without a suitable definition (Bridges, 2014). Collaboration is a real partnership in which both sides acknowledge and accept the combined and separate fields of responsibility and activity (Bridges, 2014). Collaboration involves working together with shared decision making and communication toward mutual planning and action (Schadewaldt et al., 2013).

Professional silos, hierarchies, and geographically distributed teams create psychological and organizational barriers that can increase the chance of communication failure (Weller et al., 2014). Evidence suggests that improved teamwork can lead to significant gains in patient safety, efficiency of care, complication rate and mortality (Kilpatrick, 2013; Weller et al., 2014). A failure in communication or interprofessional teamwork is directly attributed to compromised patient care, staff distress, medical error, tension and inefficiency, and a contributing factor in 61% of death or serious physical or psychological injury to patients (Bridges, 2014; Weller et al., 2014).

Trust and rapport. An organization has a financial interest in improving collaboration and teamwork as information exchange failures lead to increased costs and inefficiencies (Weller et al., 2014). Offering patients same-day appointments demonstrates a benefit by decreasing delays and wasted capacity while increasing patient and physician satisfaction (Green et al., 2013). The pressure to contain costs while

improving access and coordination of care can be an efficient approach to increasing patient throughput without compromising access (Green et al., 2013; Roots & MacDonald, 2014). Educational, psychological, and organizational barriers are contributing factors to effective communication in healthcare teams (Weller et al., 2014).

Poghosyan et al. (2013b) described some perceptions of healthcare professionals of working in collaborative practice and barriers to collaboration. Related issues include funding issues, traditional roles, legislative restrictions, and personal experience toward teamwork and organizational climate (Poghosyan et al., 2013b; Schadewaldt et al., 2013). Nurse practitioner and physician collaboration may differ from other settings and roles because of the increasing autonomy of nurse practitioners in clinical settings that challenge the traditional physician-dominated healthcare industry (Finlayson & Raymont, 2012).

Nurse practitioners have complimentary skills and similar goals as physicians yet ideological differences in the practice and approach to treatment could cause difficulties in collaborative practice (Legault et al., 2012; Schadewaldt et al., 2013). Physicians that have experience working with nurse practitioners acknowledge their competence and gain comfort when nurse practitioners understand their limits and seek assistance when needed (Weller et al., 2014). The absence of traditional hierarchical structures and the reciprocity of referrals and consultations serve to foster collaborative practice (Schadewaldt et al., 2013).

Respect. The review of the literature identified educational barriers as a consistent theme resulting from a lack of knowledge of other healthcare professionals'

roles and practices. Each professional group have different ways of organizing information and approaches to health care defined by their various educational programs (Legault et al., 2012; Weller et al., 2014). Physicians train in the medical model, which focuses on the patient's complaint, history, physical examination, diagnosis, and treatment (Kroenke, 2014). Nurses receive training in the nursing model, which is a holistic approach focusing on the patient as a whole person including their lifestyle, family, diet, emotions and seek to manipulate the patient's environment through education (Lindquist, Snyder, & Tracy, 2013).

Medical institutions exert influence over students by the statements and opinions of their educators, professional culture, and norms of their profession (Bridges, 2014). Physicians pay considerable attention to doctor-patient communication and less training on how to communicate with other health professionals in their medical curriculum (Weller et al., 2014). The lack of training routinely results in differing expectations, roles, and priorities of other groups. Education remains discipline-specific with minimal interaction among healthcare disciplines (Roots & MacDonald, 2014). The discipline-centric curriculum of physician and nursing programs result in professional silos and minimize training in teamwork and collaboration (Weller et al., 2014).

Collegiality. The tenets of Tajfel and Turner's (2014) social identity theory described that members of a professional group tend to see the attributes of their group as positive and other groups as less desirable. The predisposition or attraction of certain people to certain professions and specialties may further correlate to the allegiances, tensions, and hierarchical issues that may form psychological barriers to effective

communication (Weller et al., 2014). The psychological distinction between ingroup and outgroup is active (Turner & Haslem, 2014). A new culture of collaboration requires each person to merge the unique strengths of each profession to diffuse control and territoriality issues (Bridges, 2014).

The introduction of nurse practitioners into primary care practice created high perceptions of economic constraint among physicians (Schadewaldt et al., 2013). The lack of financial support from the healthcare system in the proper reimbursement of nurse practitioner services is not compatible with a collaborative practice. Legal responsibility is an additional concern as most physicians consider themselves liable for the care provided by nurse practitioners (Legault et al., 2012). These organizational factors serve as barriers to information sharing, teamwork, and collaboration (Weller et al., 2014).

A review of over three dozen randomized control trials demonstrated that nurse practitioners provide safe and efficient primary care services (Kilpatrick, 2013), improved health outcomes for patients (Green et al., 2013), and established the high level of patient satisfaction (Epstein, 2014). Physicians who have a working experience with nurse practitioners describe more positive attitudes toward teamwork and collaboration (Poghosyan et al., 2014). Both groups reported the advantages and value of cooperation but also concerns and negative experiences with collaborative practice (Schadewaldt et al., 2013).

Teamwork. Warshawsky, Havens, and Knafl (2012) described that engaged employees enjoy challenges, display mental resilience, and involvement in their job. Engaged employees drive high-performing organizations through their energy,

dedication, and motivation to persevere and complete their work (Warshawsky et al., 2012). The higher levels of engagement associated with higher levels of patient satisfaction, quality of care, and work effectiveness (Warshawsky et al., 2012). The aim is to ensure all members of the team share an understanding of the situation and work toward the same goals in patient care (Weller et al., 2014).

Exposure to a collaborative environment supports overcoming professional hurdles, dispels concerns, and provides clarity on the roles and meaning of physician and nurse practitioner expertise (Schadewaldt et al., 2013). While the debate about the necessity of a legislative requirement continues (Donelan et al., 2013) within each state, the research indicates collaborative relationships improve patient outcomes, reduce wait times, result in shorter treatment periods, and lower costs (Epstein, 2014). Collaboration further decreases the perception of job strain and increases work satisfaction for physicians and nurse practitioners (Warshawsky et al., 2012).

To make teamwork and collaboration work, physicians and nurse practitioners must have confidence in the competence of each other (Schadewaldt et al., 2013). The support of doctors dominates the literature in the frequency of barriers and facilitators to collaborative practice models (Roots & MacDonald, 2014; Schadewaldt et al., 2013). The evidence from the literature review is consistent that nurse practitioner and physician teamwork and collaboration result in improvements to patient access, the quality of services delivered, job satisfaction, and workplace productivity (Roots & MacDonald, 2014).

Organizational Climate

The primary goal of the study of organizational climate is to understand and improve the effectiveness of the organization. It is important that organizations consider their internal practice environment by conducting an assessment using a psychometric instrument to identify gaps and to establish a baseline before instituting an intervention (Twigg & McCullough, 2014). Schneider and Barbera (2014) described the organizational climate research that focuses on a strategic outcome or process is superior to research that is general in nature or without a particular emphasis.

The essential components of the term organizational climate focus on the conceptual abstraction about the meaning members experience and derive from the work environment (Ehrhart et al., 2013). A general definition of organizational climate is the member perception of the events, policies, practices, and procedures experienced and their association with rewarded, supported, and expected behaviors (Ehrhart et al., 2013). Previous researcher study of an organization's climate advances on the premise that employees sense the value and importance in the workplace based on their observation and experience, which is essential for maximizing efficiency and productivity (Schneider & Barbera, 2014).

Foundational research. The researcher study of organizational climate began with the psychological concern for understanding situational influences on behavior (Ehrhart et al., 2013). Early research into industrial psychology focused on the individual differences of behavior at work toward organizational effectiveness (Ehrhart et al., 2013). The Hawthorne studies were a series of investigations in the 1920s conducted by Elton

Mayo and Fritz Roethlisberger, who demonstrated that individuals working as a group with a supportive supervisor increased productivity (McCambridge, Witton, & Elbourne, 2014). The researchers further described that the working conditions and monetary incentives were less important than meeting the employees need and desire to belong to a group and inclusion in the decision-making process (McCambridge et al., 2014).

In the 1950s, Fleischman focused on the role of climate in organizational effectiveness describing that the leadership climate is a major factor intended to increase organizational productivity (Ehrhart et al., 2013). Argyris (1947) argued that the traditional organization directed behavior, which resulted in employee dissatisfaction and disconnectedness to their work and workplace (Spell, Eby, & Vandenberg, 2014).

Argyris made three important observations that include (a) the organization's climate is stable if it satisfies the employee's needs (b) management can change the environment by hiring different types of employees, and (c) identified the levels-of-analysis issue (as cited in Schneider, Ehrhart, & Macey, 2013). The levels-of-analysis issue diminished the prevailing thought that measurement and study of an organization's climate through the study of the individual as opposed to the larger group (Schneider et al., 2013).

The traditional hierarchical structure fosters a defensive, short-term, and self-focused behavior (Ehrhart et al., 2013) that inhibits the organization's productivity. In the 1960s, McGregor focused on the ways that the organization repressed employee motivation and intelligence rather than fostering the environment (as cited in Russ, 2013). McGregor's *Theory X* and *Theory Y* perspectives indicate that the climate exists in

employee behaviors and the nature of behavior forms the basis for the perceptions of the climate (Ehrhart et al., 2013).

Likert (1961) determined that the values, atmosphere, and the nature of conformity of the group determine the impact on the growth and behavior of its members (Ehrhart et al., 2013). The environment provides the context for the interaction, decision-making, and problem-solving activities of the group (Varella, Javidan, & Waldman, 2012). Schein (2016) described the necessity of viewing the organization from a systems perspective, meaning the understanding of individual behavior within the context of a *complex social system*. Schein was the first researcher to determine that the notion of motivation directed by money was no longer viable, that man had productive social, and motivation needs in the work environment (Ehrhart et al., 2013).

Tagiuri (1968) was the first researcher to provide a definition of organizational climate as an enduring quality within the organization experienced by the members, influences, behavior, and described as attributes of the environment (Ehrhart et al., 2013). The researchers of the early 1950s and 1960s considered the organization's leadership as a key factor in the individual behavior and values perceived in the working environment (Schneider et al., 2013). The research into organizational climate declined in the 1970s and 1980s as researchers focused on the organization's *culture* until the late 1990s when the researcher focus on organizational climate reemerged (Schneider et al., 2013).

The organization's culture represents the behavioral norms and expectations that characterize a work environment (Hogan & Coote, 2014). Glisson (2015) further described organizational culture as the deeply held assumptions and values, which

translate into normative expectations and behavior. In other words, organizational culture compares to the group as in sociological, whereas organizational climate associates to the individual's perceptions as in psychological aspects of the environment. The early research conducted into organizational climate implied that there might be different climates or environments in organizations.

Current study. A characterization of the early organizational climate research is a lack of agreement on a standard definition, a method of measurement, and a disassociation of the term organizational (Schneider et al., 2013). Recent organizational climate research accomplishments resulted in a resolution of the levels-of-analysis issue, a uniform agreement on a definition and a prescription for study, and methods to measure climate strength (Schneider et al., 2013). Researchers and practitioners present organizational climate as a set of shared subjective experiences that have significant outcomes for the organization's functioning and effectiveness (Ashkanasy & Dorris, 2015).

The research of organizational climate is an outcome-focused approach based on a predictive model that seeks to understand and assess significant organizational effectiveness outcomes (Ehrhart et al., 2013). Schneider and Barbera (2014) described organizational climate as the shared meaning that members associate with the policies, practices, procedures, and events and the expected, supported and rewarded behaviors. Glisson (2015) described organizational climate as the psychological impact of the shared perceptions created by employees of their work environment on their personal functioning and well-being.

