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# Mentorship in Retail Health - A Quality Improvement Project Initiative

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## Abstract

BACKGROUND: Nurse practitioners (NPs) practicing in retail health face issues that complicate provision of care including isolation, lack of support staff, and non-clinical administrative and business duties. To address this, a national retail health company implemented a mentorship program for newly graduated, newly hired NPs. This quality improvement project will facilitate the implementation and evaluation of this mentorship program in one of the company's regions in Georgia.

AVAILABLE KNOWLEDGE: Literature suggests that NPs believe that a mentor can help contribute to professional development, counter stress and anxiety, provide support, increase job satisfaction, and guide in critical decision making.

AIMS: 1. Increase newly hired NPs preparedness to practice and confidence to provide healthcare within the retail setting. 2. Increase mentor confidence with mentoring skills. 3. Identify unmet needs as well as evaluate satisfaction with the mentor program.

INTERVENTIONS: The mentorship program was designed to pair newly hired NPs with NPs experienced in the retail health setting for 10 weekly unstructured telephone-based mentoring sessions. Sessions were guided by the mentees' questions and supplemented with a recommended list of topics relevant to retail health.

RESULTS: Five mentee-mentor pairs were recruited to participate in the program. From pre- to post-intervention, mentees showed an increase in perception of preparedness to practice and confidence in the retail setting and mentors showed an increase in mentor skills. Additionally, seven unmet needs were identified by the mentees including prior authorizations, site specific protocols, internal policies, administrative questions, vaccine information, chart reviews, and clinical guidelines.

CONCLUSION: The mentoring program facilitated successful role transition for NPs by improving perception of preparedness to practice and confidence to provide care in the highly independent and autonomous setting of retail health.

Keywords: nurse practitioner, mentorship, mentorship program, job satisfaction, retail health

# Mentorship in Retail Health – A Quality Improvement Project

## Introduction

### Problem Description

Nurse Practitioners (NPs) face challenges in new environments when transitioning from school to practice, or onboarding from one practice to another. These challenges are compounded in retail health settings because the retail setting is autonomous and requires business savvy in addition to independent primary care clinical competence and critical thinking skills (Thabault, et al., 2015). The business savvy required includes non-clinical administrative and business-related duties such as office management, customer service, equipment care, information technology troubleshooting, and billing and collecting payments (Thabault, et al., 2015). These skills are not generally taught during NP training programs or in most clinical preceptorships creating a gap for NPs entering retail health.

Along with gaps in knowledge and skills, new graduate NPs entering retail health face the expectation that they will begin practicing independently despite little to no access to programs such as residencies, which help transition into a work setting (Hevesy, et al., 2016). Unlike physicians who typically undergo up to a seven-year residency program depending on specialty (Washington University School of Medicine, 2020), NPs are not required to undergo any residency program after graduation, nor do they typically have access to such programs (MacLellan, et al., 2015). Additionally, when NPs change specialties (e.g. from orthopedics to outpatient retail health), there is likely a gap in knowledge that may surface related to the specialty change. This can leave NPs feeling they have received inadequate preparation to practice (Pleshkan & Hussey, 2019). A lack of additional training can affect the NP's production, confidence, and job satisfaction which may lead to higher turnover rates. The turnover rate for

NPs is approximately 12.6% per year, compared to 6% for physicians (Cejka Search, 2014; U.S. Department of Health and Human Resources, 2016). The Center for American Progress estimates that the cost of replacing an employee is over 20% of that employee's annual salary (ThriveAP, Inc., 2018). This cost does not include lost revenue due to the position not being filled, costs of recruiting, and the costs related to new hire training.

To improve retention and reduce costs of recruiting, a national retail health company developed a mentorship program to be implemented nationwide to improve the onboarding process for newly hired, newly graduated NPs. The 10-week program was designed to take place at three set times per year. Any recently hired new graduate NP would be invited to join the program. For this quality improvement project, the question being explored is: Can a mentorship program increase the preparedness and confidence among newly hired Nurse Practitioners in the retail health setting?

**Available Knowledge**

To explore if mentorship programs improve preparedness and confidence among newly hired NPs in a retail setting, a prisma-guided systematic review of the literature was undertaken. Due to paucity of studies found, the search was expanded outside of the retail health setting to include all outpatient settings. The review of literature of postgraduate NP transition to the clinical environment was performed through an extensive search of databases Cinahl, Ovid, Medline, ProQuest Central, and ProQuest Dissertations & Thesis Global. There were 2,947 articles that were screened via reading either titles, abstracts, interventions, or full articles. Of these, five quantitative and eight qualitative studies were included in this review. The studies encompassed 1,673 participants. The study results outlined in Table 1 (Appendix A) showed that interventions that facilitate new graduate and experienced NP transition to a new practice setting

include residencies (Brown et al., 2015; Flinter & Hart, 2016; Hart & Bowen, 2016; MacKay et al., 2017; Rugen, et al., 2017), orientation (Barnes, 2015), continued education (Kopf et al., 2018; Thompson, 2019), preceptorships (Pleshkan & Hussey, 2019), fellowships (Zapatka et al., 2014), and mentoring (Horner, 2017; Jarrell, 2016; Mackay, et al., 2017; Sullivan-Bentz, et al., 2010).

Four studies directly discussed mentorship of NPs post-graduation from a masters or doctoral programs. Analysis of the articles revealed that both new graduate NPs and those who have been practicing for over two years believe that having a mentor is a positive experience (Horner, 2017; Jarrell, 2016; MacKay, et al., 2017). These studies suggest that a mentor can help contribute to professional development, counter the stress and anxiety of transferring to a new role, provide support, increase job satisfaction, and guide in critical decision making. The strategy of mentorship as an intervention to help NPs gain confidence and preparedness is favorable to future success hence the use of this program by the retail national health company.

Studies have also demonstrated that mentorship is valued by both new graduate NPs as well as veteran NPs (two or more years' experience). According to MacKay, et al. (2017) 51.4% of NPs agree/strongly agree that their first year was difficult and they felt unprepared for practice. Respondents also reported that they believed mentoring would help with critical decision making with complex patients. According to Horner (2017), a correlation was determined that having a mentor was a positive experience and there is a relationship between having a mentor and job satisfaction. One hundred percent of those who stated they had a mentor agreed that the mentor relationship had a positive influence on job satisfaction (Horner, 2017). Furthermore, 97% of those who had a mentor stated either "yes" or "maybe" to the question of are you willing to serve a mentor to help future NPs (Horner, 2017). Jarrell (2016) found

statistically significant results that novice NPs believe that a mentor would be helpful and veteran NPs also believed that mentoring would contribute to their professional development. In another study, Sullivan-Bentz, et al. (2010) paired new NPs graduates with physicians, NP colleagues, or administrators familiar with the NP role for a one-year mentorship. Results showed that new graduate NPs had increased confidence in ability to function and began to look for more opportunities to improve care (Sullivan-Bentz, et al., 2010). Due to this evidence that mentorship improves job satisfaction and preparedness for practice, implementing a mentorship program could be beneficial for newly hired NPs irrespective of years of experience. Therefore, the purpose of this project is to implement and evaluate a national retail health company's mentorship program in a region in Georgia to improve preparedness to practice and confidence in the retail health setting for newly hired NPs.

**Rationale**

The theoretical model used to inform the mentee outcomes in this project to guide newly hired NPs in the retail setting is Brown & Olshansky's *Limbo to Legitimacy* model (1997). The model was developed to describe the transition of new NPs during their first year of practice while highlighting the stressors and accomplishments during this transition period. This model was chosen because stages of transition can be similar for NPs transitioning from school to practice or from one specialty to another (e.g. from orthopedics to retail health). The four stages are Laying the Foundation, Launching, Meeting the Challenge, and Broadening the Perspective. The Laying the Foundation stage for this project takes place between graduation and an initial NP position, prior to entering the mentorship program. As seen in Table 2, Appendix B, the Launching and Meeting the Challenge stages refer to the routine challenges such as managing time constraints and recognizing issues in the work environment represented by the project

outcomes of increased mentee perception of preparedness to practice and increased mentee perception of confidence to practice in the retail setting. Additionally, the Meeting the Challenge stage informed the project aim to identify mentees' needs that were not met either by weekly discussions or program materials. Finally, the Broadening the Perspective stage refers to developing capabilities within the larger system represented by the outcomes of increased confidence in mentoring skills for mentors. This stage also informed the mentee/mentor satisfaction with the mentor training and resources provided to the mentors.

The change theory that influenced this project was Rogers' Diffusion of Innovation Theory. This theory uses knowledge, persuasion, decision, implementation, and confirmation to inform the decision to adopt or reject an idea or process (Udod & Wagner, 2019). The knowledge phase consists of first being exposed to an innovation but not having information about it. This phase occurred with the introduction of the mentor program to the NPs working in the region (see Figure 1, Appendix C). Persuasion is having interest in the innovation and seeking information and details. In this phase, the information about the program was disseminated prior to recruitment. The decision phase is when the individual considers the change and weighs the advantages and disadvantages of implementing the innovation. During this phase, the mentors and mentees decided to participate and fill out the surveys providing the data to determine the outcomes. During the implementation phase the individual determines if the operation is useful and finds more information about it. In this phase, the survey data was analyzed and results synthesized to find out if the mentor program was successful in achieving the proposed outcomes. Finally, in the confirmation phase, a decision is made whether to continue using the innovation. In this phase, the results of this project were disseminated to retail health company members. This model helped guide the implementation and evaluation of the

mentorship program in the designated region as well as influence the final determination of the mentorship program's usefulness (Udod & Wagner, 2019).

### Specific Aims

Aim: To implement and evaluate a mentorship program among newly hired NPs at retail clinics in a region in Georgia of a national retail health company.

Sub-aims:

- Identify and enroll 10 mentor/mentee pairs in the mentorship program.
- Increase mentee perception of preparedness to practice as an independent NP.
- Increase mentee perception of confidence to practice in the retail health setting.
- Increase mentor confidence in mentoring skills.
- Evaluate satisfaction with mentor program materials, training, and resources.
- Identify potential mentees' unmet needs not represented in the mentorship program materials or training.

## Methods

### Context

The national retail health company where this project took place developed a mentorship program for newly hired new-graduate NPs with the intent to implement it nationwide early in 2020. Each region was assigned an experienced retail NP to act as the mentorship coordinator to promote, recruit, launch, and coordinate the mentorship program on a local level. However, implementation was delayed in one of the regions in Georgia because the assigned mentorship coordinator left employment and the role was not reassigned, thus the program was never implemented in the region. Due to this oversight, the proposed quality improvement project filled the gap for a mentorship coordinator and a comprehensive program implementation.

According to the program materials, the purpose of the mentorship program is to build relationships in order to expand professional growth.

