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Incentives and Barriers to Precepting Nurse Practitioner Students

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ABSTRACT

This study investigated incentives and barriers to precepting nurse practitioner students. Four hundred fifty-three providers from multiple settings, self-identified as qualified to precept, responded to the Web-based survey. The 64-item survey developed by the authors assessed the degree of incentive on 40 items and the influence of 17 additional factors. The leading barriers were time factors and productivity demands. The most highly rated incentives were credit toward professional recertification, program information, access to clinical references, and remuneration. Influential factors depending on the site or circumstances were professional obligation, learning opportunities, and prior relationship with faculty or student. Recognition and gifts were the lowest rated incentive factors.

Keywords: clinical preceptors, graduate nursing education, nurse practitioner preceptors

Nursing education has traditionally relied heavily on the use of preceptors. Preceptors extend the reach of nursing faculty to clinical settings and provide students with mentored real-world experiences. Preceptors are experienced clinicians who, primarily on a volunteer basis, during the hours of their normal employment, teach, mentor, and supervise a student. Those who precept NP (nurse Practitioner) students include NPs, MDs, DOs, and PAs. Many NP programs in the United States have difficulty securing adequate clinical preceptors for students, yet little is known about the attitudes of the preceptors themselves about specific incentives and barriers to serving in this role. In addition to perceived barriers and incentives, the preceptor shortage is influenced by multiple factors including increased enrollment of NP students, competition for clinical sites from other health sciences programs, and competing demands on preceptor time. Reducing barriers and increasing incentives may help alleviate some of the factors contributing to the shortage of clinical preceptors.

The increase in enrollment in NP programs is primarily driven by the convergence of political factors creating a workplace demand for more NPs. There is growing acceptance of NPs as health care providers. There is also support by important stakeholders for adding more NPs to the health care workforce. The acceptance of NPs as health care providers has been supported by multiple outcomes studies performed over the last 20 years showing the effectiveness of NPs to meet the needs of patients in primary care settings.[1,2] In 2011, the Institute of Medicine report on the future of nursing called for the removal of barriers to practice for NPs and for all health care providers to practice to the full extent of their educational preparation.[3] This endorsement further fueled the demand for NPs. Also, fewer physicians are choosing primary care as a specialty, leaving gaps in primary care that are effectively filled by NPs.[2] The implementation of the Patient Protection and Affordable Care Act gives previously uninsured Americans the opportunity to obtain primary health care, driving millions of patients to seek care from a shrinking number of primary care physicians.[4,5]

NP programs across the country are responding to the demand for NPs by increasing student enrollment, resulting in an unprecedented need to recruit preceptors. Between 2002 and 2012, there were an additional 57 schools of nursing offering NP programs, bringing the number of accredited programs to 392.[5,6] This growth has resulted in a 215% increase in total enrollment in NP programs in a single decade. The American Association of Colleges

of Nursing 2012 annual enrollment and graduation survey reported that insufficient clinical preceptors limited enrollments for 60% of programs.[7]

Although the need for preceptors is growing, NPs in clinical practice are experiencing greater demands on their time, affording them less time for mentoring novice NP students. Many practices compensate health care providers based on a relative value unit model related to the billable clinical care performed, resulting in increased emphasis on efficiency. Preceptors who must meet productivity benchmarks may find it difficult to incorporate uncompensated time for teaching into their practices.[8,9]

There is a dearth of information regarding the value of specific interventions to improve recruitment and retention of preceptors. The purpose of this study was to determine preceptors' self-identified incentives and barriers and to learn the value of actual or potential interventions that would incentivize them to precept. Ultimately, the aim is to reduce barriers and improve incentives, thereby increasing the number of active preceptors.

REVIEW OF LITERATURE

We examined the extant literature in CINAHL, Ovid, and Google Scholar using search terms such as "preceptor," "nurse practitioner," "graduate nursing education," and "education." We eliminated articles on preceptors of undergraduate students. We identified 10 articles reporting on preceptors in NP education published from 2003 to 2013.[9-18] Previous studies explored various barriers and incentives to precepting. However, the samples were small (ie, 12-58 participants). In addition, the majority of studies were limited to a single school of nursing. All the studies we reviewed documented NPs' desire to "give back" as a primary motivation to precept.[9-16] Practicing NPs reported that credits toward recertification were an important incentive. In addition, they appreciated open and accessible communication with faculty while precepting.[9,14,17,18] Barriers to precepting included the effect on productivity, patients' expectations for care by the provider, discomfort with the teaching role, competition from other programs, space limitations, and short duration of the experience.[9,10,14,16] In our review of the literature, we did not find a recent survey of facilitators and barriers to precepting that included a large sample of representative preceptors from multiple sites or schools. Therefore, the purpose of this study was to conduct a geographically broad multisite survey to identify NPs' perceptions of barriers and incentives to precepting NP students.

METHODS

Participants

Inclusion criteria were US health care providers self-identified as qualified to serve as a clinical preceptor to NP students.

Instrumentation

Items were initially generated deductively from existing evidence and qualitative data to create 2 general domains related to precepting. The first domain was "incentives to precepting" and was comprised of 7 subscales from 40 items with the following stem: "How would these items, if available, influence your decision to serve as a preceptor?" Responses were scored on the following 5-point Likert-type scale with anchors of 1 = not at all, 2 = slightly, 3 = somewhat, 4 = very, and 5 = extremely. The subscales were developed by using a semi-Delphi method. A panel of NP faculty with at least 7 years of experience in precepting anonymously reviewed the appropriateness of items and their respective scales. A series of iterations of reviews by the panel produced a unanimous consensus of the items to the 7 domains: 1) credit toward certification, 2) professional affiliation, 3) program information, 4) remuneration, 5) access to resources, 6) recognition, and 7) gifts.

The second domain was "influential factors," which was composed of 17 items reflecting whether an influential item was perceived as 1) barrier, 2) incentive, or 3) neither. These items were scored on a bidirectional scale using the following anchors: −2, strong barrier; −1, weak barrier; 0, neither incentive nor barrier; 1, weak incentive; and 2, strong incentive. The stem for these items was "Please evaluate the following items and determine whether they are incentives, barriers, or neither to serve as a preceptor." Each item in both domains included the opportunity for respondents to add additional information in open-ended questions.

There were 14 demographic items, including qualified to serve as a preceptor, willingness to serve