The organization's climate links to the perceptions employees believe to be real within the workplace (Randhawa & Kaur, 2014). Argyris described the organization's climate as the totality and complexity of life that encompasses the structure and employee interactions, each of which determines the culture (Spell et al., 2014). The organizational environment is a key factor that contributes to employee well-being (Randhawa & Kaur, 2014). Glisson (2015) further identified that the employee perceptions of a given organizational environment represent an agreement of the significance and personal appraisal of the meaning of their work.

Organizational climate refers to the employees' measured, quantified, and modified attitudes related to the workplace (Poghosyan et al., 2013a). In basic terms, organizational climate refers to the perceptions employees place on their working conditions. The organization's managerial behavior, leadership style, participation, support, and work area all factor into the work environment (Randhawa & Kaur, 2014). The organizational climate emerges through social exchanges concerning the interrelated meaning attributed to workplace experiences (Schneider & Barbera, 2014). The social exchanges shape the employee schema of the organization's character.

Nursing environment. The nursing practice environment relates to the characteristics of a work setting that enables or hinders professional nursing practice (Twigg & McCullough, 2014). Nursing shortages challenge healthcare systems to provide solutions to prevent escalating adverse health outcomes (Green et al., 2013; Yee et al., 2013). The shortage of healthcare provider's forces policymakers and employers to address staff training and recruitment issues, retention policies, and cost strategies that

are beneficial to health outcomes (Iglehart, 2013; Martin et al., 2013). Schein (2016) explicitly described that the management's policies and procedures developed to maximize the day-to-day effectiveness may serve to punish innovation and creativity.

Healthcare employees' empowerment occurs when the organization provides access to information, support, and resources toward quality patient care (Iglehart, 2013). Positive organizational climates improve nurse retention, reduce turnover, and foster quality patient care (Twigg & McCullough, 2014). According to Argyris (1947), organizations that make their employees feel secure and in control at work contribute to their motivation, energy, and improve the organization's effectiveness by creating the right *atmospheric conditions* (as cited in Ehrhart et al., 2014). The research indicates that the interventions intended to improve the quality of the environment have a greater effect on retention and staffing than increasing recruitment and salary (Twigg & McCullough, 2014). A review of the literature indicates an increase in productivity issues and adverse patient outcomes when organizations fail to provide information, support, and resources (Poghosyan et al., 2014).

Nurse practitioners that have greater autonomy, sufficient resources, and supportive leadership achieve role satisfaction (Twigg & McCullough, 2014). Nurse practitioners view collaboration, physician relationships, and staff support as important organizational climate factors (Poghosyan et al., 2013c). Twigg and McCullough's (2014) conducted a study demonstrating the importance of supportive practice environments and the need for management involvement. Organizational restraints relate to policies, practices, and procedures each of which defines the objective characteristics

of the workplace (Randhawa & Kaur, 2014). Management may never realize the full potential of employees due to behavioral constraints imposed by the organizational environment (Randhawa & Kaur, 2014).

Poghosyan et al. (2013a) conducted a literature review focusing on the quality of the organizational climate research in healthcare delivery investigations because of the significant impact on the provider, patient, and organizational outcomes. Clear roles and expectations build confidence in the healthcare team and are significant factors in supportive practice environments (Pfaff, Baxter, Jack, & Ploeg, 2014). A review of the literature demonstrates that autonomy is a critical aspect of professional nursing practice that fosters and enables quality patient care (Kuo et al., 2013; Laschinger & Fida, 2015; Pron, 2013). The collaborative relationships between the medical and nursing staff, effective communication, and supportive management are important factors in a positive practice environment (Twigg & McCullough, 2014).

A review of the literature identified that organizations that make their nurse practitioner's patient care contributions visible, that foster supportive medical and nursing staff relationships, and allow the nurse practitioners to practice independently are important organizational climate domains that require further study (Poghosyan et al., 2013c). Supportive environments are necessary for expanding nurse practitioner professional practice, building efficient multidisciplinary healthcare teams, and delivering high-quality patient care (Poghosyan et al., 2013c). The organizations that have poor communication practices fail to support nurse practitioner practice and prevent the advanced practice nurses from fully utilizing their skills and knowledge create

organizational climate barriers that hinder productive healthcare practices (Naylor & Kurtzman, 2010; Poghosyan et al., 2013a).

Barriers to practice. The U.S. healthcare system has a critical shortage of primary care physicians to meet demand (Pettersen et al., 2012) and will worsen as the nation's population ages and grows and insurance coverage expands (Auerbach et al., 2013; Green et al., 2013). The ACA's provisions expand insurance coverage for low-income populations, which initiated a focus on low-cost alternatives to traditional primary care (Auerbach et al., 2013; Erickson, 2013). Policy experts recommend expansion proposals for nurse practitioner supply and scope of practice (National Governors Association, 2012), which are controversial with physicians and physician associations.

Major transformations in care delivery and payment models move to bring the industry closer to the Institute for Healthcare Improvement's (IHI) *triple aim* of improving patient experience of care and population health while reducing costs (Erickson, 2013). Transformations in care delivery and payment models offer solutions that may offset primary care shortages (Dentzer, 2013). Organizations should optimize and incentivize an efficient and productive workforce to counter the expected physician shortages (Kirch et al., 2012). According to a report by the Bipartisan Policy Center and Deloitte Center for Health Solutions, current models of care do not account for new delivery models or the role that other healthcare professionals contribute to care delivery (Erickson, 2013).

Restrictive legislation can limit nurse practitioner scope of practice and utilization (Hooker & Muchow, 2015). Nurse practitioners face some barriers including restrictive scope of practice laws (Auerbach et al., 2013; Green et al., 2013) that require physician involvement in certain care processes and patients' perceptions of nurse practitioners (Yee et al., 2013). Managers and policymakers should reassess the nurse practitioners increasing roles in healthcare access because of the PPACA (Henry & Hooker, 2014). The debate about the necessity of a legislative requirement will continue at different speeds across each state legislature.

Measurement. Valentine, Nembhard, & Edmondson (2015) reviewed 39 survey instruments that measured various aspects of the practice environment within the healthcare sector. Some survey instruments measure organizational climate, yet none focus on the general organizational attributes that affect the nurse practitioner practice in primary care (Poghosyan et al., 2013b). Ohman-Strickland et al. (2007) developed the survey of organizational attributes for primary care to measure the organizational practices internal resources for change focusing on *communication*, *decision-making*, and *stress/chaos*. The survey instrument does not align with the nursing philosophies that account for the organizational attributes necessary for providing care (Poghosyan et al., 2013b).

The Misener nurse practitioner job satisfaction scale (MNPJSS) measures job satisfaction focusing on six subscales including (a) collaboration, (b) autonomy, (c) environment interaction, (d) professional growth, (e) time, and (f) benefits (Misener & Cox, 2001). The survey only focuses on job satisfaction and does not align with the

organizational climate attributes that affect nurse practitioner practice. Warshawsky et al. (2013) developed the nurse manager practice environment scale to describe and assess nurse managers' environments (Warshawsky, Rayens, Lake, & Havens, 2013).

The instrument focuses on the practice environment in the organizational context of achieving optimal staff, patient, and organizational outcomes (Warshawsky et al., 2013). The scale is not appropriate because it does not measure the nurse practitioner organizational climate context. Poghosyan et al. (2013) designed the nurse practitioner–primary care organizational climate questionnaire (NP-PCOCQ) to measure the nurse practitioner work background in primary care settings (Poghosyan et al., 2014). The development of the instrument implemented existing evidence and qualitative data produced from in-depth nurse practitioner interviews (Poghosyan et al., 2014).

The NP-PCOCQ focuses on the nurse practitioners' role, independent practice, and teamwork and have strong psychometric properties (Valentine et al., 2015). There are many instruments available to defend aggregation of individual perceptions to yield a representative score of the organization (Schneider et al., 2013). The measurement of organizational climate yields that a higher consensus provides for a more reliable mean, which further results in greater validity and a relevant relationship with the outcomes (Schneider et al., 2013). I selected the NP-PCOCQ because it aligns with the nurse practitioner organizational climate context of practice and Lewin's field theory.

Transition

In section 1, I presented the foundation of the study including the background of the problem, problem statements, the purpose of the study, the research question and

hypotheses, the theoretical framework, operational definitions, significance of the study, and an extensive review of the literature. In section 2, I presented the research project including a review of the purpose statement, the role of the researcher, participants, research method and design, population and sampling, ethical research, instrumentation, data collection and analysis techniques, and study validity. In section 3, I presented the findings, and discuss the application for professional practice and implications for social change. I closed the study with recommendations for action and further research, doctoral journey reflections, and a conclusion.

Section 2: The Project

The purpose of Section 2 is to describe the research project by restating the study's purpose and communicating the role of the researcher, participants, research method, and design. It includes the nurse practitioner population of the healthcare industry that I surveyed during data collection, the methods used to recruit participants, and ethical considerations. The section further contains a description of the population and sampling, ethical research, data collection, organization, and analysis of the quantitative study. The section concludes by addressing the study validity and reliability, and then a summary and transition to Section 3.

Purpose Statement

The purpose of the quantitative correlation study was to examine the relationship between the ARNP role identification, autonomy, collaboration, and organizational climate. The independent variables are (a) role identification (X_1), (b) autonomy (X_2), and (c) collaboration (X_3). The dependent variable is organizational climate (Y_1). The targeted population consists of ARNP practicing in the state of Florida. The implications for positive social change include the potential to provide significant knowledge to influence policy, practice, and research to reduce healthcare costs and increase patient satisfaction and outcomes.

Role of the Researcher

My role as a researcher aligns with the standardized protocols established by Walden University and the independent Institutional Review Board (IRB). A researcher must not disclose a participant's confidential information. The participants and users of

the data expect researchers to maintain the highest standards of conduct and ethical morals and values. Alignment with the governing protocols established by the Belmont Report ensured that the method, analysis, and conclusions are valid and reliable.

I identified the sample population ensuring that it aligned with the purpose of the study, analysis method, sample size in similar research, and established research parameters (Bryman & Bell, 2015). Eligible respondents must serve as a nurse practitioner specializing in primary care within the state of Florida. I provided sufficient information to the participants before the conduct of the study via informed consent and ensured the participants were aware of their ability to withdraw consent at any time per the Belmont Report protocol (Lantos & Spertus, 2014).

I enclosed a letter of introduction and invitation to participate in an email along with the survey link to each participant. I gathered the Likert-type survey data through an online survey via SurveyMonkey®, which allowed for anonymous member input. I then organized and analyzed the resultant data and apply multiple regression to establish the correlation between the independent variables and the dependent variable using the Statistical Package for the Social Sciences (SPSS 23) software (Habib, Pathik, & Maryam, 2014).

Upon completion of the data collection, analytical, and statistical process, I presented the findings of the research topic in a neutral, ethical, and unbiased manner (Khan, 2014). There are no direct or personal relationships with any of the study participants. In full disclosure, my wife is a registered nurse (RN) considering the pursuit of the ARNP qualification. I did not have any previous experience or working knowledge

of the role of a nurse practitioner. The lack of experience or working knowledge assisted in my ability to remain unbiased and objective in the interpretation of results.

Participants

Sampling a subset of a population allows researchers to draw inferences about the general population (Meeden, 2012). A sample must be representative of the population to provide the greatest degree of generalizability (Acharya, Prakash, Saxena, & Nigram, 2013). I analyzed survey responses from participants employed as nurse practitioners in the Florida healthcare industry. The eligibility criteria for the participants included (a) working in the *primary care* specialization, (b) at least weekly contact with their immediate supervisor, and (c) working full-time or part-time within the state of Florida (Poghosyan et al., 2013b).