In this region in Georgia at the beginning of the project timeline (mid-2021) there were approximately 55 practicing NPs with one or fewer NPs hired every month. Nationwide, the retail health company employs many NPs to independently run these small clinics primarily consisting of one provider in a small space (approximately 80 square feet). NPs are expected to treat acute problems such as ear-nose-throat, musculoskeletal, dermatology, gastrointestinal, genitourinary, and other episodic issues. Also, this retail health company, and the retail health industry in general, continues to expand into chronic care issues including thyroid, hypertension, hypercholesterolemia, and diabetes (Calandra, 2016). Being newly employed in a retail health setting can be a challenging process for both new graduates and experienced NPs due to the highly independent and autonomous nature of the setting which includes business savvy in addition to independent primary care clinical competence and critical thinking skills (Thabault, et al., 2015). This business savvy includes non-clinical administrative and business-related duties that do not normally fall in the NP role in other settings. Depending on the specific retail health company, these additional duties include, but are not limited to, office management, customer service, equipment care, information technology troubleshooting, supply ordering, cleaning, and insurance billing and collecting payments.

The retail health company in this region of Georgia is structured so that when an NP is hired, they start a one- to two-week orientation (45 hours for experienced NPs and 70 hours for newly graduated NPs) with one or more NP preceptors at the preceptor's clinic. The orientation entails company-mandated learning modules and clinical training for point-of-care testing, daily NP duties, training in the electronic medical charting system, and clinical skills checkoffs such as

pelvic exams, phlebotomy, injections, and ear wax removal. After orientation, the NP is assigned to either independently run a designated clinic or, more often, “float” to different clinics and fill gaps in staffing. The NP is responsible for assessing, diagnosing, and treating patients autonomously as well as communicating with pharmacists, store employees, any licensed practical nurse they may be working with, supply chains, laboratories, and sometimes the information technology department during their workday. Figure 2 (Appendix D) illustrates the microsystem in which these NPs practice.

There are many factors that influence the successful onboarding of the newly hired NP in this setting. Constructing a cause-and-effect diagram (see Figure 3, Appendix E) allowed for examining the factors that were relevant to the problem. The environment is an isolated setting, the treatment rooms are small, and the patients highly influence the workflow due to online self-scheduling and the policy to accept walk-in patients all day. Additionally, since the NPs usually work independently without any support staff, the company expects a lot of multi-tasking including verifying insurance, ordering supplies, dealing with equipment failure such as printers or vaccine refrigerators, emptying trash, and cleaning the clinics and waiting area. New initiatives and clinical guideline changes are implemented frequently which adds to the NP workload. It can also be difficult for the NP to access the supervisor for the region should there be any questions.

A force-field analysis (see Figure 4, Appendix F) revealed the current and potential driving and constraining forces that could influence implementation of the mentorship program. Driving forces included the experienced NPs’ desire to guide and coach, as well as the new hire NPs’ desire for a resource, fear of a new environment, isolation, and fear/anxiety of an autonomous role that includes business aspects of practice. Potential driving forces were the need

to feel supported, increase expertise, improve staff confidence, increase communication, and improve the competence of running a solo clinic.

It was also important to consider restraining forces which could impede implementation of the mentorship program. There were possible skill deficits among the mentors of which they were not aware. Recruitment of mentors could be negatively affected if experienced NPs are not comfortable with their mentoring skills. Recruitment of mentees could be negatively affected if new hire NPs, especially experienced ones, feel they already have a good foundation and might not see value in mentorship. Additionally, there were physical restraining forces such as lack of time, different work schedules, and disruption to current workday.

This quality improvement project capitalized on the driving forces by reaching out to NPs who recently onboarded with the company and extended invitations to participate as mentees in the mentorship program. The invitation outlined the purpose of the program including the time commitment and the expected outcomes. Experienced NPs in the region also received an invitation to participate as mentors. This invitation discussed communication, expertise, and explained the mentor guide. The identified constraints identified on the force-field analysis (see Figure 4, Appendix F) were mitigated by the proprietary Mentor Toolkit Guide and Peer-to-Peer Mentorship program materials provided to the mentors and mentees.

With this quality improvement project, the established mentorship program was implemented for newly hired NPs. By implementing the mentorship program into the region, certain factors such as fear of new environment, isolated setting, and fear or anxiety of the autonomous role may have been lessened by the pairing of the newly hired NP with an assigned mentor for weekly support. Also, certain factors such as grasping business practice, feelings of confidence and support, and the handling of new initiatives may have been enhanced by having a

mentor/mentee relationship in which the mentee could contact the mentor to ask questions. The mentee could also feel confident knowing there were scheduled meetings in which new challenges could be discussed. These aspects helped capitalize on the driving forces for success and mitigate the restraining forces during implementation.

## Interventions

### *Pre-implementation phase*

A logic model helped inform the resources and activities necessary for the successful implementation of this quality improvement project (see Figure 5, Appendix G). Those involved in influencing the project were the members of the retail health company's DNP committee which included attorneys, NP supervisors, and other leadership members such as the Chief Nursing Officer. Resources included the NP staff, NP new hires, and the mentorship coordinator (who is also this quality improvement project director). Other resources included mentor/mentee buy-in, time, and proprietary mentorship program materials. Given these resources, the project director was able to gather the mentorship programs' materials before introducing the program to a region in Georgia. The project director acted as mentorship coordinator and recruited current experienced NP staff as mentors and newly hired NPs to be mentees then provided the program materials as well as answered any questions about the program. The expectations of participation in this quality improvement project were to execute the mentorship program as intended by the retail health company with weekly sessions for the required 10-week duration, independently complete a pre- and post-mentorship survey for later evaluation by the mentorship coordinator, do a mid-point check-in with the mentor coordinator to ensure successful initiation of the mentorship, and to complete and return the Weekly Mentor/Mentee Plan with suggested topics by the mentees.

This project was designed to maintain compliance with organizational policies for the mentorship program minus two exceptions which were to target all newly hired NPs as mentees, not limiting to newly graduated NPs, and to set a limit of four months from onboarding for mentee participation in the mentorship program. These modifications were meant to maximize potential recruitment and were approved by the retail health company. The other organizational policies regarding implementation were as follows: The mentorship coordinator would recruit mentors via email invitation. Mentors were required to have two years' experience in a retail health setting. Once the mentors were recruited, all NPs onboarded within four months were contacted and provided a mentor (to form a dyad) if they agreed to participate in the mentorship program. For the purposes of the evaluation component of this project, each mentor and mentee in the dyad was to be assigned a number that coordinates with each other. For example, dyad number one had the mentee as Participant 101 and the mentor as Participant 102. Dyad number two had the mentee as Participant 201 and the mentor as Participant 202, and so forth. Only the mentorship coordinator knew the identity of each member of each dyad and only to address problems within the program, problems with the meetings or contacting each other, or questions regarding any materials that were to be returned to the project director/mentorship coordinator at the end of the program.

### *Implementation*

First, experienced NPs were recruited to participate as mentors. Email invitations were sent to 10 experienced NPs in the region explaining the requirements of participation in the mentorship program. The three requirements given were: have a minimum of two years' experience in retail health, be willing to complete pre- and post-surveys and fill out the weekly Mentee/Mentor Mentorship Plan form, and participate for the full duration of the 10-week program. Of the 10 NPs approached, seven readily agreed to participate. Then, as illustrated in

Figure 6 (Appendix H), the project director acted as mentorship coordinator and contacted all NPs onboarded within four months from the mentorship program launch date, either during or after orientation, to assess their interest in participating as a mentee via email invitation with a secondary email reminder two weeks after the initial email. If the new hire was not interested in having a mentor, they could change their mind within two weeks and decide to participate. If they declined after the second outreach, they would not be contacted further. The newly hired NP was then paired with an NP with experience in a retail health setting from a pool of mentors. Once invited to participate, these mentor/mentee dyads received the current mentorship program's established training materials. The training materials consisted of a proprietary Peer-to-Peer Mentorship training packet as well as a weekly Mentor/Mentee Mentorship Plan (see Figure 7, Appendix I) consisting of topics that are important to practice in the retail health company. The proprietary training on Peer-to-Peer mentorship included topics on:

- mentorship definitions
- benefits of mentoring for both the mentee and mentor
- principles of mentoring
- supporting the transition and professional growth
- providing protection and security of the mentee by the mentor
- advocacy
- mentor skills
- mentee skills
- how the program works
- where to find mentor support on the company intranet

A week after the materials were distributed, the mentorship coordinator briefly met with each dyad via zoom to introduce the mentee to the mentor and answer any questions. Once the zoom meeting was completed and prior to the first weekly session, each mentee and mentor completed a pre-mentorship survey (see Survey 2 and Survey 5, Appendix J). The weekly mentor/mentee meeting discussions were unstructured in that they were driven by the mentees' questions for a mentee-centered approach. Space is located on the weekly Mentor/Mentee Plan (see Figure 7, Appendix I) for the mentee to write the topics they would like to discuss that week (these lists were collected at the end of the mentorship so the mentee-suggested topics could be evaluated and studied for potential unmet needs by the current program materials). If the mentee did not have a topic they would like to discuss, the dyad could refer to the subjects listed on the Plan for that, or any other week, and each member of the dyad was to circle each topic discussed. The mentor also filled in the space each week on what topic they discussed with the mentee to confirm agreement of mentee-suggested topics.

After the materials were provided to the mentor/mentee dyad, each dyad was to introduce themselves through email or phone call. For the first nine weeks of the mentorship, they were to schedule a weekly telephone call or similar either during regular work hours or at a time outside of work hours that was convenient for both members of the dyad. At the halfway point of the mentorship program (week 5), the mentorship coordinator called the mentee and asked the Mentee Mid-point Survey questions (see Survey 3, Appendix J). The mentorship coordinator also called the mentor and asked the Mentor Mid-point Survey questions (see Survey 6, Appendix J). These surveys were not to determine any measures or results from the mentorship program, but instead were conducted to determine if the dyads were meeting as scheduled. In the final week, the mentor/mentee dyad were to discuss any final advice or recommendations from

the mentor as well as any agreement for the mentor/mentee pair to continue their relationship. The mentors and mentees then completed a post-mentorship survey (see Survey 4 and Survey 7, Appendix J), and returned the completed weekly Mentor/Mentee Mentorship Plan to the mentorship coordinator via fax, email, or regular mail.

**Evaluation of the Interventions**

Rogers' Diffusion Theory of Innovation was the change theory used to evaluate the interventions. This began after the mentorship program was introduced to the NPs in the region in the Knowledge phase, the information about the program was disseminated to the mentors and mentees in the Persuasion phase, and the surveys were completed in the Decision phase. Beginning with the fourth phase, the Implementation phase, the survey information was synthesized to determine if the mentorship program was useful. In the Confirmation phase, the information will be disseminated to the retail health company's members to determine if the mentorship is worth continuing using the innovation of the mentorship program in the designated region (see Figure 1, Appendix C).

**Measures**

There were separate pre- and post-mentorship surveys for mentees (Surveys 2 and 4, Appendix J) and mentors (Survey 5 and 7, Appendix J). Both mentees and mentors were asked questions regarding demographics, including information relative to experience being a mentee or a mentor and experience having a mentor in the pre-mentorship surveys (Survey 1, Appendix J).

Surveys included items adapted from Tiew, et al.'s, (2017) Graduate Nurses' Evaluation of Mentorship tool, and Melnyk, et al.'s, (2008) Evidence Based Practice Beliefs and Implementation Scales (see Surveys 2, 4, 5, and 7, Appendix J). Other items were created based

on the company's proprietary Peer-to-Peer Mentorship training materials. The survey site Qualtrix was utilized to collect data for the surveys. Each member of the dyad received an individual link so the mentor coordinator could identify individuals who completed the survey so that matched pairs could be analyzed.

There were six expected outcomes for the quality improvement project (see Table 3, Appendix K). One outcome was to enroll 10 mentor/mentee NP pairs. This was measured with administrative records of how many dyads were able to be recruited into the mentorship program.

Two outcomes were mentee-centered including increased perception of preparedness to practice as well as increased confidence to practice in the retail health setting. The specific items corresponding to these outcomes are outlined in Survey 2 and Survey 4, Appendix J and were collected at pre- and post-program timepoints. The outcome of "perception of preparation to practice" is representative of an NP preparedness to enter practice in general (indicated as "practice" in Appendix J). Increased mentee perception of preparedness to practice was assessed with items regarding the mentee's knowledge and tools to practice, care delivered to patients, electronic charting system, and access to collaborating physician as they would in any new setting. The outcome of "confidence with the retail setting" is representative of an NP being confident to practice in the specific setting of retail health. Increased mentee confidence in the retail health setting was assessed with questions specific to practice in a retail health setting including intranet and peer resources, guidelines and clinical questions, customer service, organizational metrics, marketing, cultural diversity, and Culture of Excellence (indicated as "setting" in Appendix J).

Two outcomes were mentor-based regarding increased confidence in mentoring skills and mentor and mentee satisfaction with mentor training resources. Specific items corresponding to these outcomes are outlined in Survey 5 and Survey 7, Appendix J and were collected pre- and post-program timepoints. Increased mentor confidence in mentoring skills was addressed with questions that addressed the mentors' role as a mentor, providing feedback, communication skills, creating a supporting environment, leadership, and skills for effective mentor/mentee relationship. Satisfaction with mentor training resources was addressed with questions that addressed the mentor/mentee relationship regarding the mentors helping with mentees' strengths and development, mentees' understanding of company vision, mentees' comfort level, and mentees' understanding of their role, as well as mentors' comfort with training resources and the mentors' agreement with the frequency of meetings.

The final outcome was to identify any suggested topics of discussions based on mentees' needs that are not included in the current training materials (see Table 3, Appendix K). Each mentor and mentee received the weekly Mentor/Mentee Mentorship Plan with suggested topics (see Figure 7, Appendix I). At each meeting, both the mentor and mentee were to make notes on any topics of discussion that were not listed on the plan and circle any topics of discussion that they did utilize from the Plan. At the end of the mentorship, each mentor and mentee was to return the Plan to the mentorship coordinator for a qualitative analysis on sessions completed or missed and suggested topics by mentees. The information that was collected was looked at critically, and if there were any notes that were illegible or the mentor coordinator did not understand the note, they mentee or mentor was contacted via phone to qualify. Additionally, mentees' possible unmet needs were addressed in the Mentee Survey Post-Mentorship program

(Survey 4, Appendix J) with questions that addressed the mentees' skills as a mentee, weekly meeting subject matter, and frequency of weekly meetings.

All survey items in the pre- and post-mentorship surveys (Appendix J) were reviewed with the faculty advisor for congruence and consistency with each concept being measured.

## Analysis

### *Quantitative Analysis*

Analysis was done using these pre-and post-program surveys for mentees and mentors. Survey items were rated on a Likert scale with 5 = completely agree, 4 = somewhat agree, 3 = neither agree or disagree, 2 = somewhat disagree, and 1 = completely disagree. The outcomes to increase mentee perception of preparedness to practice as an independent NP and to increase mentee perception of confidence to practice in the retail health setting were determined using the difference in mean scores for each item from pre- to post-program (see Table 4, Appendix L). The outcome to increase mentor confidence in mentoring skills from pre- to post-program used a similar approach by using a difference in mean scores of each item representing the outcome (see Table 5, Appendix M).

The aim to evaluate satisfaction with mentor program including training, objectives, and resources was determined using questions posed to both the mentees and mentors on their post-mentorship surveys only. Analysis was completed using a mean score at post-program for each survey question to determine satisfaction on a scale of 1-5 (see Table 6, Appendix N)

### *Qualitative Analysis*

The qualitative data collected for analysis of this quality improvement project was drawn from the weekly Mentor/Mentee Mentorship Plan that the participants were to fill out at each of the 10 meetings between the mentee/mentor pair. The data from each dyad was cross referenced

between the mentor's and the mentee's notes to ensure that topics discussed were not "double counted". Also, if a topic was written on one of the dyad's participant's Plan but not the other, it was included in the analysis as the project coordinator saw that some participants kept better notes during weekly sessions. The topics of discussion were categorized based on similarity and once categorized, the number of times each topic was discussed was evaluated to discover which topics were most frequently discussed by the mentees.

There were two classifications used for data. The first classification consisted of the pre-printed items under Topic Discussion / Notes (see Table 7, Appendix O). These are referred to as "suggested" on the Plan. Each time a suggested item was noted on either of the dyad's participant's weekly Mentor/Mentee Mentorship Plan form, the subject was considered a topic of discussion of the weekly meeting (same week duplication on the mentor and mentee's Plan form was only counted as discussed once). Similar responses by general theme were determined through compiling patterns of comparable responses. These items are marked with an asterisk to identify the specificity of the topic that was noted on the weekly Mentor/Mentee Mentorship Plan (see Table 7, Appendix O). For example, a mentee's note regarding discussing how to order labs was categorized with "Patient visit work flow", since ordering labs is done during a patient visit and considered part of the work flow of seeing a patient in retail health.

The second classification used for data consisted of topics that were not "suggested" on the weekly Plan Items list. It was assumed that the mentee brought up any non-suggested topics as the mentorship program was designed for unstructured meeting discussions driven by the mentees' ideas for a mentee-centered approach. Again, similar responses by general theme were determined through compiling patterns of comparable responses. These topics were placed in the category "Topics Added by Mentee" (see Table 7, Appendix O).

**Ethical Considerations**

Pre- and post-intervention surveys were utilized to determine if the mentorship program achieved the aims identified. Additionally, a brief mid-mentorship "check in" was performed by the mentorship coordinator via phone or email to ensure each dyad was meeting regularly. Data from the surveys was presented at the aggregate level to remain anonymous and comport with standard quality improvement project evaluation methods.

Guided by the policies of the University of Massachusetts, Boston, the project met the criteria for quality improvement (see Checklist 1, Appendix P). The project proposed was quality improvement and did not meet the definition of human subject's research because it was not designed to generate generalizable findings but rather to provide immediate and continuous improvement feedback in the local setting in which the project is carried out. The University of Massachusetts Boston IRB has determined that quality improvement projects do not need to be reviewed by the IRB.

The project site required the project to not use or analyze any patient data, pull patient or employee statistics, data, or any other related information from any organizational system or database (see Checklist 2, Appendix Q). The retail health company has a DNP Project Committee which reviews the proposal and all supportive documents (surveys, educational materials, etc.) for approval prior to beginning the QI project. This Committee is comprised of multiple regional supervisors, the Chief Nursing Officer, and legal representation. The project leader attested and had approved by the retail health company that no data can be used for research purposes (see Attestation 1, Appendix R). Written confirmation was provided by the DNP Project Committee of approving the QI project (see Proposal 1, Appendix S, and Approval 1, Appendix T).

## Results

A convenient sample of five newly hired NPs (mentees) and seven retail-experienced NPs (mentors) were recruited to participate in the 10-week mentorship program. All five mentees and five of the seven mentors were paired together to form five mentor/mentee dyads. The only aim that was not met was identify and enroll 10 mentor/mentee pairs in the program due to a hiring freeze by the retail health company during the period of enrollment. However, all newly hired NPs that onboarded within four months of beginning the mentorship program expressed interest in participation at first contact and participated in the program. The mentorship program requirement for mentors to have two years' experience was not met. Due to a misunderstanding and unbeknownst to the program coordinator, one mentor had only 19 months' experience in a retail setting when the mentorship program began. Also, not all dyads were able to meet for 10 consecutive weeks due to vacation or other reasons. One dyad opted to cancel one of the meetings to complete the program on time (providing only nine meetings for that mentor/mentee pair), and one dyad extended their meetings around vacation time to have all 10 meetings over a 12-week period.

All the mentees and mentors completed their respective pre- and post-mentorship surveys. All the mentees and all but one of the mentors returned the completed weekly Mentor/Mentee Mentorship Plan to the mentorship coordinator for a 90% response rate for the full program. The mentorship coordinator made unsuccessful attempts to retrieve the missing data including calls, texts, and emails over a one-month period.

### Sample Characteristics

As seen in Table 8, Appendix U, four of the five mentees were female (80%) and all the mentors were female (100%). The age of the mentees ranged from 30-49 and the age of the

mentors ranged from 30-59. All participants were Masters' level graduates. Prior to participation in the program, most (80%) of the mentees had 0-2 months experience in the retail setting and one mentee (20%) had 3-4 months retail experience. The mentors had different levels of experience in the field of retail health. One had 18-23 months (20%), one had 2-3 years (20%), and three had 6-10 years' (60%). Only one of the mentees had ever had a mentor in the past (20%) and none of the mentees had been a mentor or participated in a mentorship program either in or out of retail health prior to this program. One out of five mentors had a mentor in the past and one had prior experience as a mentor in retail health.

## Quantitative Results

### *Pre- and Post-Program Comparison – Mentee Perception of Preparedness to Practice and Confidence to Practice in the Retail Health Setting*

All mentee participants completed the pre- and post-program surveys. As seen in Table 4, Appendix L, all items showed an increase in mean score for mentee perception of preparedness to practice as an independent NP from pre- to post-program except for item three, which asked about confidence with the electronic medical record (EMR) system (practice-related). Additionally, all items showed an increase in mean score for mentee perception of confidence to practice in the retail health setting from pre- to post-program.

### *Pre- and Post-Program Comparison – Mentor Confidence in Mentoring Skills*

All mentor participants completed the pre- and post-program surveys. As seen in Table 5, Appendix M, three of the items (numbers one, three, and four) successfully increased in mean score over the mentorship program. Item two reflected no change from the pre- to post-mentorship survey but a high level of confidence with communication skills, problem solving skills, and decision-making skills was reported prior to the program's beginning. Item five,

which asked about confidence in the ability to have an effective mentor/mentee relationship, reflected a decrease in confidence from pre- to post-program.

### *Satisfaction with Mentor Program Materials, Training, and Resources*

All participants completed the feedback portion of the post-mentorship surveys. These questions provided feedback on the 10-week mentorship program from both the mentees and mentors including satisfaction and comfort meeting mentees' needs, and satisfaction with mentors' training, and mentors' skills (see Table 6, Appendix N). All feedback scores reflected satisfaction (mean score greater than 4.5) from both the mentees and the mentors with the mentor program materials, training, and resources. Feedback scores also demonstrated that mentees felt the mentorship program was successful in meeting the needs of the mentees including mentor/mentee relationship skills and frequency of meetings.