I contacted the Florida Association of Nurse Practitioners (FLANP) because the association was the largest organization in the state of Florida with access to over 10,000 licensed nurse practitioner providers (Poghosyan et al., 2013b). The chief executive officer (CEO) responded to my request, and a discussion of the purpose of the study and the ethical measures for the conduct of the research occurred. The CEO, serving on my behalf, presented the proposal to the FLANP board meeting to gain approval. The board approved the study, and the chairman of the board signed the Letter of Cooperation (Appendix E).

I coordinated through the FLANP to distribute the online survey via email to the association membership (Downes-Le Guin, Baker, Mechling, & Ruylea, 2012; Sue & Ritter, 2012). The respondents included nurse practitioners with a variety of experience

specializing in primary care practice. The potential respondents received an email invitation to participate with my credentials under my signature and the purpose of the study. The participants received encouragement to respond to the survey due to their contributions resulting in an analysis of how to make themselves and their organizations more efficient (Rickards, Magee, & Artino, 2012).

The participants aligned with the overarching research question because the sample provided personal insight (Bryman & Bell, 2015) into their organization's climate and are in a position to address practice support. I chose the purposive sampling strategy because it was the most common method used in correlational designs for convenience and cost effectiveness in support of the research question (Kandola, Banner, O'Keefe-McCarthy, & Jassal, 2014). The participants represented a sample of the nurse practitioners practicing in the state of Florida because each association member had an equal opportunity to respond to the survey (Acharya et al., 2013).

Research Method and Design

The conduct of the study followed a quantitative, correlational research design to determine the strength of the relationship between role identification, autonomy, collaboration and organizational climate. Researchers use the quantitative method to test theories by examining the relationships among the variables measured to analyze the data using statistical procedures (Polit & Beck, 2013; Vance, Talley, Azuero, Pearce, & Christian, 2013). The purpose of the study was to gain an understanding of a sample population to arrive at inferences about the characteristic, attitude, or behavior of the

population (Rothman, Gallacher, & Hatch, 2013). The choice of the type of study was due to my advocacy and participatory worldview.

Research Method

I used the quantitative research method to determine the statistical significance or lack of significance of the strength of the relationship between variables (Polit & Beck, 2013). Quantitative research instills statistics to generalize about an aspect of a population for the development or testing of a theory (Vance et al., 2013). The quantitative approach was justifiable because I intended to use the NP-PCOCQ survey instrument to gather data regarding nurse practitioner role identification, autonomy, and collaboration to determine a relationship or correlation between the variables (Poghosyan et al., 2013b; Mertens, 2014).

The qualitative research method was more appropriate to determine causation among variables (Bailey, 2014; Mertens, 2014). The qualitative method was not appropriate because the intent of the research was to examine the relationship or correlation between the variables (Punch, 2014). The complimentary nature of the mixed method approach ensures that the strengths and weaknesses of each method toward a greater understanding and consideration of the research problem (Christ, 2013; Hussein, 2015). The mixed method approach was not appropriate because the extant research does not require a holistic understanding of the phenomenon and was not inconclusive, equivocal, or fragmented (Venkatesh, Brown, & Bala, 2013).

Research Design

I used the correlational design to evaluate the statistical relationships among naturally occurring variables. The correlational design allows for the use of inferential statistics to assess the strength of the relationship between the independent variables of role identification, autonomy, and collaboration and the dependent variable of organizational climate (Mertens, 2014; Punch, 2014). The experimental design requires the manipulation of an independent variable to measure the effect on the dependent variable (Hayes & Preacher, 2014).

The experimental design is best when the researcher can control or manipulate the variables and randomly assign the participants to explore possible cause and effect relationships (Mertens, 2014; Polit & Beck, 2013). The correlational research design via survey research allows for the empirical description of a given population, which could further serve to influence positive social change (Hodkinson & Macleod, 2013; Punch, 2014). I chose the correlational design because it provided the data required to address the research question and described the positive organizational climate desired in the workplace.

Population and Sampling

The purpose of sampling a subset of a population is to allow researchers to draw inferences about the general population (Meeden, 2012). The basis of the predominant method of selection involves the methodology and topic, and not the generalizability of the research findings (Mertens, 2014). The target population for the study consisted of nurse practitioners specializing in primary care within the state of Florida. The ARNP is a

nationally licensed healthcare provider with a master's degree from an approved school program (U.S. Department of Labor, 2014).

Researchers must ensure the population sample aligns with the overarching research question (Uprichard, 2013). A systematic and detailed sampling following established protocols generates valid interpretations (Acharya et al., 2013). The participants aligned with the overarching research question because the sample provided personal insight (Bryman & Bell, 2015) into their organization's climate, and the participants were in a position to address practice support.

The nonprobability purposive sampling strategy is the most common method used by researchers interested in participants with the greatest knowledge of the topic (Bryman & Bell, 2015). The disadvantage of purposive sampling is the reader's interpretation of trustworthiness (Elo et al., 2014). The random sampling method provides the greatest degree of representativeness (Acharya et al., 2013). The disadvantage of random sampling is the statistical exclusion of any person or group. I selected the nonprobabilistic purposive sampling strategy because it is the most common method used in correlational designs for convenience in support of the research question (Kandola et al., 2014).

Selection of the sampling method and the appropriate sample size are essential components of quality research studies (Elo et al., 2014). I conducted an *a priori* power analysis because I used multiple linear regression to test the stated hypothesis via G*Power software (Beck, 2013) to compute the minimum number of participants. The *a*

a priori power analysis served to avoid a Type II error by not rejecting the null hypothesis when it required rejection (Murphy, Myors, & Wolach, 2014).

I used the statistical software package G*Power 3.1.9.2 to perform an *a priori* analysis validation to determine the minimum sample size requirement (Beck, 2013). I conducted a sample size calculation that indicated, assuming a medium effect size ($f^2 = .15$), $\alpha = .05$, and three independent variables, require a sample size of 77 to achieve a power of .80. Increasing the sample size to 161 increased the power to .99 (see Figure 2).

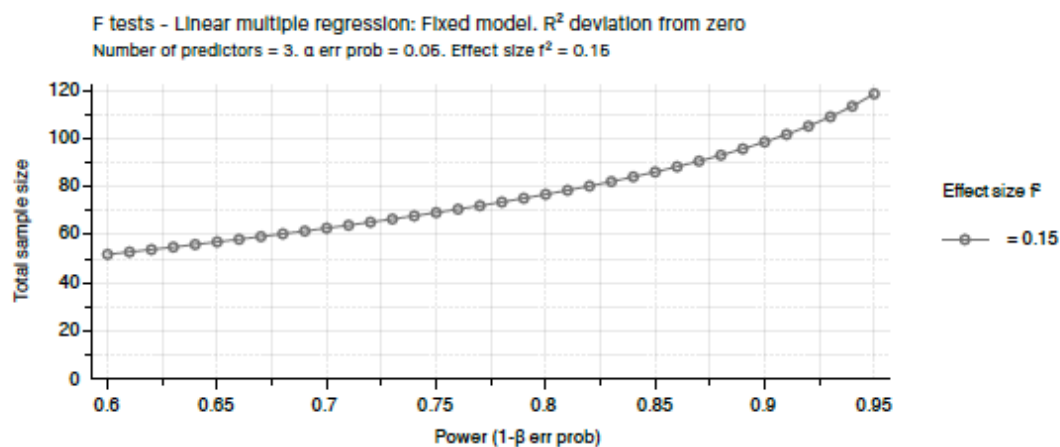


Figure 2. Power as a function of sample size (Beck, 2013).

Ethical Research

The conduct of ethical research supports the study objectives and promotes the accountability and responsibility of researchers (Von Schomberg, 2013). I integrated the measures of ethical protection of participants into the study per the Belmont Report guidance (U.S. Department of Health & Human Services, 1974). I obtained the approval from the nurse practitioner association representatives to survey their membership before

collecting data. Data collection occurred upon obtaining Walden University IRB approval number 09-14-16-0525874.

Each potential respondent received a description of the purpose of the study and the assurance of anonymity and confidentiality to encourage honest and credible responses (Merianos, King, & Vidourek, 2013). The respondents consented to participate before accessing the electronic survey via the consent form (Appendix G). The respondents did not receive an incentive for participation in the study. The study guidelines described the participant's right to withdraw from the study via nonparticipation, an incomplete survey, or improper submission. There was not a signature requirement to ensure there are no opportunities to record personally identifiable information maintaining anonymity for the participants.

The Walden IRB approval number and the final date allowed for collection are in the consent form. I protection encrypted the data collected for confidentiality and will maintain the files in a personal safe for 5 years upon completion of the research. I deleted the encrypted data with the appropriate computer program and will destroy the backup devices to protect the rights of the participants after 5 years. The risk to the participants was minimal, and their identities and responses remained anonymous. The participants received my contact information for response to inquiry and clarification purposes.

Data Collection Instrument

I administered the NP-PCOCQ, a psychometric survey tool developed by Poghosyan et al. (2012) to measure the significant relationship between the ARNPs' motivation and the organizational climate (Poghosyan et al., 2013b). The instrument

consists of 35 items generated from existing evidence (Poghosyan et al., 2013a) and qualitative data (Poghosyan et al., 2013c) from the research team consisting of nurse researchers and a psychometrician. The subscales serve to indicate the extent to which a nurse practitioner perceives his or her role identification, autonomy, and collaboration within the context of their organizational environment.

Each of the NP-PCOCQ subscales contains four to six subthemes. Four subthemes were combined under the role identification theme emphasizing role awareness, contributions and recognition, care coordination, and place in the organization (Poghosyan et al., 2013b). Four subthemes were incorporated under the autonomy theme emphasizing policies, independent decision making, being responsible for patient care, and practice within the scope of practice (Poghosyan et al., 2013b). Six subthemes were combined under the collaboration theme emphasizing communication, support, trust/rapport, respect, collegiality, and teamwork (Poghosyan et al., 2013b).

The NP-PCOCQ uses a Likert-type scale, which is the standard psychometric scale to measure responses (Wakita, Ueshima, & Noguchi, 2012). The instrument contains a modified 4-point Likert-type scale, which is an ordinal scale of measurement used in behavioral and organizational research to measure the subscales or themes (Hartley, 2014; Mazzetti, Schaufeli, Guglielmi, & Depolo, 2016). The themes indicate the frequency of working behaviors, where 1 = *strongly disagree*, 2 = *disagree*, 3 = *agree*, and 4 = *strongly agree* (Poghosyan et al., 2013b). The instrument was appropriate for use because there are no other tools to assess the nurse practitioner organizational climate in primary care settings.

Poghosyan et al. (2013b) piloted the original instrument to conduct an initial item analysis and to obtain an initial assessment of reliability. The original survey instrument included 55 items and reduced to 34 items after the pilot test. Field testing of the NP-PCOCQ took place May to July 2012 with primary care nurses recruited from the nurse practitioner association (NPA) in New York State (Poghosyan et al., 2013b). Poghosyan et al. (2013b) emailed the members requesting their participation in the survey via the online professional version of SurveyMonkey®. Poghosyan et al. (2013b) sent second and third email reminders to encourage a satisfactory response rate. The online survey took approximately 15 minutes to complete.