## Qualitative Results

### *Weekly Mentor/Mentee Mentorship Plan Discussion Topics – Identifying Potential Mentees' Unmet Needs Not Represented in the Mentorship Program Materials or Training*

All mentees and mentors were asked to track their topics of discussion on the Weekly Mentor/Mentee Mentorship Plan form (see Figure 7, Appendix I and Table 7, Appendix O). All mentees and four mentors returned their completed Weekly Mentor/Mentee Mentorship Plan. The Mentorship Coordinator attempted to contact the fifth mentor several times over one month without success, however, the mentee from this dyad did submit the Plan with the topics discussed.

There were two topics discussed five times over the 10-week Mentorship program for an average of once per mentor/mentee dyad. Both these topics were "suggested" Plan Items: "Get to know each other, share information about professional and person life"; and "Plan future

meetings, develop a schedule of how and when meetings will continue" (see Table 7, Appendix O).

Five topics were discussed at least eight times between the five mentor/mentee dyads. Two of these were from the "suggested" Plan Items list and three of these were topics that were added by the Mentee of a dyad. The two topics discussed most from the "suggested" Plan topics were: Dealing with adversity/conflict (all were patient-related including angry patients, demands for medication, and refusing to pay), which was discussed 12 times; and documentation tips and tricks (EMR), which was discussed eight times between the five dyads (see Table 7, Appendix O). The three topics most discussed from the topics added by Mentees were: Specific protocols (STI treatment, DOT, diabetics, OSA, sports physicals, pinworms, nPep, one-time medication renewals), Internal policies (call out procedures, PTO, raises/reviews, CME, skills validations), and Administrative questions (supply ordering, equipment repair or replacement, document storage, cash drawer, daily HUB tasks, expired vaccines/test disposal). Specific protocol topics were discussed 11 times between four of the five dyads, Internal policies were discussed eight times between three of the dyads, and Administrative questions were discussed eight times between all five dyads.

Several topics in the Suggested Plan Items were not discussed at all by any of the dyads during the Mentorship program. These included Marketing, Relationship development, Cultural diversity, Email etiquette, Precepting, Career ladder program advancement, and Pursuit of formal education (DNP, PhD, MBA) (see Table 7, Appendix O).

## Discussion

### Summary

Mentoring programs can have different objectives, but the mentor/mentee relationship is designed to provide guidance and assist transitions (Chen & Lou, 2014). This project implemented and evaluated this mentorship program to provide information to the organization on outcomes and feedback for possible improvement.

This project achieved the outcome of implementation and evaluation of a mentorship program for all newly hired NPs at retail clinics in a region in Georgia of a national retail health company. Of the six sub-aims included in this project, all but one (identify and enroll 10 mentor/mentee pairs) was achieved due to a hiring freeze that was implemented due to an overage of staffing at the time. This project also moved through the five phases of Roger's Diffusion of Innovation Theory. Information about the mentorship was introduced and disseminated to the mentors and mentees (knowledge and persuasion phases), and the mentors and mentees were able to weigh the advantages and disadvantages of the mentorship through pre- and post-mentorship surveys (decision phase) designed to evaluate the aim and sub-aims.

This quality improvement project's key findings provided insights into mentee perception of confidence with NP practice and the perception to practice in the retail health setting, satisfaction with the current mentor training, and unmet needs in the suggested discussion topics. Mentees showed modest increases in scoring from pre- to post-mentorship for all questions related to clinical practice and setting (except for confidence with the EMR which remained 4.6, indicating a high level of confidence in the electronic charting system). Two factors may have affected these results: one of the five mentees was already an experienced NP demonstrating a high perception of preparedness to practice as a NP prior to joining retail health, and one newly graduated mentee scored every pre-mentorship survey question with the maximum "completely agree". When the mentorship coordinator reached out to this mentee to question the scoring, the

mentee expressed a high satisfaction with the person who completed their orientation, and the mentee did not want any low score to poorly reflect on that person. This aligns with the difficulty someone new to a setting may have providing feedback that they believe reflects on someone more experienced in the setting. Additionally, this may reflect the knowledge that employees of corporations have regarding the monitoring of emails and other forms of communications. Knowing that no work-related communications are truly private, some participants in company-sponsored programs may be hesitant to provide any negative information, especially about colleagues or those they consider to be more experienced than themselves. Mentees showed the greatest increases in questions related to confidence with the retail setting, which was the purpose of the mentorship program in this retail setting. Additionally, this increase in confidence is consistent with the additional 10 weeks of experience working in the retail health setting that the mentees accumulated while participating in the mentorship program.

Mentors showed increases in scoring from pre- to post-program for questions related to comfort in a leadership role, confidence in role as a mentor, and the ability to create a supportive environment for a mentee. However, the pre- to post-program score for communication skills/ problem solving skills/ decision making skills remained static and mentor confidence in the ability to have an effective mentor/mentee relationship had a modest decline. The lack of change in scoring from pre-to post mentorship in communication skills/ problem solving skills/ decision making skills likely reflect the confidence that those who are already experienced in the role of NP have. Also, the decrease in mentor confidence in the ability to have an effective mentor/mentee relationship may reflect that these experienced retail health NPs may have presumed mentoring to be less challenging prior to experiencing the role. According to Dunning, et al., (2004), people often overrate their skills. On average, most people find themselves to be

"above average" (which is a statistical impossibility) and these overly optimistic estimates may be challenged after completing a skill, especially one they have not actually done before (Dunning, et al., 2004). Moreover, the organization defines a mentorship mentor/mentee relationship as a "one-to-one long-term trusting relationship that develops over time between a novice and a more experienced practitioner and promotes support during transition periods, teaching learning, increased coping skills, and a safe environment for sharing and discovery". Once completing the program, mentors may have found the role more challenging than originally anticipated.

Mentors and mentees were satisfied with the mentor training materials as reflected by mentees felt mentors helped with awareness of strengths, development needs, company vision, feedback, and company objectives. Mentors also express satisfaction with the mentor program materials including coaching materials, resources, and feedback. Also, both the mentors and mentees expressed the highest level of satisfaction with the frequency of the meetings of the program.

Finally, there were some unmet needs not currently found in the training and mentorship materials identified by the mentees and some suggested topics that may not be particularly helpful. The mentors and mentees were able to track their discussions to focus on what they deemed the most important learning topics during the mentorship. These findings suggest that as many as seven of the suggested plan items on the Weekly Mentor/Mentee Mentorship Plan can be removed (zero times discussed throughout all five mentor/mentee dyads) and replaced with seven new items (discussed between one and eleven times throughout all five mentor/mentee dyads) (see Table 7, Appendix O). Topics added by mentees could also be related to preparedness to practice as an independent NP such as seeking prior authorizations and questions

about specific vaccines. Mentees had three, eight, and eleven conversations about retail health setting specific topics Clinical guidelines, Administrative, and Specific protocols respectively. This shows that these topics may not be adequately covered during orientation, possibly due to its short duration of 45 to 70 hours depending on experience. Since retail health is corporate run, there are rules and limitations of practice due to liability issues. Guidelines and protocols are developed by a team of medical, nursing, and legal personnel and familiarization with these guidelines and specific protocols is imperative to not increase liability for the corporation or for the NP. Furthermore, retail health offers many services and the number of and extent of guidelines and protocols (which are updated frequently) can take weeks or months to become familiar with. Additionally, administrative duties such as ordering supplies and document storage is site-specific and learning the "ins and outs" of these duties may not be considered a priority when beginning with a new employer. Also, mentees had eight conversations about Internal policies. This could demonstrate a lack of discussion or a lack of understanding during the onboarding process regarding internal policies such as time off, raises, and continuing education, which is normally discussed with the new hire by either the recruiter or the hiring manager.

Strengths of the project included the high level of interest in participating in the mentorship program by mentors and mentees. Seven of the ten approached mentors and all the approached mentees readily agreed to participate. This may have been influenced by the fact that the mentorship coordinator (also the QI project director) had a history of orienting four of the five mentees and one of the mentors, so the coordinator had already built positive relationships with many of the participants. This may have helped them to feel comfortable agreeing to participate as well ask questions and provide needed feedback. Future implementations of the mentorship program may benefit from having the mentorship coordinator be someone with a

history with some of the newly hired NPs. This could be a person who frequently helps onboard NPs or a person who frequently orients NPs to the setting. Another strength of the project is the personalized approach the mentorship coordinator chose to do by having initial individual dyad live phone calls and zoom meetings.

**Interpretation**

Based on the survey results, the mentorship program had a positive impact on mentee perception of preparedness to practice as an independent NP and perception of confidence to practice in the retail health setting. The positive changes in mentee confidence and preparedness are consist with the literature, which has shown that mentoring positively influences job satisfaction and retention, helps with professional development, and helps new NPs transition to practice (Horner, D. K., 2017; Jarell, L. 2016; Mackay et al., 2017; Sullivan-Bentz, et al., 2010). Results also showed that mentors felt at least minor increases in confidence in their mentoring skills after acting as mentors for the program. Furthermore, seven new unmet needs were discovered that could be added to the mentorship program materials, replacing the seven that were never discussed during the 10-week program. Finally, the mentorship program participants were satisfied with the mentor program materials, training, and resources.

The mentorship program was implemented into the region with minimal costs. The mentor training materials were disseminated via work email approximately one week prior to the beginning of the mentorship so that the participants could learn at their leisure. The mentorship launches in which the mentorship coordinator introduced each dyad via zoom took minimal time (15 minutes per dyad). As the nurse practitioners gain experience as mentors, support by the mentorship coordinator could be changed to email support. Then each weekly meeting was short (20-25 minutes) for the 10 weeks. The estimated maximum time per participant for the

mentorship was five hours including the 15-minute introduction, the ten weekly meetings, and the time needed to fill out the pre- and post-mentorship surveys. Employees are hourly and it is estimated that the employees made between $48 and $58 per hour based on experience and onboarding negotiations. Also, it was expected that participants would incorporate at least some of their meetings during "down time" between patients or at slow portions of their work schedule. However, even if all meetings were completed outside of "down time", the total cost for time is estimated around $2,915 ($53 average per hour times eleven participants including the mentorship coordinator times five hours each). Other than time, no additional costs were incurred as Qualtrix, which was used for the surveys, is a free application to the University of Massachusetts students.

**Limitations**

This quality improvement project was limited to newly hired NPs at retail clinics in a region in Georgia of a national retail health company. Unfortunately, shortly after the project was launched, a hiring freeze was implemented in the region allowing for only five mentor/mentee pairs. However, these five mentees included 100% of the newly hired NPs to the region from four months prior to two months after the project launch. This small number of participants limits the ability to generalize results outside of the study setting without additional studies to confirm results.

Confounding factors include possible misunderstandings in the feedback from the mentees suggesting they may reflect how the mentees felt regarding their onboarding and the support they felt from their orienter versus mentor. When the mentorship coordinator/QI project director asked for clarification from one of the mentees who had responded "completely agree" to every question on the pre-mentorship survey, the mentee responded that she was very pleased with the

person who oriented her and implied that she thought a lower score may reflect poorly on this person.

Additionally, there may be imprecision in the design and methods of this study due to the 10-week length. Improvements in confidence and satisfaction in both NP practice and NP confidence is expected to increase with time and experience. As the mentorship program progressed, increases in these outcome measures could be affected by time and number of patients seen. Another limitation discovered was that instructions should have been more specific as to what to do if the dyad could not meet due to vacation or other reasons. Adjustments should have been made to minimize this limitation by advising what to do if a mentor/mentee dyad could not meet.

**Conclusion**

Since the setting for this quality improvement project was a nationwide retail health company which already had a mentorship program in place for newly graduated, newly hired NPs, sustainability of mentorship is achievable. Data from this project can help shape and advance the mentorship program for future NPs to feel prepared and confident to practice in the retail health setting. It is suggested that future mentorship coordinators in regions are chosen not based on availability or volunteering, but more on length of time with the company and how many NPs they have oriented in the past year. By hand-picking mentorship coordinators that meet these criteria, there may be increased participation from newly hired NPs as well as additional feedback for a continual Plan-Do-Study-Act process of the retail health mentorship program.

NP confidence and satisfaction after transitioning to practice either from school or another practice setting is supported through mentorship programs both formal and informal. Employers

have an opportunity to strengthen NP transition to a new setting by including elements that support NP role transition such as mentorship. Further study in the field of transitioning from school or other specialties to retail health is necessary to truly understand the challenges of NP needs in this highly independent and autonomous setting. There are many retail health clinic companies including The Little Clinic (Kroger), Minute Clinic (CVS), RediClinic (Rite Aid), Community Clinic (Walgreens), and Walmart Care Clinic (Walmart) that employ thousands of nurse practitioners. Future studies can help posit which methods best support the thousands of nurse practitioners entering this specialized field. The successful role transition process may lead to more NPs choosing to stay in the retail setting, improving this field's availability to health care access for the populations they serve.

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## Appendix A

**Table 1**

*Summary of Evidence Table*

| Significant Finding/Theme | Studies by Title | Level of strength and Conceptual Framework/Research Design | Number of participants and demographics |
|---|---|---|---|
| Formal orientation has positive correlation with NP role transition | a. Exploring the factors that influence NP role transition | a. III, B | a. N=352: 81.8% white, 9.4% black/AA; MSN=86.6%, DNP=10.2%, Outpatient=57.1% |
| Mentoring helps toward professional experience | b. Professional development and mentorship needs of NPs<br>c. NP residency programs and transition to practice<br>d. Mentoring: Positively influencing job satisfaction and retention of new hire NPs.<br>e. Supporting primary health care NP transition to practice | b. III, B<br>c. Mixed method, none stated<br>d. Qualitative, non-experimental, mixed method<br>e. Focused ethnography, from limbo to legitimacy | b. N=198: Master's=165, Doctorate=33, novice NPs in primary care=37, veteran NPs in primary care=76<br>c. N=159: primary care NP=108, acute care=52, community health=33, long-term care=22, school health=17, other=70; age 40+ =80%, current practicing=96.8%, current practice in Primary Care=66%<br>d. N=37: inpatient NPs=6, outpatient NPs=27, both=4; family care NPs=17, adult care=7, acute care=3, other=10.<br>e. N=23: 17 anglophone and 6 francophone; mean age=42.8, mean years of practice=11.1 |
| Continued education in the first year of NP practice to help with role transition | f. A competency-based curriculum for critical care NP transition to practice<br>g. An educational intervention to enhance NP role transition in the first year of practice | f. III, B<br>g. II, B | f. N=31: no demographics<br>g. N=40: white=90%, age 18-30=23%, 31-39=30%, 40+ =45% |
| Need for residency program to prepare NPs for independent practice | h. Evaluation of VA primary care NP residency: Achievement in competencies | h. III, B<br>i. qualitative, Phenomenology | h. N=36: 84% female; BSN to MSN program=55.2%, years of RN experience mean=5.46<br>i. N=52: 98% female, 37% with masters degree, 26% currently practicing, 33% teaching at medical center |

| | | | |
|---|---|---|---|
| | i. Recommendations for NP residency programs<br>j. Thematic elements of the postgraduate NP residency year and transition to the PCP role in a federally qualified health center<br>c. NP residency programs and transitions to practice<br>k. New NP perceptions of preparedness for and transition into practice | j. Qualitative, no conceptual framework stated<br>c. Mixed method, none stated<br>k. Qualitative, none stated | j. N=24: 100% female; mean age 30; RN experience in years 8=0, mean=2 years; NP experience in years 1=1, 23=0<br>c. N=159: primary care NP=108, acute care=52, community health=33, long-term care=22, school health=17, other=70; age 40+ =80%, current practicing=96.8%, current practice in Primary Care=66%<br>k. N=698: masters program=90.2%; NPs=69.4% |
| Preceptorship needed after graduation | l. NP experiences with role transition: Supporting the learning curve through preceptorship | l. Qualitative, hermeneutic phenomenology | l. N=16: no demographics provided |
| Need for post-masters' NP interprofessional fellowship | m. Pioneering a primary care adult NP interprofessional fellowship | m. Qualitative, none stated | m. N=7: graduates from 3 nursing schools in CT, no demographics stated |

## Appendix B

### Table 2

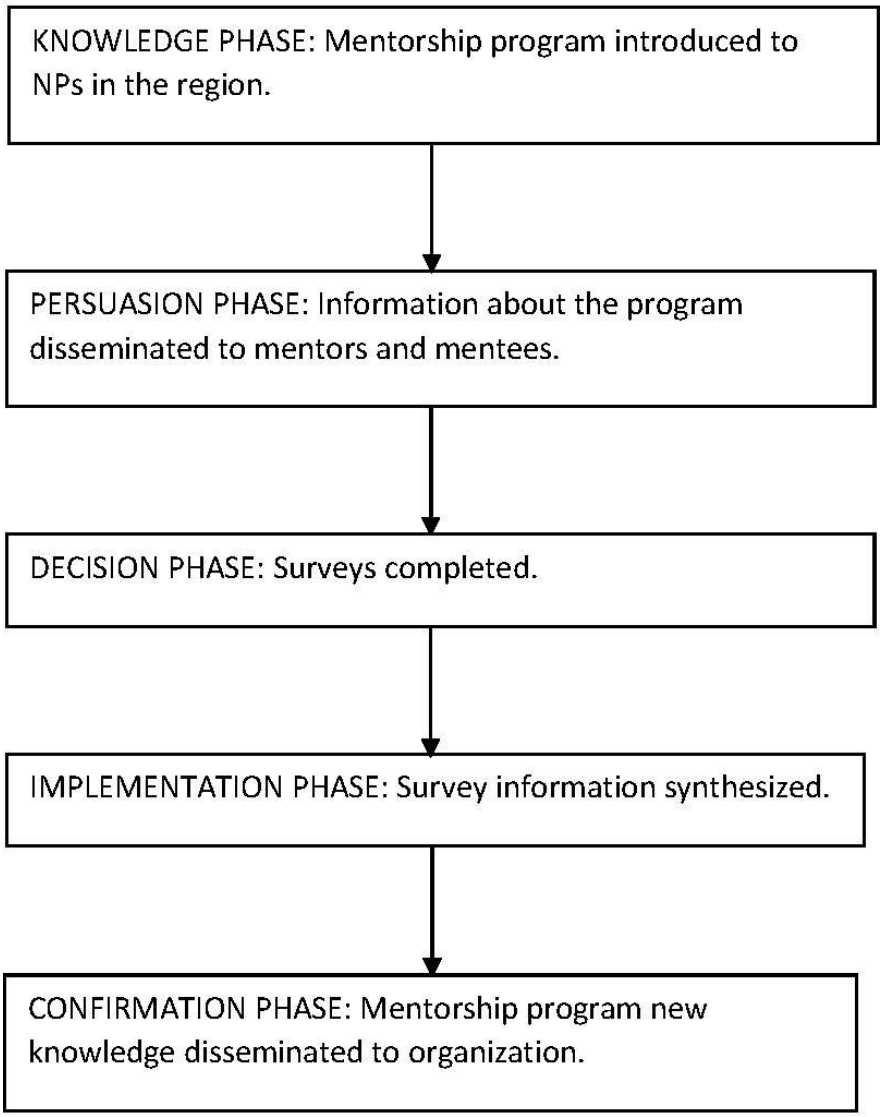
*Instruments, Theoretical Model and Change Theory for Outcomes in Mentorship Program*

| Expected Outcome | How will the outcome be operationalized/measured? | Instrument Used to Develop Questions | Stage of Limbo to Legitimacy THEORETICAL MODEL that informs outcome | Phase of Rogers' Diffusion of Innovation CHANGE THEORY that informs outcome |
|---|---|---|---|---|
| Enroll 10 mentor/mentee pairs | Administrative records to count number of pairs | | | |
| Increased mentee perception with preparedness to practice | Pre to post increase in knowledge and tools, care delivered, electronic charting, and collaborating physician | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales and organizational weekly Mentor/Mentee Mentorship Plan | Launching Meeting the Challenge | Decision Implementation |
| Increased mentee confidence with retail setting | Pre to post increase in intranet, guidelines, customer service, organizational metrics, marketing, diversity, and Culture of Excellence | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales and organizational weekly Mentor/Mentee Mentorship Plan | Launching Meeting the Challenge | Decision Implementation |
| Increased confidence in mentoring skills for mentors | Pre to post increase in role, feedback, communication, supporting environment, leadership, and effective relationships | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales and organizational weekly Mentor/Mentee Mentorship Plan | Meeting the Challenge Broadening the Perspective | Decision Implementation |
| Satisfaction with mentor training and resources | Pre to post increase in mentee strengths and development, company vision, mentees' comfort, mentees' understanding of role, and mentors' opinion of frequency of meetings. Also, mentors' opinions re: the weekly sessions' suggested topics and the training materials | Tiew, et al., (2017) Graduate Nurses' Evaluation of Mentorship, organizational weekly Mentor/Mentee Mentorship Plan, and organizational Peer-to-Peer Mentorship packet | Broadening the Perspective | Decision Implementation |
| Identify topics based on mentees' needs not in current training materials | Post-mentorship mentee opinion of frequency of meetings and mentees' opinions re: the weekly sessions' suggested topics | Organizational weekly Mentor/Mentee Mentorship Plan | Meeting the Challenge | Decision Implementation Confirmation |