Poghosyan et al. (2013b) targeted a sample size of 300 participants to conduct an exploratory factor analysis. The data extraction occurred from the SurveyMonkey® website as an SPSS database to examine for normality, outliers, and multicollinearity concerns (Tabachnick & Fidell, 2013). The researchers identified the critical value for statistical significance using the standard normal distribution (Poghosyan et al., 2013b). The goal of the research was to develop a survey instrument with strong psychometric properties to produce evidence for the creation of favorable nurse practitioner organizational climates supporting their practice (Poghosyan et al., 2013b).

The most common measurement of internal consistency or reliability is the coefficient alpha also known as Cronbach's alpha (α) (Cohen, Cohen, West, & Aiken, 2013). The researchers computed and investigated Cronbach's alpha for each of the subscales. The measure of reliability for the role identification subscale received a Cronbach's alpha of .87 (Poghosyan et al., 2013b). The subscale autonomy measure of

reliability resulted in a Cronbach's alpha of .89 (Poghosyan et al., 2013b). The reliability score for the collaboration subscale received a Cronbach's alpha of .90 (Poghosyan et al., 2013b). Scores closer to 1.0 as a correlation-based measure indicate a higher reliability (Cohen et al., 2013).

The NP-PCOCQ's face validity, a form of construct validity, addresses the concerns for appearance and appropriateness but not the quality of the instrument (Newman, Lim, & Pineda, 2013). The content validity addresses the actual relevance of the items to the substance of the domain assessed (Thorndike & Thorndike-Christ, 2010). Poghosyan et al. (2013b) conducted two meetings with experts including nurse practitioner researchers and nurse practitioners with a minimum of 5 years of experience in primary care practice. The nurse practitioner panel reviewed each item and the scale to ensure the questionnaire met the design intent. Poghosyan et al. (2013b) entered the rating data in SPSS and computed the content validity index (CVI) (Poghosyan et al., 2013b). The instrument received a CVI of .90 demonstrating an excellent content validity (Wilson, Pan, & Schumsky, 2012).

I sent an email (Appendix A) requesting the use of the NP-PCOCQ to Dr. Poghosyan, a professor at Columbia University. I included a copy of my approved prospectus and a description of my intention to extend the work of Dr. Poghosyan and colleagues in New York State. I received permission to use the NP-PCOCQ from Dr. Poghosyan via email (Appendix B). There is a sample copy of the survey instrument located in (Appendix C). There was no intent to adjust or revise the approved questionnaire.

I maintained the data collected and analyzed in a personal safe to protect the rights and security of participants for no fewer than five years. I am the only person that had access to the personal safe. The information remained in my secure possession and available to the Walden University supervising faculty and representatives responsible for the conduct of my doctoral study review and acceptance processes. I deleted the data from all electronic media following the five-year minimum retention requirement.

Data Collection Technique

Ensuring a representative sample of the population and accounting for all possible answers are the predominant weaknesses of the survey instrument (Cruces, Perez-Truglia, & Tetaz, 2013). Upon IRB approval of the study, an FLANP liaison forwarded a participation recruitment letter (Appendix F) to the association membership list requesting their participation in the study. I presented the NP-PCOCQ (Poghosyan et al., 2013b), a 35 question survey instrument generated on SurveyMonkey®. SurveyMonkey® was a secure online survey provider, which enabled participants to provide responses anonymously (Waclawski, 2012).

Poghosyan et al. (2013b) conducted a pilot test and field test of the NP-PCOCQ instrument in New York State. The potential participants received a link to the online survey hosted by SurveyMonkey® and assigned a universal alphanumeric code to satisfy confidentiality and anonymity requirements. I conducted data collection through the third party, SurveyMonkey® (Waclawski, 2012) online survey instrument allowing respondents to answer the provided questions at their convenience (Downes-Le Guin et al., 2012; Sue & Ritter, 2012).

The FLANP did not discuss my study or recruit members to participate in the study to avoid the perception of coercion. I did not interact with any of the survey participants. The informed consent form (Appendix G) appeared on the third page of the survey, before the survey questions, but after the confirmation of age over 18 on the second page. I imported the raw survey data into an Excel spreadsheet upon receipt of the 187 completed survey responses. I imported the raw data from the Excel spreadsheet into SPSS 23 and then conducted a multiple linear regression analysis and reported my findings in Section 3 of the doctoral study. I sent a one-page summary to the FLANP leadership and the NP-PCOCQ developer.

Data Analysis

The research question that guided the study was: What is the strength of the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate?

The null and alternative hypotheses were:

$H1_0$: There is not a statistically significant relationship between ARNPs' role identification and organizational climate.

$H1_a$: There is a statistically significant relationship between ARNPs' role identification and organizational climate.

$H2_0$: There is not a statistically significant relationship between ARNPs' autonomy and organizational climate.

$H2_a$: There is a statistically significant relationship between ARNPs' autonomy and organizational climate.

$H3_0$: There is not a statistically significant relationship between ARNPs' collaboration and organizational climate.

$H3_a$: There is a statistically significant relationship between ARNPs' collaboration and organizational climate.

I inputted the survey data into SPSS version 23 and analyzed the data using multiple regression/correlation analysis (MRC), which was highly general and flexible (Cohen et al., 2013). Researchers use MRC to analyze the relationship between the single dependent variable with two or more independent variables (Karadas, Celik, Serpen, & Toksoy, 2015). MRC was the appropriate data analysis technique because the form of the relationship can be simple or complex, not constrained, and the well-mannered nature of the data analyzed meets the underlying assumptions of the model (Cohen et al., 2013).

I screened the data, checking for missing values and survey errors (Fink, 2012). I identified the total number of participants and then determined the number of respondents that failed to complete the items in the NP-PCOCQ (Poghosyan et al., 2013). I then excluded the incomplete surveys from the analysis of the data phase (Little & Rubin, 2014).

The addition of assumptions about the population's characteristics increased the potential that I drew inferences about the population (Cohen et al., 2013). All statistical procedures require assumptions for the development of the mathematical process (Cohen et al., 2013). The use of MRC required the testing and assessing of the following assumptions: (a) normality, (b) linearity, (c) heteroscedasticity, (d) multicollinearity, and (e) autocorrelation (Karadas et al., 2015).

Normality assumed that each independent variable would have a normal distribution. I used a normal probability plot to determine the distribution of data around the dependent variable. If the distribution is not between -1.0 and +1.0, then the independent variable may need transformation (Karadas et al., 2015). Linearity focuses on the relationship between the dependent and independent variables. I used the test statistic to determine insignificant variables for removal, then the F -test to ascertain the usefulness of the model (Karadas et al., 2015).

The third assumption was that the data should be free from heteroscedasticity, meaning that the subpopulations have different variabilities from others. Heteroscedasticity is the absence of homoscedasticity, which results in errors of the same variance (Karadas et al., 2015). Multicollinearity results in the high degree of correlation among the controlled variables (Karadas et al., 2015). I used the variance inflation factor (VIF) function in the SPSS 23 software to test multicollinearity to ensure the data was useful for analysis. If the VIF value was less than 5, then multicollinearity was not an issue.

I used the Durbin-Watson test statistic (d) function of the SPSS 23 software to check for autocorrelation among errors. If the value of d equals 2, then autocorrelation was not present. A value significantly less than 2 indicated a positive serial correlation and a value greater than 2 indicated a negative correlation (Karadas et al., 2015). If autocorrelation occurs, then I used the Orcutt-Cochran method and Prais-Winsten procedure to eliminate the model (Midi, Ann, & Rana, 2013; Karadas et al., 2015).

I took the resulting data from the survey to analyze the relationships between role identification, autonomy, collaboration, and organizational climate within Florida health care organizations. The analysis determined the normal distribution, variance, and standard deviation for each question to determine reliability and validity. Given the test statistic and the sampling distribution, I intended to assess the probabilities associated (Konasani & Kadre, 2015).

Study Validity

Validity is the measurement of consistency in a psychometric measurement tool used to assess the study objectives (Streiner, Norman, & Cairney, 2015). I addressed the threats to validity in the study, specifically external, internal, and statistical conclusion validity. The threats to external validity relate to generalizability, meaning that the findings of the nurse practitioner population in Florida may not be generalizable in other states. Poghosyan et al. (2013) conducted a similar study in New York state from the state's nurse practitioner association (NPA) membership list with the same psychometric testing instrument (Poghosyan et al., 2013b). The questions regarding role identification, autonomy, and collaboration are applicable in other states.

The threats to internal validity relate to the organization, consistency, and causal conclusions of the research (Hales, 2016). Internal validity is susceptible to extraneous or confounding variables, which could inhibit cause and effect conclusions (Nkwake, 2015). The organization and conduct of the survey are in agreement with research protocols and approval of the IRB. The consistency of the results aligned with the reliability that responses would be consistent regardless the time of implementation. I addressed the

threat by confirming the qualifications and specialization of the nurse practitioners before taking the survey.

The threat to statistical conclusion validity describes the degree to which the findings relate to the correctness and reasonableness of the relationship between variables (Hales, 2016). I addressed the threat to the statistical conclusion by adhering to scientific research processes, and the Walden University standardized protocols. The other risk related to Type I error and the researcher's ability to arrive at the correct conclusion by rejecting the null hypothesis when it should have accepted it (Murphy et al., 2014). Statistical reference material supported the proper interpretation of results (Hales, 2016).

The intent of the study was to provide a greater understanding of the nurse practitioners' organizational climate that was accurate, consistent, and generalizable to other states and possibly other countries. The psychometric survey tool was written in non-specific geographic terms (Poghosyan et al., 2013b). The sample population was specific to the healthcare industry, yet role identification, autonomy, and collaboration are concerns for most professional occupations, regardless of industry.

Transition and Summary

In section 2, I restated the purpose of the study. I also discussed the role of the researcher, participants, research method and design, population sampling, ethical research, a review of the instrument, presented data collection and analysis procedures, and study validity. In Section 3, I discussed study results, application to professional practice, implications for social change, and recommendations for further research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of the quantitative correlation study was to examine the relationship between the ARNP role identification, autonomy, collaboration, and organizational climate. I used the 35-item NP-PCOCQ to evaluate the relationship between the independent variables of (a) role identification (X_1), (b) autonomy (X_2), and (c) collaboration (X_3) and the dependent variable of organizational climate (Y_1). After sending survey invitations to members via the FLANP liaison, I received 229 survey responses. I rejected 42 incomplete surveys and used the remaining 187 completed surveys in the study. The overall response rate is unknown because the association did not disclose the number or email addresses of the survey invitations sent. The completion rate of the survey responses was 81.66%. I rejected the null hypothesis and accepted the alternative hypothesis since the analysis demonstrated role identification, autonomy, and collaboration did have a significant relationship to the organizational climate. I present the findings, application to professional practice, and implications for social change, which provide the basis for the recommendations for future research. The section also includes reflections from the study process.

Presentation of the Findings

In this subsection, I discuss the testing of assumptions, present descriptive and inferential statistics, provide a theoretical interpretation of the findings, and conclude with a concise summary. I employed bootstrapping, using 2,000 samples, to adjust for the

possible influence of assumption violations. Presentation of bootstrapping 95% confidence intervals occurred where appropriate.

Tests of Assumptions

I evaluated assumptions of multicollinearity, outliers, normality, linearity, homoscedasticity, and independence residuals. I presented the tables and figures as required for the tests of the assumptions. Bootstrapping, using 2,000 samples, enabled me to adjust for the possible influence of assumption violations.

Multicollinearity. I conducted a test in SPSS version 23 regarding the severity of multicollinearity. I used the test to determine whether the linear relationship of the independent variables to one another, depicted in Table 2, was too close for data analysis. Predictor variable collinearity refers to a situation where explanatory variables correlate with each other in linear regression (Liao & Valliant, 2012). Testing multicollinearity was essential because there were three predictor variables requiring calculation of tolerance and variance inflation factor (VIF). Table 2 indicates no independent variable conflicts as the VIF was less than 10 for each, with a tolerance of 1.0 greater than .1 (Liao & Valliant, R. 2012).