## Appendix C

**Figure 1**

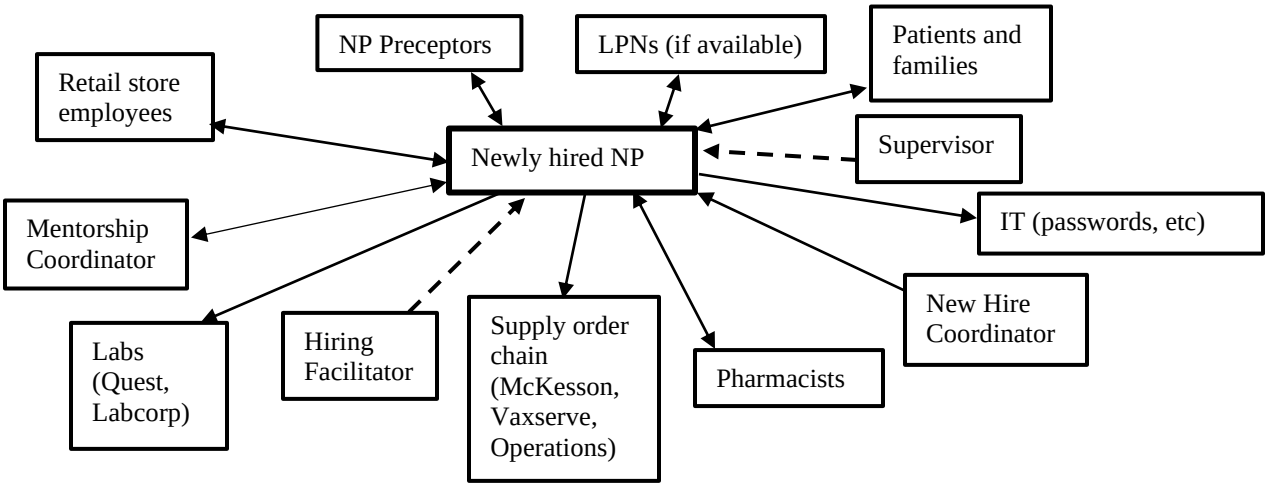
*Change Theory: Rogers' Diffusion of Innovation*



## Appendix D

**Figure 2**

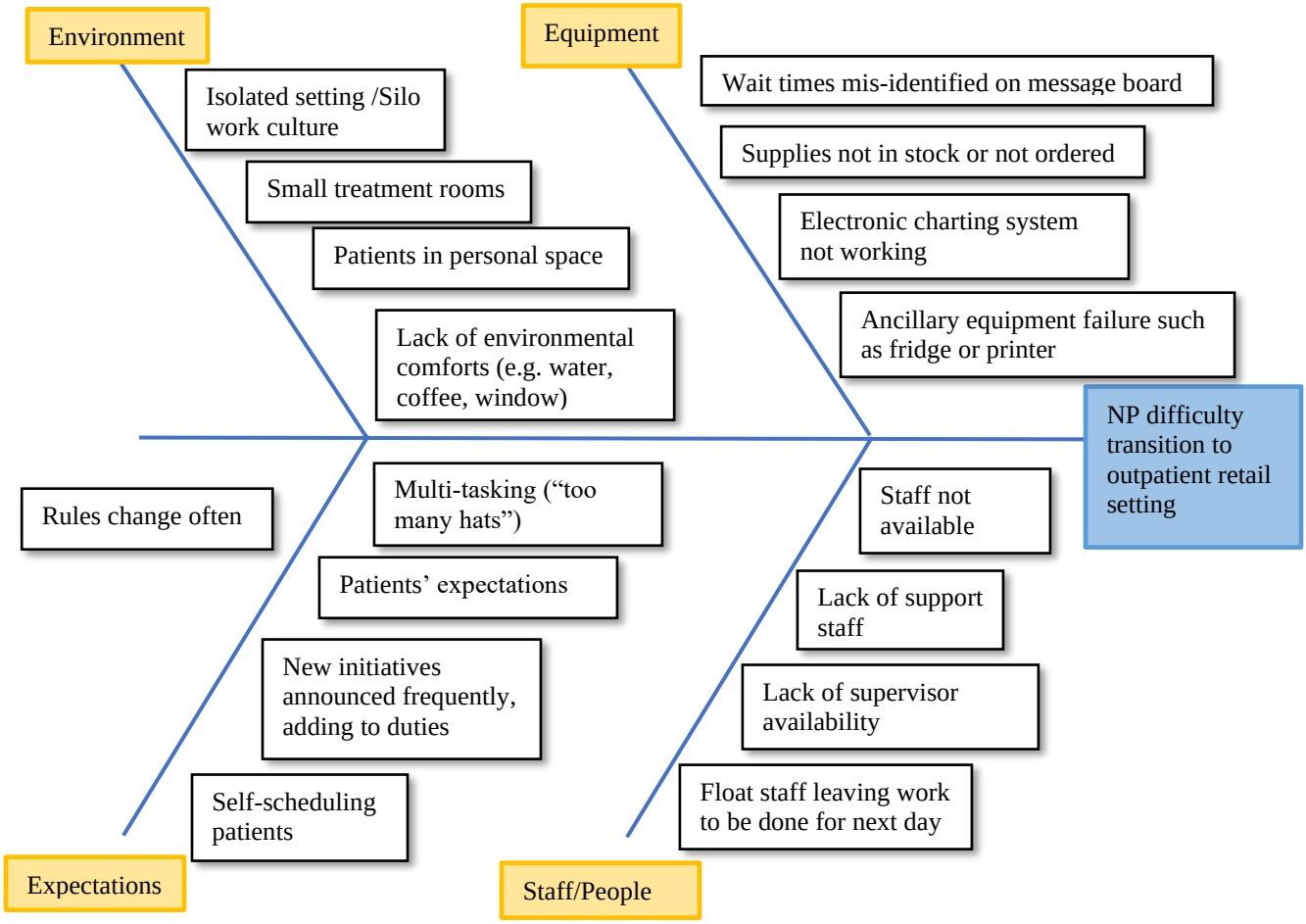
*Understanding the Microsystem from the Perspective of the New Hire NP*



## Appendix E

**Figure 3**

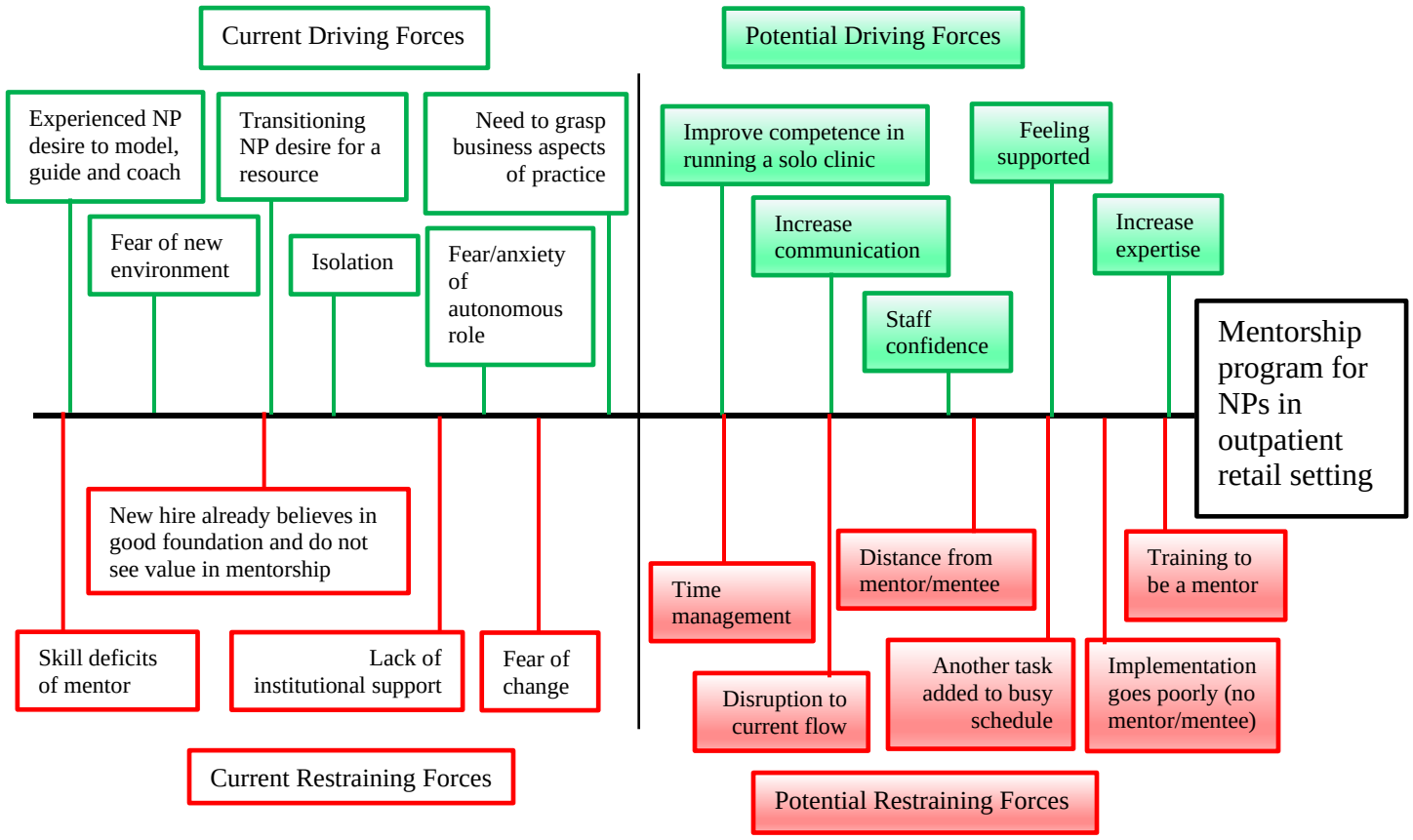
*Factors Relevant to NP Difficulty in Transitioning*