Table 2

Multicollinearity of Independent Variables

Model		Collinearity statistics	
		Tolerance	VIF
1	Role identification	.611	1.638
	Autonomy	.611	1.638
2	Autonomy	.512	1.954
	Collaboration	.512	1.954
3	Collaboration	.338	2.958
	Role identification	.338	2.958

Outliers, normality, linearity, homoscedasticity, and independence of residuals. I evaluated outliers, normality, linearity, homoscedasticity, and independence of residuals by examining the normal probability plots (P-P) as shown in Figures 3, 4, 5, and 6, and the scatterplots of the studentized deleted residuals as shown in Figures 7, 8, and 9. The visual examinations indicated no major violations of the assumptions. The tendency of the points formed a reasonably straight line without major deviations, as shown in Figures 3, 4, 5, and 6. The points fell diagonally from bottom left to top right, which supports no gross violations of the normality assumptions (Cohen et al., 2013).

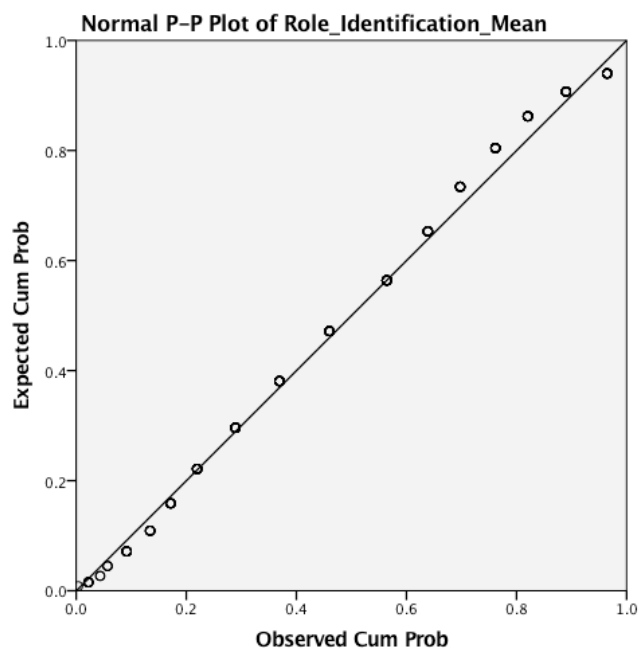


Figure 3. Normal probability plot (P-P) of role identification.

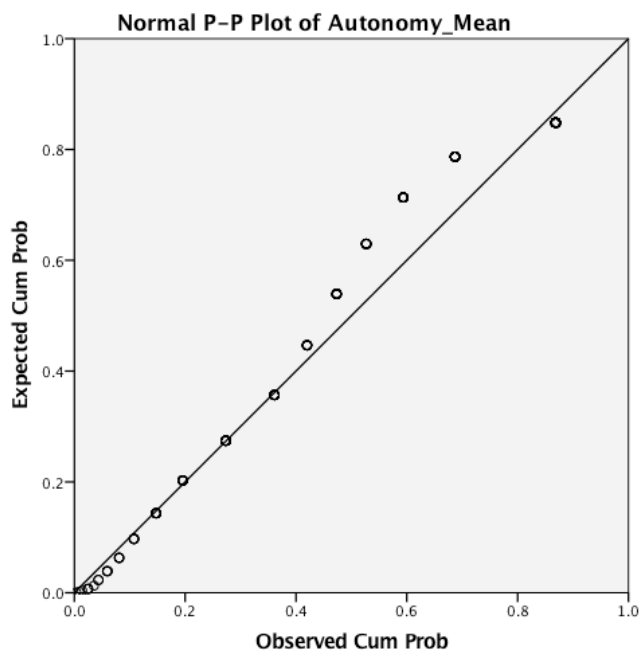


Figure 4. Normal probability plot (P-P) of autonomy.

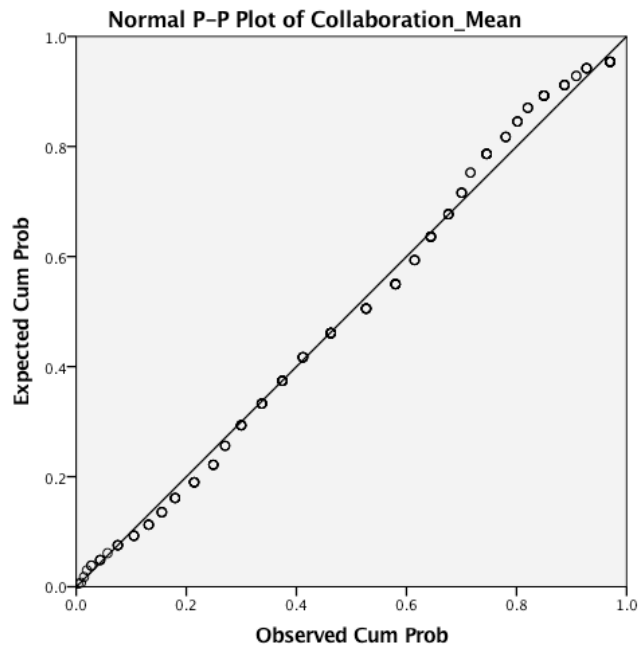


Figure 5. Normal probability plot (P-P) of collaboration.

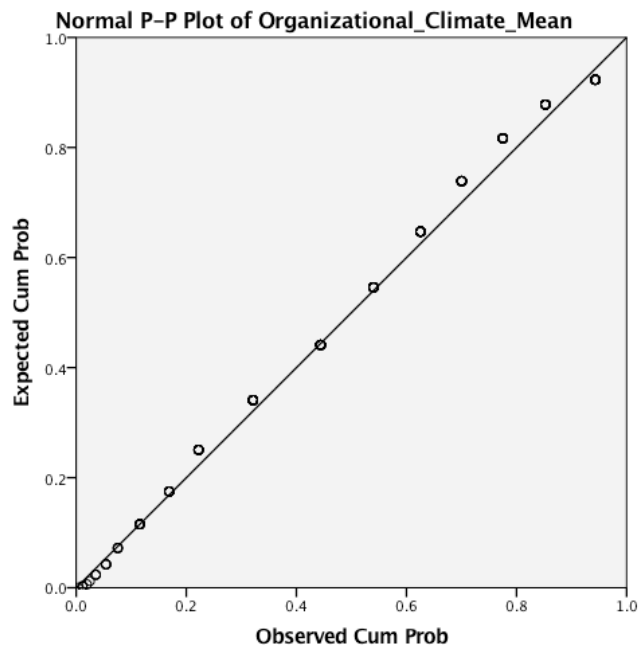


Figure 6. Normal probability plot (P-P) of organizational climate.

The lack of a systematic pattern in the scatterplots of the studentized deleted residuals also supported that there were no serious violations of assumptions (see Figures 7, 8, and 9). Studentized deleted residuals assist researchers by excluding the focal observation, which prevents the inflation or deflation of the residual value masking the existence of any outliers (Aguinis, Gottfredson, & Joo, 2013). I detected no major violations of regression assumptions; however, I computed 2,000 bootstrapping samples to combat any possible influence of assumption violations, reporting 95% confidence intervals based on the bootstrap samples where appropriate.

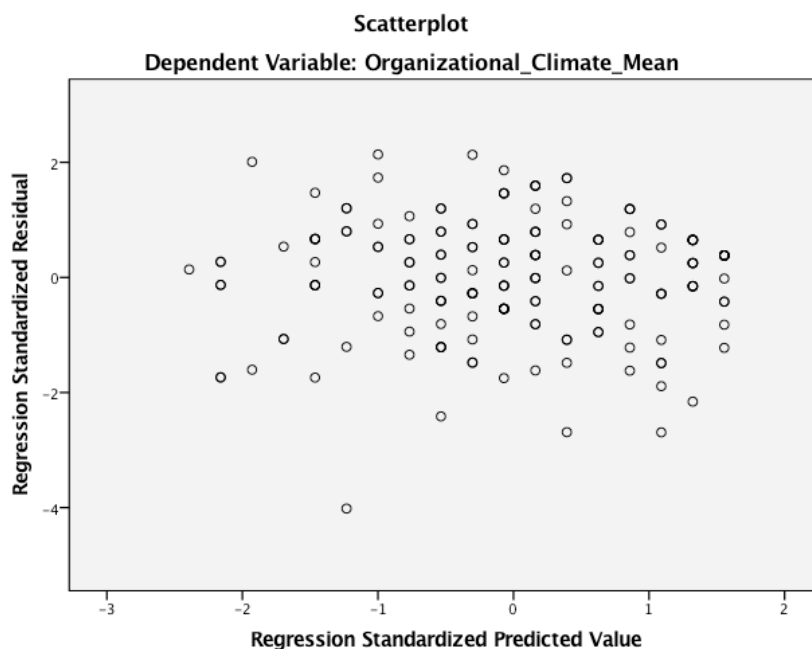


Figure 7. Scatterplot of studentized residuals for role identification.

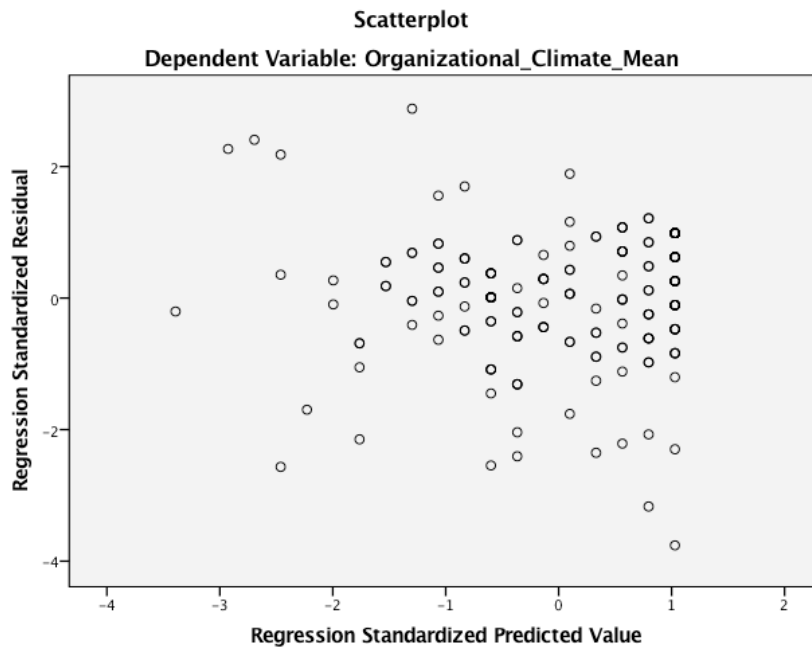


Figure 8. Scatterplot of studentized residuals for autonomy.