## Appendix F

**Figure 4**

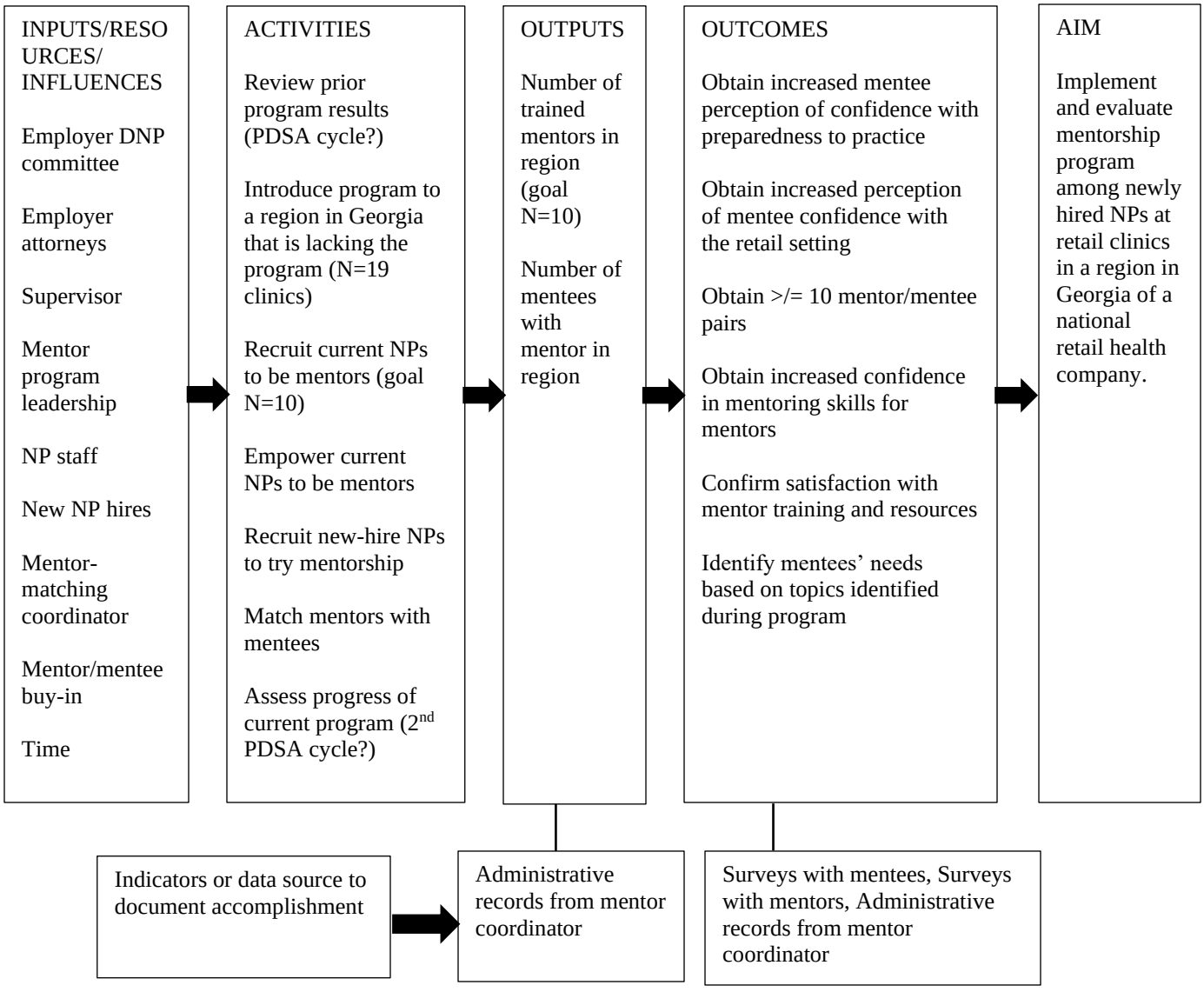
*Driving and Restraining Forces for Mentorship Program*



## Appendix G

**Figure 5**

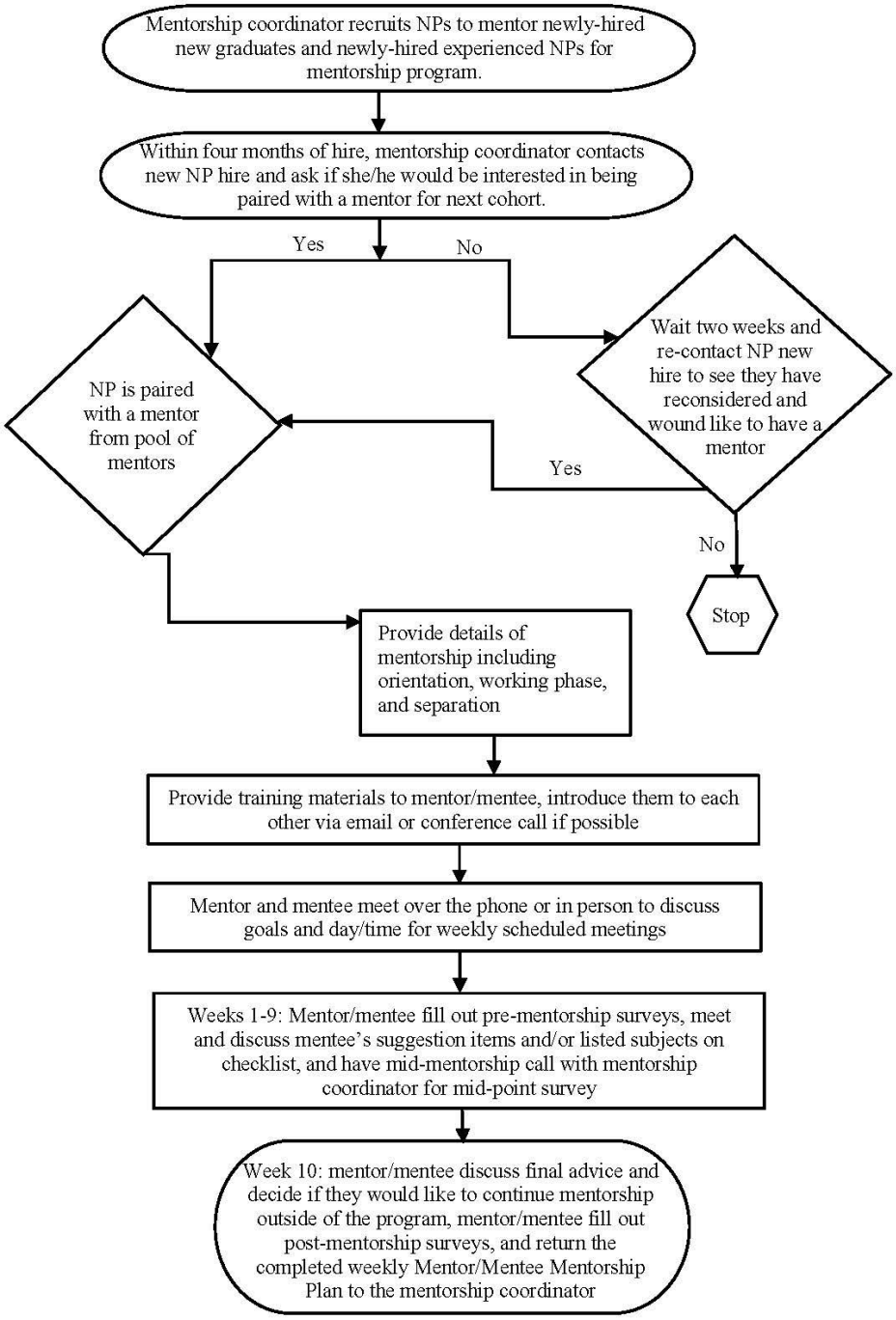
*Logic Model Toward Aim of QI Project*



## Appendix H

**Figure 6**

*Implementation of New Hire Mentorship Program to Local Region of Retail Health*



# Appendix I

## Figure 7

*Weekly Mentor/Mentee Mentorship Plan*

**Mentor/Mentee Mentorship Plan**

**Goals: The Mentee/New Hire will prepare a few questions, or topics that they would like to discuss each week. The Mentee/New Hire will guide the discussion. Ideally the weekly topics are emailed or text messaged to the Mentor prior to the meeting. Below is a suggested plan, please modify to meet individual needs**

| Week | Date of meeting | Topic of discussion/notes |
|---|---|---|
| **Week 1** | | • Get to know each other, share information about professional and personal life.<br>• Plan future meetings, develop a schedule of how and when meetings will continue<br>• Set goals for mentoring relationship, and create a personal plan.<br><br>Notes_____ |
| **Week 2** | | • Transition to the advance practice role.<br>• Patient visit work flow<br>• Dealing with adversity/conflict<br><br>Notes_____ |
| **Week 3** | | • Customer service<br>• Wait room management<br>• Time management<br><br>Notes_____ |
| **Week 4** | | • Antimicrobial stewardship<br>• Metrics: (HEDIS, CQI, NPS, etc.)<br><br>Notes_____ |
| **Week 5** | | • How to take ownership of your clinic<br>• Marketing<br><br>Notes_____ |
| **Week 6** | | • Relationship development<br>• Communication with clinic partner<br>• Cultural diversity<br><br>Notes_____ |
| **Week 7** | | • Patient visit work flow<br>• Email etiquette<br><br>Notes_____ |
| **Week 8** | | • Operational support questions<br>• EPIC documentation tips and tricks<br><br>Notes_____ |
| **Week 9** | | • Peer mentor panels: DOT, Travel Health, STI, Chronic Care<br>• Precepting<br>• Collaborating Physicians<br><br>Notes_____ |
| **Week 10** | | • Involvement and professional development within MinuteClinic<br>• Career ladder program advancement<br>• Pursuit of formal education (DNP, PhD, MBA)<br><br>Notes_____ |

Other Suggested Topics: Review of Resources on Intranet, Self-Care, Emotional Intelligence, discussion of Journal Articles/books.

## Appendix J

### Survey 1

*Pre-program Characteristics of Mentees and Mentors*

| **Demographics** | |
|---|---|
| What is your gender? | Male; Female, Prefer not to answer |
| What is your age? | 21-29; 30-39; 40-49; 50-59; 60+ |
| What is the highest degree you have received? | Masters; Doctorate |
| How much time have you been practicing in the clinic at the organization? | 0-2 months; 3-4 months, 18-23 months; 2-3 years; 4-5 years; 6-10 years; 10+ years |
| Mentor Defined by Organization:<br>A mentor is an experienced practitioner who establishes a caring relationship with a novice practitioner as a trusted counselor, guide, role model, teacher, and friend, providing opportunities for personal and career development, growth, and support to the less experienced individual (mentee). | |
| Based on this definition of Mentor, have you HAD a mentor (i.e. you have been a MENTEE) prior to working at this organization? | Yes; No |
| Based on the definition of Mentor in Question 5, have you BEEN a mentor (i.e. you have been a MENTOR) prior to working at this organization? | Yes; No |
| I have participated in a mentorship program at this organization in the past | Yes; No |

### Survey 2

*Pre-program Mentee Survey*

| **MENTEE Survey PRE-Mentorship Program** | **Instrument Used to Develop Question** | **Outcome Assessed** |
|---|---|---|
| 1. I am very confident about the care that I deliver to my patients. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Practice |
| 2. I am very confident I have the knowledge and tools to see patients in a time efficient way. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Practice |
| 3. I believe I can find the resources (guidelines) to answer clinical questions in a time efficient way. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Settings |
| 4. I am very confident with Epic including charting, macros, and smartphrases. | Organizational weekly Mentor/Mentee Mentorship Plan | Practice |

| | | |
|---|---|---|
| 5. I know how to access resources through the intranet and through peers to do my job effectively. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Setting |
| 6. I am very confident in handling customer service issues including wait room management. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 7. I am very confident with contacting my collaborating physician. | Organizational weekly Mentor/Mentee Mentorship Plan | Practice |
| 8. I completely understand the organizational metrics including antimicrobial stewardship, HEDIS, CQI, and NPS. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 9. I feel very confident with the organization's promotion of cultural diversity and know where to find resources for cultural diversity. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 10. I am very confident with the organization's Culture of Excellence including professional development, career development, and pursuit of formal education. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 11. I am very confident that I can access the marketing materials I need for my clinic. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

**Survey 3**

*Mid-program Mentee Survey*

| **MENTEE Questions at Mid-point (5 weeks) of Mentorship Program** | |
|---|---|
| 1. Have you been able to meet with your mentor at all scheduled sessions so far? If not, why not? | |
| 2. Have you found the need to contact your mentor between sessions, if so, did your mentor have availability to meet or talk? | |
| 3. How have you been meeting your mentor? | Phone, e-mail, in person |