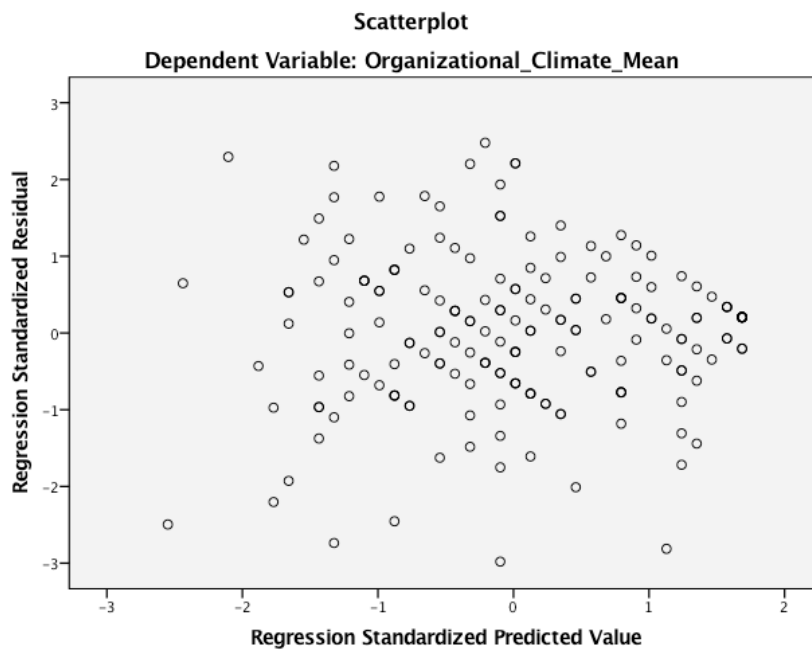


Figure 9. Scatterplot of studentized residuals for collaboration.

Descriptive Statistics

I received a total of 187 completed and usable surveys. Table 3 shows descriptive statistics of the variables including the mean, standard deviation, skewness, and kurtosis of role identification, autonomy, collaboration, and organizational climate. Table 3 illustrates that each of the predictor variables and the dependent variable organizational climate has a negative skew. A negative skew indicates that the tailed distribution is longer on the left side and that the bulk of the values lie to the right of the mean (Kim, 2013). A skewness number greater than 2 represents a substantial departure from normality (West, Finch, & Curran, 1995). Table 3 illustrates that autonomy and organizational climate have a positive number within 1.0 while role identification and collaboration have a negative number within 1. Kurtosis measures the amount of probability in the tails of the distribution (Kim, 2013). A kurtosis number greater than 7 represents a substantial normality departure (West et al., 1995). Table 4 shows the bootstraps for coefficients of the role identification, autonomy, and collaboration independent variables.

Table 3

Descriptive Statistics of Study Variables

	<i>N</i>	Min.	Max.	Mean	Std. Deviation	Skewness	Kurtosis
Role identification	187	1.00	4.00	3.0435	.61522	-.286	-.638
Autonomy	187	1.00	4.00	3.3682	.61397	-.867	.202
Collaboration	187	1.00	4.00	2.9198	.64077	-.067	-.717
Organizational climate	187	1.00	4.00	3.2231	.54409	-.572	.289

Table 4

Bootstraps for Coefficients of Independent Variables

Model	β	Bootstrap				
		Bias	SE	Sig. (2-tailed)	95% Confidence Interval	
					Lower	Upper
1 (Constant)	1.183	.005	.135	.000	.929	1.467
Role identification	.670	-.002	.042	.000	.583	.750
(Constant)	.704	-.012	.176	.001	.349	1.032
2 Role identification	.468	-.003	.052	.000	.358	.562
Autonomy	.325	.006	.063	.000	.212	.449
(Constant)	.739	.007	.165	.000	.413	1.075
Role identification	.306	-.001	.072	.000	.160	.448
3 Autonomy	.243	.001	.063	.000	.124	.372
Collaboration	.251	-.002	.070	.000	.110	.389

a. Unless otherwise noted, bootstrap results are based on 2,000 bootstrap samples.

Note. $N = 187$

Inferential Results

I chose to use multiple linear regression analysis in the evaluation of the study because it supports a statistical assessment of correlations (Cohen et al., 2013). I used the standard multiple linear regression, $\alpha = .05$ (two-tailed) to examine the effectiveness of the independent variables in predicting the dependent variable, specifically to ascertain the relationship between role identification, autonomy, collaboration, and organizational climate. The independent variables were (a) role identification (X_1), (b) autonomy (X_2),

and (c) collaboration (X_3). The dependent variable was organizational climate (Y_1). There were no violations of the assumptions, as discussed in Section 2.

The null hypothesis was that the independent variables did not have a statistically significant relationship with the dependent variable. The alternative hypothesis was that the independent variables did have a statistically significant relationship with the dependent variable. The model was able to significantly predict the dependent variable, $F(3, 183) = 12.498, p = .001, R^2 = .681$; therefore, the null hypothesis was rejected. The linear combination of the predictor variables role identification, autonomy, and collaboration account for the R^2 (.681) value indicating approximately 68% of the variation in organizational climate as shown in Table 4. Table 5 illustrates the results of the multiple linear regression analysis. The model was predictive of organizational climate.

Table 5

Model Summary of Regression Analysis

Model	R	R ²	Adjusted R ²	Std. Error of the estimate	Change statistics				Durbin-Watson	
					R Square Change	F Change	df 1	df2		Sig. F Change
1	.758 ^a	.574	.572	.35594	.574	249.597	1	185	.000	
2	.810 ^b	.657	.653	.32054	.657	175.950	2	184	.000	
3	.825 ^c	.681	.676	.30983	.681	130.202	3	183	.000	1.976

Note. a. Predictors: (Constant), Role Identification
b. Predictors: (Constant), Role identification, Autonomy
c. Predictors: (Constant), Role identification, Autonomy, Collaboration
d. Dependent Variable: Organizational climate

In Table 6, the model was predictive of organizational climate with role identification, autonomy, and collaboration shown as statistically significant. Role identification ($\beta = .346, p = .001$) accounted for a higher contribution than collaboration ($\beta = .296, p = .001$), which accounted for a slightly higher contribution than autonomy ($\beta = .275, p = .001$). The final predictive equation was the following:
 organizational climate = 0.739 + 0.306 (role identification) + 0.243 (autonomy) + 0.251 (collaboration).

Role identification. The positive slope for role identification (.306) as a predictor of organizational climate indicated there was an approximate .306 increase in role identification issues (see Table 6). The organizational climate tends to decrease as role identification decreases. The squared semipartial coefficient (sr^2) estimated the variance in the organizational climate predictable from .758, indicating role identification uniquely accounted for 76% of the variance in the organizational climate when controlling for the collaboration and autonomy variables.

For Alternative Hypothesis 1 ($H1_a$), the results of the multiple regression models, with role identification used as the independent variable and organizational climate as the dependent variable resulted in $F(1, 185) = 31.623, p = .001, R^2 = .574$. The predictor variable explained 57% of the variability in organizational climate. The independent variable role identification significantly predicted organizational climate scores ($\beta = 0.306, p = 0.001$). The finding indicates that I can reject null hypothesis one for the organizational climate.

Autonomy. The positive slope for autonomy (.243) as a predictor of organizational climate indicated there was an approximate .243 increase in autonomy issues (see Table 6). The organizational climate tends to decrease as autonomy decreases. The squared semipartial coefficient (sr^2) that estimated the variance in organizational climate predictable from .697, indicating autonomy uniquely accounted for 70% of the variance in the organizational climate when controlling for the role identification and collaboration.

For Alternative Hypothesis 2 ($H2_a$), the results of the multiple regression models, with autonomy used as the independent variable and organizational climate as the dependent variable resulted in $F(1, 185) = 26.757, p = .001, R^2 = .486$. The predictor variable explained 49% of the variability in organizational climate. The independent variable autonomy significantly predicted organizational climate scores ($\beta = 0.243, p = 0.001$). The finding indicates that I can reject null hypothesis two for the organizational climate.

Collaboration. The positive slope for collaboration (.251) as a predictor of organizational climate indicated there was an approximate .251 increase in collaboration issues (see Table 6). The organizational climate tends to decrease as collaboration decreases. The squared semipartial coefficient (sr^2) that estimated the variance in the organizational climate predictable from .769, indicating collaboration uniquely accounted for 77% of the variance in the organizational climate when controlling for the role identification and autonomy variables.

For Alternative Hypothesis 3 ($H3_a$), the results of the multiple regression models, with collaboration used as the independent variable and the organizational climate as the dependent variable resulted in $F(1, 185) = 32.562, p = .001, R^2 = .591$. The predictor variable explained 59% of the variability in organizational climate. The independent variable autonomy significantly predicted organizational climate scores ($\beta = 0.251, p = 0.001$). The finding indicates that I can reject null hypothesis three for the organizational climate.

Regression and Pearson product-moment analysis. Regression analysis (see Table 4) showed there was a significant positive relationship between organizational climate and role identification ($\beta = 0.306$), between organizational climate and autonomy ($\beta = 0.243$), and between organization climate and collaboration ($\beta = 0.251$). I determined the variance in the predictors as role identification (3.011), autonomy (1.990), and collaboration (3.594) were less than 10 indicating no independent variable conflicts (see Table 6) (Liao & Valliant, R. 2012). I noted that the tolerance values of role identification (.332), autonomy (.503), and collaboration (.278) were greater than 0.10 signifying the predictors were not redundant (see Table 6) (Liao & Valliant, R. 2012). The Durbin-Watson statistic is used to detect the presence of autocorrelation (Cohen et al., 2013). The Durbin-Watson test resulted in an independence value of 1.976 (see Table 5). The value is always between 0 and 4, which means the tested value of 1.976 indicates that there is no autocorrelation in the observation (Cohen et al., 2013).

The Pearson product-moment correlation coefficient is a value between +1 and -1 with a number closer to 0 indicating a weak relationship (Cohen et al., 2013). Table 7

illustrates the Pearson product-moment correlation coefficients for the variables. The correlation demonstrated a significant positive strong relationship between role identification and organizational climate with $r = 0.758, p < 0.01$; autonomy and organizational climate with $r = .697, p < 0.01$; and collaboration and organizational climate with $r = .769, p < 0.01$. The Pearson product-moment results confirmed the multiple linear regression analysis.

Table 6

Regression Analysis Summary for Predictor Variables

Variable	B	SE B	β	t	p	B 95%
						Bootstrap CI
(Constant)	.739	.135		5.495	.001	[.413, 1.075]
Role identification	.306	.064	.346	4.775	.001	[.160, .448]
Autonomy	.243	.052	.275	4.663	.001	[.124, .372]
Collaboration	.251	.067	.296	3.735	.001	[.110, .389]

Note. $N = 187$.

Table 7

Pearson Correlation Analysis

	Role identification	Autonomy	Collaboration	Organizational climate
Role identification	1			
Autonomy	.624	1		
Collaboration	.814	.699	1	
Organizational climate	.758	.697	.769	1

Note. $p < 0.01$

Analysis summary. The purpose of the study was to examine the relationship between the independent variables of (a) role identification (X_1), (b) autonomy (X_2), and (c) collaboration (X_3) of nurse practitioners in healthcare organizations and the dependent variable of organizational climate (Y_1). I used multiple linear regression and Pearson's product-moment correlation to examine the ability of role identification, autonomy, and collaboration to predict organizational climate. I tested the assumptions associated with multiple linear regression with no violations noted. The multiple linear regression model was able to significantly predict organizational climate, $F(3, 183) = 12.498, p = .001, R^2 = .681$, therefore, the null hypothesis was rejected. The $R^2 (.681)$ value indicated that approximately 68% of the variation in organizational climate is descriptive of the linear combination of the predictor variables role identification, autonomy, and collaboration. The conclusion from the analysis is that role identification, autonomy, and collaboration has a statistically significant relationship with organizational climate.

Theoretical discussion of findings. I used Lewin's field theory as the theoretical framework to support the study (Lewin, 1939). The current study extended the knowledge of field theory because there was no evidence of other studies examining the healthcare industry, specifically the ARNP organizational climate context before this study. I also did not find any research examining the relationship between the ARNPs' role identification, autonomy, collaboration, and organizational climate through the theoretical lens of field theory.

The only similar studies published examining ARNP organizational climate context were through a 2012 study conducted in New York (Poghosyan et al., 2013b),

and a 2012 study undertaken in Massachusetts (Poghosyan, Liu, Shang, D'Aunno, 2015), each of which used Kanter's theory of structural power. Poghosyan et al. (2013c) conducted a qualitative 2011 qualitative study in Massachusetts using the same variables. The results of the current study were consistent with the prior studies on the topic, demonstrating a significant positive relationship between the dependent variable organizational climate and the independent variables of role identification, autonomy, and collaboration.

To maximize the use of the study results, healthcare managers and policy makers must first understand field theory and how the concept may affect the organizational climate when considering the three factors toward the formulation and implementation of change within their organizations. Lewin argued that the totality of forces within a given environment and the relatedness of the interactions with each other require consideration as opposed to isolating one or two forces that may impinge on the individual or group (Lewin, 1942).

Kadu and Stolee (2015) conducted a study that found the current primary care system is not adaptive to rapid change, accommodating of new interventions, or adopting additional duties. The major themes emerging from the study related to the organizational setting, implementation process, and the individual provider characteristics (Kadu & Stolee, 2015). The study concluded that transforming the care practices of readiness, networks and communication, and provider attitudes and beliefs requires a supportive culture of change (Kadu & Stolee, 2015). Pearson (2012) found ARNP practice restrictions by many states regulating physician supervision and collaboration.

Although the ARNPs' educational preparation and training comply with accreditation agencies and national certification examinations, the regulation of these professionals is inconsistent across the United States (Pearson, 2012). Some states support ARNP practice within the scope of their training and education, which includes evaluation, diagnosis, treatment, and prescription (Barton Associates, 2014). Other states reduce or restrict the ARNP scope of practice by requiring supervisory, geographic, and collaborative relationships with physicians to provide care (Poghosyan et al., 2015).

The ARNPs' practicing in New York can order physical therapy for their patients, while Florida restricts the practice (Barton Associates, 2014). Furthermore, some states allow ARNP to admit patients, order tests or medical equipment, while others do not, which affects their ability to provide care (Poghosyan, Boyd, & Clarke, 2016). The ARNP practicing in New York, California, or Texas cannot complete a worker's compensation claim while ARNP practicing in Florida have the authority (Barton Associates, 2014). The inconsistency in ARNP practice from setting to setting lead to distinct variations across the states in autonomy (Poghosyan et al., 2016).

Kuo et al. (2013) conducted a study demonstrating that the ARNPs' see more patients in states with the least restrictive scope of practice regulation. Buerhaus et al. (2015) found that ARNP and physicians deliver similar services and provide care in nearly identical ways. Stanik-Hutt et al. (2013) found that ARNP involvement in patient care improves the overall health of their patients. It is clear that identifying the factors that affect the utilization of ARNP is a significant policy, practice, and research priority (Poghosyan et al., 2016).

Desborough (2012) described the ARNP professional progression as an altered social construction of roles and the effect on the associated challenges of their relationships within the healthcare system. The association of the current climate with the structural capacity of the healthcare industry to accommodate the contemporary ARNP role are resistant to change by the traditionalist within (Desborough, 2012). Despite these barriers, the ARNPs' are implementing their roles and improve the quality and safety of patient care (Desborough, 2012). The current study contributes to the literature of the ARNP role integration, independent practice, and collaboration within the organizational climate context.

Applications to Professional Practice

Physicians traditionally govern the management of nursing practice. State medical boards that govern the scope of practice regulations and senior administrators within healthcare organizations are most often physicians (Pearson, 2012). State nursing boards are engaging state legislatures for an equal voice in the assemblies and an easing of restrictive regulation (Pearson, 2012). The medical and nursing professional culture results from the establishment of over a century of associated relationships and processes (Desborough, 2012). The emergence of the ARNP role is challenging these long-standing traditions (Desborough, 2012).

Nurses comprise a significant proportion of the healthcare workforce, the loss of which would have a considerable impact on the costs and efficiency of quality care (U.S. Department of Health & Human Services, 2014). About half of the ARNP in the United States provide direct primary care services and comprise approximately 20% of the total

primary care workforce (Agency for Healthcare Research and Quality, 2012; U.S. Department of Health and Human Services, 2014). Utilizing primary care ARNP to their full capacity may mitigate or eliminate primary care shortfalls (Green et al., 2013). Policymakers and administrators can drive change by providing ARNP staff supports and ensuring resource availability (Kadu & Stolee, 2015).

Research is necessary for the healthcare industry to design a comprehensive approach to resource allocation, improve healthcare quality and safety, and retain the workforce (Li & Jones, 2013). Nursing turnover is a critical issue attracting attention because of the negative impact on hospital budgets, staff, and patient outcomes (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014). Organizations must spend money to advertise, recruit, and train new nurse employees to replace nurses that leave (Li & Jones, 2013). Blatter et al. (2015) conducted a study that associated the costs of recruiting and training new employees as potentially exceeding the annual salary of the position (Blatter, Muehleemann, Schenker, & Wolter, 2015).

A review of the literature identified that ARNPs' have low job satisfaction (Pasaron, 2013; Aiken, Sloane, Bruyneel, Van den Heede, & Sermeus, 2013). The Poghosyan (2015) study described the significant positive practice implications of healthcare organizations that support ARNP autonomy, clarify their roles and foster collaborative relationships that may further promote ARNP job satisfaction and job retention (Poghosyan et al., 2015). It is important to understand the impact of the ARNP practice environments on job satisfaction and intent to leave as the workforce is expected to grow (Auerbach, 2012; Poghosyan et al., 2015). The evidence is clear that the ARNP

workforce is capable of providing quality patient care and should practice to the full extent of their education and training (Institute of Medicine, 2010).

Implications for Social Change

It is necessary to understand the ARNP perceptions of their practice environments and the influence of the setting on the workforce to promote their practice in primary care (Poghosyan et al., 2015). I collected survey data from ARNPs' serving in primary care positions in the state of Florida to fill gaps in the understanding of how role identification, autonomy, collaboration effect the organizational climate. Respondents provided their opinions as responses to questions regarding each of the independent variables, and the dependent variable within their organizations. The participants provided their responses independently, based on their opinions, without using any organizational documentation.

Poghosyan et al. (2015) conducted a study describing the importance of understanding organizational climate that may lead to ways to improve the practice environment, decrease intent to leave, and increase job satisfaction. The results of the study could also address the significant amount of role overlap in primary care practice (Brault et al., 2014). Even in states where ARNP regulations are less restrictive, organizations continue to use these professionals in narrow ways (Poghosyan et al., 2016). The evidence from this study and the Poghosyan studies may promote organizational interventions that foster positive practice environments and retain ARNP in their clinical positions (Poghosyan et al., 2015).

The study's value to social change began with the ARNP responses based on the knowledge and perceptions of their organization concerning role identification, autonomy, collaboration, and organizational climate. Improvements in these key areas could lead to increased contribution of ARNP engagement, expanded practice roles, and independent practice (Pogohosyan et al., 2015). The ARNP workforce is not optimally utilized to practice within their respective organizations (Pearson, 2012). The results of the study confirm the need to continue support of a positive organizational climate that may improve retention, quality of care, and reduce costs (Poghosyan et al., 2016).

The research findings of Desborough (2012) demonstrated the lack of ARNP implementation models for newly certified ARNP creates isolation, uncertainty, disorganization, and insecurity. Poghosyan et al. (2015) identified that suboptimal organizational climates could prevent ARNP from utilizing training and education, lead to job dissatisfaction, and further contribute to intentions to leave. It is human nature to develop and maintain connections that are meaningful and provide affirmation and support in work contexts (Desborough, 2012). The findings highlight the potential value of the ARNP workforce by promoting their personal worth, professional capabilities, and demonstrating the quality of their patient care within the healthcare industry.

Recommendations for Action

The findings support the Institute of Medicine (2010) study that recommended achieving appropriate scope of practice without restriction (Institute of Medicine, 2010).

The results of the survey may be relevant to the healthcare sector, but also to other stakeholders including government bodies that provide funding and regulation to the

industry. Policymakers and administrators could use the study findings to promote ARNP practice environments that support and maintain the expansion of the ARNP workforce (Poghosyan et al., 2016). A greater understanding of the practice environment factors may assist in the development of a model for ARNPs' considering independent practice.

Any actionable recommendation for organizations begins with an awareness of the current organizational climate to inform, communicate, and educate ARNP practice reform. A lack of policymaker, administrator, and practice manager understanding of the ARNP education, role, and experience is a concern because they play an important part in the design of organizational structures and the distribution of resources (Poghosyan et al., 2015). It is possible that employees are not aware of their organizational procedures, policies, and practices, which could lead to role confusion, dependency, and teamwork issues. Training at the organizational, section and individual levels may improve the understanding of ARNP roles, abilities, and implementation. Clarifying professional roles can be an effective approach facilitate integration, foster collaboration, and mitigate power struggles (Brault et al., 2014).

Disseminating the results to the association is important since I gathered the participants from their membership. I will present the findings to the Chairman of the Board and the Chief Executive Officer of the participating association. I will also offer the results to the designer of the NP-PCOCQ survey instrument. The findings may have value for insurance companies as they reconsider their reimbursement policies. The study may inform healthcare organizations and other providers of the benefits associated with the ARNP role. Furthermore, findings may inform the healthcare consumers regarding

the ARNP as primary care providers. Finally, I may share the results through publication in peer-reviewed or scholarly journals.

Recommendations for Further Research

Policymakers, administrators, and health care professionals require research to design supportive organizational structures and practice environments that promote ARNP care and maximize their contribution to patient outcomes (Poghosyan et al., 2016). Researchers have taken a fragmented approach focusing on unique aspects of the issues facing the ARNP practice and challenges (Berg & Roberts, 2012). For future studies, it is recommended to explore ARNP factors within the organizational climate context via a qualitative case study. The conduct of a case study would add personal interaction to reveal personal perceptions and allow for follow-up questions (Yin, 2014). A longitudinal study may provide an understanding of how changes in the scope of practice regulations affect ARNP practice and trends over time and the impact on patient access and outcomes (Poghosyan et al., 2016).

Since the study only examined the perspective of ARNP serving in the state of Florida, it would be good to gather samples from other states and levels of restriction. Future research could compare the data to this study and disclose additional avenues for exploration. The study in other nurse practitioner associations may reveal an increase in statistically significant relationships between role identification, autonomy, collaboration, and organizational climate. I also recommend continued examination of the nurse practitioner practice environments in restrictive and less restrictive states as a mixed study to add depth to the research. Future case or mixed studies may include focus groups

of ARNPs' to further explore the barriers and facilitators NPs experience when entering independent practice. Additional study may also include ARNPs' in partnership, group practice, or independent providers.

If the quantitative method is preferred, surveying physicians and administrators will provide a greater understanding of the ARNP work environment (Desborough, 2012). I recommend expanding the scope of research geographically. The perceptions of ARNPs' in Florida, New York, or Massachusetts may not correspond with the opinions of ARNPs' in California, Washington, or Oregon. I further recommend extending the research to include the factors of job satisfaction, intent to leave, and turnover to address the outcomes of the various perceptions of the practice environment.

The limited scope of the study is the greatest strength and weakness. While the study was conducted in Florida allowing the results to have professional practice application within the state, it raises the issue of generalization. ARNP may have different perceptions of their organizational climate in other states and associations (Poghosyan et al., 2015). The study represents a sample of a restrictive state's policies toward nurse practitioner scope of practice and may be generalizable to other states with similar restrictions. The current study coupled with the Poghosyan studies (2012) conducted in the less restrictive scope of practice states of Massachusetts and New York may serve to inform a greater population. Future research may help to address the generalizability issue.

Reflections

The DBA Doctoral Study process was challenging in balancing work, school, and life events. I had to learn to embrace the process and attain new levels of patience and flexibility. I learned to temper my expectations and personal timeline with the speed of the committee and university processes. I had to moderate my bias as my wife is a nurse practicing as a Registered Nurse. It is also important to note once again, that I do not and have not worked in the healthcare industry. My other bias was toward barriers to entry or practice. Barriers represent a physical, psychological, or social impediment toward progress in an organization. I had the honor and privilege to serve among our Nations special operations warriors who took steady aim at barriers and broke through, minimized or eliminated them altogether.

The information in the study provided a means to research nurse practitioner perceptions of their organizational climate. It is difficult to examine a single aspect of an interdependent system without acknowledging the other components of a complex and diverse industry. The literature addressing nurse practitioner perceptions of their organizational climate is sparse. The information gathered from the study has increased my understanding of how legislation affects a business model and the performance of experienced and educated nurse practitioners. I am grateful to the nurse practitioner participants without whom the study would not be possible. I am hopeful that the study will increase the interest in identifying environments that are conducive to nurse practitioner employment within their full scope of practice.

Conclusion

The findings of this study and a review of the literature identified the need to expand the primary care workforce as the demand for care increases. The ARNP workforce is expected to double within the next 15 years and represents a viable solution to the healthcare provider shortage. The ARNP could provide a critical role in meeting the growing demand for primary care if the current restrictive legislation were reduced or eliminated in their respective states limiting their ability to practice to their optimal utilization.

Further study into the relationship of role identification, autonomy, collaboration on the organizational climate may provide the necessary insight to inform policy and organizational change. Through this quantitative correlation study, I examined the relationship between role identification, autonomy, collaboration and organizational climate of the Florida nurse practitioner workforce through members of the FLANP. I conducted an online survey via SurveyMonkey® exported directly to SPSS. I used the 35-item Nurse Practitioner – Primary Care Organizational Climate Questionnaire (NP-PCOCQ) (Appendix C) for the study.

The results of the study were statistically significant for a positive correlation between role identification, autonomy, collaboration, and organizational climate. Each of the independent variables was equally influential on the dependent variable. I rejected the null hypothesis based on the resultant positive correlation. The results are informative academically and professionally applicable to Florida's healthcare industry. As the demand for healthcare increases, it is necessary to understand the nurse practitioner

environments that are supportive of their contributions and improve patient outcomes.

Together the findings of the study contribute to the foundation into whether the variables can influence the nurse practitioner workforce positively or negatively toward meeting the demand. This concludes the study.

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Appendix A: Survey Instrument Request

Walden University Mail - NP-PCOCQ permission 12/28/15, 5:11 PM

NP-PCOCQ permission
1 message

 Mon, Dec 28, 2015 at 5:11 PM

Dr. Poghosyan,

I am a Doctor of Business Administration (DBA) student at Walden University working on my capstone requirement.

I am interested in extending your work in New York and Massachusetts using the Nurse Practitioner Primary Care Organizational Climate Questionnaire (NP-PCOCQ), to measure the relationship between overall job satisfaction and satisfaction with the professional practice environment. I intend to conduct a quantitative study to examine nurse practitioner organizational climate in the state of Florida.

I am writing to gain your permission to use the survey through Survey Monkey to measure the organizational climate of nurse practitioners in the state of Florida. I am further interested in identifying the theory you used to develop the psychometric instrument.

I am hopeful that my study will add to the broader understanding of desired practice environments, support the development of change initiatives to retain and attract nurse practitioners, and reduce restrictive barriers to practice. I would greatly appreciate your support in this endeavor.

Respectfully,

Eric Haupt
Doctor of Business Administration (DBA) Student
Walden University

Appendix B: Survey Instrument Permission



Appendix C: Sample of Instrument

Instructions: For each item, please indicate the extent to which you agree that the following items are present in your practice site. Indicate your degree of agreement by selecting **ONE** option that best applies to you.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. In my organization, NP role is well understood.	4	3	2	1
2. I feel valued by my organization.	4	3	2	1
3. Physicians support my patient care decisions.	4	3	2	1
4. NPs are represented in important committees in my organization.	4	3	2	1
5. NPs are an integral part of the organization.	4	3	2	1
6. Physicians ask NPs for suggestions.	4	3	2	1
7. In my practice setting, staff members have a good understanding about NP roles in the organization.	4	3	2	1
8. In my organization, there is a system in place to evaluate my care.	4	3	2	1
9. I feel valued by my physician colleagues.	4	3	2	1
10. In my organization, NPs and physicians collaborate to provide patient care.	4	3	2	1
11. In my organization, physicians and NPs practice as a team.	4	3	2	1
12. I regularly get feedback about my performance from my organization.	4	3	2	1
13. Physicians in my practice setting trust my patient care decisions.	4	3	2	1
14. Physicians may ask NPs for their advice to provide patient care.	4	3	2	1
15. Administration is open to NP ideas to improve patient care.	4	3	2	1
16. Administration takes NP concerns seriously.	4	3	2	1
17. Physicians seek NPs' input when providing patient care.	4	3	2	1
18. I do not have to discuss every patient care detail with a physician.	4	3	2	1
19. Administration shares information equally with NPs and physicians.	4	3	2	1

20.	Administration is well informed of the skills and competencies of NPs.	4	3	2	1
21.	In my organization, I freely apply all of my knowledge and skills to provide patient care.	4	3	2	1
22.	Administration treats NPs and physicians equally.	4	3	2	1
23.	Administration informs NPs about changes taking place in the organization.	4	3	2	1
24.	Administration makes efforts to improve working conditions for NPs.	4	3	2	1
25.	In my organization, there is constant communication between NPs and Administration.	4	3	2	1
26.	My organization does not restrict my abilities to practice within my scope of practice.	4	3	2	1
27.	In my organization, I can provide all patient care within my scope of practice.	4	3	2	1
28.	Physicians and NPs have similar support for care management (e.g., help with patient follow-up, referrals, labs, etc.).	4	3	2	1
29.	My organization creates an environment where I can practice independently.	4	3	2	1
30.	In my practice setting, I have colleagues who I can ask for help.	4	3	2	1
31.	I independently make patient care decisions within my area of competency without input from a physician.	4	3	2	1
32.	In my practice setting, I have enough resources to provide patient care.	4	3	2	1
33.	There are enough ancillary staff to prepare my patients (e.g., height, weight, bring patient to examining room) for their visit.	4	3	2	1
34.	During visits, I have enough scheduled time with each patient.	4	3	2	1
35.	In my organization, NP competencies are well understood.	4	3	2	1

Survey used with permission from Poghosyan, L., Nannini, A., Finkelstein, S. R., Mason, E., & Shaffer, J. A. (2013). Development and psychometric testing of the nurse practitioner primary care organizational climate questionnaire. *Nursing Research*, 62, 325-334. doi:10.1097/NNR.0b013e3182a131d2

Appendix D: Request for Association Cooperation

**Request to Complete Doctoral Study Survey**

6 messages

Thu, May 12, 2016 at 8:20 AM

Dear FLANP representative,

My name is Eric Haupt. I am a student at the School of Management at Walden University and have not previously worked in the healthcare industry. I am conducting a research study as part of the requirements for the Doctor of Business Administration degree and request your organization's permission to include some of your members as participants.

I am conducting a quantitative correlation study to examine the relationship between the Advanced Registered Nurse Practitioners' (ARNPs) role identification, autonomy, teamwork, and organizational climate. The study extends a 2012 study conducted in New York by Dr. Lusine Poghosyan and associates using the Nurse Practitioner - Primary Care Organizational Climate Questionnaire (NP-PCOCQ).

If your organization decides to participate, I will provide an email to send to the membership describing the study and intent. The email will provide a link to direct the nurse practitioners that identify as primary practice providers to SurveyMonkey, a confidential website that I will place the NP-PCOCQ. The members will be requested to acknowledge an informed consent form and rank a response via a four-point Likert-type scale to 35 questions. The survey will take approximately 10 minutes to complete. Participation is confidential, and the survey does not require personally identifiable information.

Taking part in the study is discretionary. Participants may choose to quit at any time prior to the submission. There are no ramifications for not completing the survey. The identification and description of relevant organizational domains of concern may foster reciprocal relationships that will increase nurse practitioner willingness to engage in positive organizational behaviors. Your participation may further assist healthcare leaders, and policymakers realize the benefits of expanded Nurse Practitioner practice.

Thank you in advance for your consideration. If you would like to participate, please begin by responding to the completed letter of cooperation and I will be in contact to arrange the details of the survey. If you have any questions regarding the survey, you may contact me at [REDACTED]

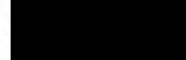
Respectfully,

Eric Haupt
[REDACTED]

Appendix E: Letter of Cooperation

6 June 2016

Florida Association of Nurse Practitioners, Inc.
PO Box 602
Lake Helen, FL 32744



Dear Eric Haupt,

Based on the review of your research proposal, the Florida Association of Nurse Practitioners, Inc., (FLANP) will support the project entitled *Predictors for Florida Nurse Practitioners' Characterization of Organizational Climate*. As part of the study, the FLANP will assist you in soliciting members to provide opinions of their organization's management processes, policies, and programs via the confidential survey conducted via the internet. Individual participation will be entirely voluntary and at their discretion.

The FLANP will assist you in your access to the member database for members that identify as primary care providers within their organizations and their authorized email addresses of members meeting your inclusion criteria.

FLANP reserves the right to withdraw from the study at any time.

I am authorized to approve research in this setting and that this request complies with the organization's policies.

I understand that data collected will remain entirely confidential and not provided to anyone outside of the research team without permission from the Florida Association of Nurse Practitioners and the Walden University Institutional Review Board (IRB).

Sincerely,

A large solid black rectangular redaction box covering the signature and name of the sender.

Appendix F: Participant Recruitment Letter

15 September 2016

Dear Primary Care Nurse Practitioner,

I am a Doctor of Business Administration (DBA) (Candidate) at the Walden University School of Management, and I am requesting your participation in a study that I am conducting. Approval to conduct the study has been granted by the Institutional Review Board (IRB) at Walden University.

I am requesting primary care nurse practitioners like you to reflect on your perceptions of your work environment to complete a survey. Your responses to the survey are relevant and may help to provide knowledge about your work environment and increase your level of engagement.

Please click on the link below to go to the survey website
<https://www.surveymonkey.com/r/MY6WZNW>.

Your participation in the survey is voluntary and anonymous, and you may discontinue participation at any time without penalty. All responses will be kept confidential. Once data are submitted, they will not be able to be withdrawn, since the data is anonymous. I will not collect personally identifying or demographic information before, during or after the survey. Your employer will not see your responses. There are no known risks or direct benefits expected from the research. Submission of the survey questionnaire will constitute consent.

Should you have any questions or comments about the research, please feel free to contact me XXX@waldenu.edu (Principal Researcher).

Should you have any questions about the rights of human participants, please contact:

Dr. Leilani Endicott (Walden University representative), (800) 925-3368, extension 3121210.

I appreciate your time and consideration in completing the survey. With the help of nurse practitioners like you, researchers can gather information to help improve work environments and increase their level of engagement in their organization.

Respectfully,

Eric Haupt
Doctor of Business Administration (Candidate)
Walden University

Appendix G: National Institutes of Health Certificate of Completion