**Survey 4**

*Post-program Mentee Survey*

| **MENTEE Survey POST-Mentorship Program** | **Instrument Used to Develop Question** | **Outcome Assessed** |
|---|---|---|

| | | |
|---|---|---|
| 1. I am very comfortable with the skills needed to have an effective mentor/mentee relationship (e.g. listening, accepting feedback, and asking questions). | Organizational Peer-to-Peer Mentorship packet | Unmet mentee needs |
| 2. I am very satisfied with the frequency of the meetings in the mentorship program. | Organizational weekly Mentor/Mentee Mentorship Plan | Unmet mentee needs |
| 3. My mentor helped me to be aware of my strengths and development needs. | Tiew, et al., (2017) Graduate Nurses' Evaluation of Mentorship | Satisfaction with materials, training |
| 4. My mentor helped me to be aware of the company vision and mission and understand how I can contribute to these. | Tiew, et al., (2017) Graduate Nurses' Evaluation of Mentorship | Satisfaction with materials, training |
| 5. My mentor helped me to feel comfortable requesting and receiving feedback. | Tiew, et al., (2017) Graduate Nurses' Evaluation of Mentorship | Satisfaction with materials, training |
| 6. My mentor helped me to understand how my role contributes to achieving company objectives. | Tiew, et al., (2017) Graduate Nurses' Evaluation of Mentorship | Satisfaction with materials, training |
| 7. I am very confident about the care that I deliver to my patients. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Practice |
| 8. I am very confident I have the knowledge and tools to see patients in a time efficient way. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Practice |
| 9. I believe I can find the resources (guidelines) to answer clinical questions in a time efficient way. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Setting |
| 10. I am very confident with Epic including charting, macros, and smartphrases. | Organizational weekly Mentor/Mentee Mentorship Plan | Practice |
| 11. I know how to access resources through the intranet and through peers to do my job effectively. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Setting |
| 12. I am very confident in handling customer service issues including wait room management. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 13. I am very confident with contacting my collaborating physician. | Organizational weekly Mentor/Mentee Mentorship Plan | Practice |

| | | |
|---|---|---|
| 14. I completely understand the organizational metrics including antimicrobial stewardship, HEDIS, CQI, and NPS. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 15. I feel very confident with the organization's promotion of cultural diversity and know where to find resources for cultural diversity. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 16. I am very confident with the organization's Culture of Excellence including professional development, career development, and pursuit of formal education. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 17. I am very confident that I can access the marketing materials I need for my clinic. | Organizational weekly Mentor/Mentee Mentorship Plan | Setting |
| 18. I am willing to become a mentor in a future cycle of the mentorship program. | Yes, No, Unsure | |
| 19. I completed and returned my Weekly Mentor/Mentee mentorship Plan to the Mentorship Coordinator. | Yes, No | |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

**Survey 5**

*Pre-program Mentor Survey*

| **MENTOR Survey PRE-Mentorship Program** | **Instrument Used to Develop Question** | **Outcome Assessed** |
|---|---|---|
| 1. I am very comfortable in a leadership role. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 2. I am very confident in my communication skills, problem solving skills, and decision making skills. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 3. I am very confident in the role as a mentor as defined by the organization. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Confidence in skills |
| 4. I am very comfortable with creating a supportive environment for my mentee. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 5. I am very confident with the skills needed to have an effective mentor/mentee relationship (e.g. sharing, role modeling, motivation, finding other's strengths, and positivity). | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

**Survey 6**

*Mid-program Mentor Survey*

| MENTOR Questions at Mid-point (5 weeks) of Mentorship Program | |
|---|---|
| 1. Have you been able to meet with your mentee at all scheduled sessions so far? If not, why not? | |
| 2. How have you been meeting your mentee? | Phone, e-mail, in person |

**Survey 7**

*Post-program Mentor Survey*

| MENTOR Survey POST-Mentorship Program | Instrument Used to Develop Question | Outcome Assessed |
|---|---|---|
| 1. I am completely satisfied with the mentor training materials provided including coaching materials, SMART objectives, and mentor coordinator resource. | Organizational Peer-to-Peer Mentorship packet | Satisfaction with materials, training |
| 2. I feel very confident in providing my mentee with honest, direct, and respectful feedback. | Organizational Peer-to-Peer Mentorship packet | Satisfaction with materials, training |
| 3. I am very satisfied with the frequency of the meetings in the mentorship program. | Organizational weekly Mentor/Mentee Mentorship Plan | Satisfaction with materials, training |
| 4. I am very comfortable in a leadership role. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 5. I am very confident in my communication skills, problem solving skills, and decision making skills. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 6. I am very confident in the role as a mentor as defined by the organization. | Melnyk, et al., (2008) Evidence-Based Practice Beliefs and Implementation Scales | Confidence in skills |
| 7. I am very comfortable with creating a supportive environment for my mentee. | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 8. I am very confident with the skills needed to have an effective mentor/mentee relationship (e.g. sharing, role modeling, motivation, finding other's strengths, and positivity). | Organizational Peer-to-Peer Mentorship packet | Confidence in skills |
| 9. I am willing to be paired with another mentee in the future. | Yes, No | |

| | | |
|---|---|---|
| 10. I completed and returned my Weekly Mentor/Mentee Mentorship Plan to the Mentorship Coordinator. | Yes, No | |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

Tiew, L.H., Koh, C.S.L., Creedy, D.K., & Tam, W.S.W. (2017). Graduate nurses' evaluation of mentorship: Development of a new tool. *Nurse Education Today*, *54*, 77–82. https://doi.org/10.1016/j.nedt.2017.04.016

Melnyk, B.M., Fineout-Overholt, E., & Mays, M.Z. (2008). The evidence-based practice beliefs and implementation scales: Psychometric properties of two new instruments. *Worldviews on Evidence-Based Nursing*, *5*(4), 208–216. https://doi.org/10.1111/j.1741-6787.2008.00126.x

# Appendix K

## Table 3

*Measures and Analysis for Outcomes in Mentorship Program*

| Expected Outcome(s) | How will you operationalize/measure the outcome | Where will you get the information | Will you have a comparison group | Analysis |
|---|---|---|---|---|
| Identification and enrollment of 10 mentor/mentee pairs | | Administrative records | None | |
| Increased mentee perception with preparedness to practice | • Knowledge and tools to see patients<br>• Care delivered to patients<br>• Electronic charting system<br>• Collaborating physician | Mentee Survey | Scores pre/post | Change scores post 10-week cycle from survey results |
| Increased mentee confidence with retail setting | • Intranet and peer resources<br>• Guidelines and clinical questions<br>• Customer service<br>• Organizational metrics, HEDIS, CQI, and NPS scores<br>• Marketing<br>• Cultural diversity<br>• Culture of Excellence | Mentee Survey | Scores pre/post | Change scores post 10-week cycle from survey results |
| Increased mentor confidence in mentoring skills | • Role as a mentor<br>• Providing feedback<br>• Communication, problem solving, and decision-making skills<br>• Supporting environment<br>• Leadership role<br>• Effective mentor/mentee relationship | Mentor Survey | Scores pre/post | Change scores post 10-week cycle from survey results |
| Mentor and mentee satisfaction with mentor training and resources | • Mentor helped with awareness of strengths and development (mentee)<br>• Mentor helped with company vision and mission (mentee)<br>• Mentor helped mentee feel comfortable (mentee)<br>• Mentor helped mentee understand role (mentee)<br>• All sessions (mentor)<br>• Mentor training including resources (mentor)<br>• Frequency of meetings (mentor) | Mentee and Mentor Surveys | Scores pre/post | Change scores post 10-week cycle from survey results.<br><br>Qualitative analysis on session completed or missed and suggested topics in Peer-to-Peer mentorship materials. |
| Identification of suggested topics of discussions based on mentees' needs differing from current training materials | • Skills for effective mentor/mentee relationship<br>• All sessions<br>• Frequency of the meetings | Mentee and Mentor Surveys | Scores pre/post | Qualitative analysis on sessions completed or missed and suggested topics by mentees.<br><br>Change scores post 10-week cycle from survey results. |

## Appendix L

### Table 4

*Mentee Pre-Post Item Responses (N=5)*

| Item | Pre-program mean score | Post-program mean score |
|---|---|---|
| Aim: Increase mentee perception of preparedness to practice as an independent NP | | |
| 1. I am very confident about the care that I deliver to my patients. | 4.4 | 4.6 |
| 2. I am very confident I have the knowledge and tools to see patients in a time efficient way. | 4.2 | 4.6 |
| 3. I am very confident with Epic including charting, macros, and smartphrases. | 4.6 | 4.6 |
| 4. I am very confident with contacting my collaborating physician. | 4 | 4.4 |
| Aim: Increase mentee perception of confidence to practice in the retail health setting | | |
| 1. I believe I can find the resources (guidelines, etc.) to answer clinical questions in a time efficient way. | 4.4 | 4.8 |
| 2. I know how to access resources through the intranet and through peers to do my job effectively. | 4.2 | 4.8 |
| 3. I am very confident in handling customer service issues including wait room management. | 4.4 | 4.8 |
| 4. I completely understand the organizational metrics including antimicrobial stewardship, HEDIS, CQI, and NPS. | 3.2 | 4.2 |
| 5. I feel very confident with the organization's promotion of cultural diversity and know where to find resources for cultural diversity. | 3.4 | 4.4 |
| 6. I am very confident with the organization's Culture of Excellence including professional development, career development, and pursuit of formal education. | 3.4 | 4.4 |
| 7. I am very confident that I can access the marketing materials I need for my clinic. | 3.6 | 4.6 |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

## Appendix M

### Table 5

*Mentor Pre-Post Item Responses (N=5)*

| Item | Pre-program mean score | Post-program mean score |
|---|---|---|
| Aim: Increase mentor confidence in mentoring skills | | |
| 1. I am very comfortable in a leadership role. | 4.4 | 4.8 |
| 2. I am very confident in my communication skills, problem solving skills, and decision making skills. | 4.8 | 4.8 |
| 3. I am very confident in the role as a mentor as defined by the organization. | 4.6 | 4.8 |
| 4. I am very comfortable with creating a supportive environment for my mentee. | 4.8 | 5 |
| 5. I am very confident with the skills needed to have an effective mentor/mentee relationship (e.g. sharing, role modeling, motivation, finding other's strengths, and positivity). | 4.8 | 4.6 |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

## Appendix N

### Table 6

*Feedback on Mentorship Program*

| Mentee Questions post-mentorship | |
|---|---|
| Item | Mean score |
| Aim: Evaluate satisfaction with mentor program materials, training, and resources | |
| 1. My mentor helped me to be aware of my strengths and development needs. | 5 |
| 2. My mentor helped me to be aware of the company vision and mission and understand how I can contribute to these. | 4.8 |
| 3. My mentor helped me to feel comfortable requesting and receiving feedback. | 5 |
| 4. My mentor helped me to understand how my role contributes to achieving company objectives. | 5 |
| Aim: Identify potential mentees' unmet needs not represented in the mentorship program materials or training | |
| 1. I am very comfortable with the skills needed to have an effective mentor/mentee relationship (listening, accepting feedback, and asking questions). | 4.8 |
| 2. I am very satisfied with the frequency of the meetings in the mentorship program. | 5 |

| Mentor Questions Post-Mentorship | |
|---|---|
| Item | Mean score |
| Aim: Evaluate satisfaction with mentor program materials, training, and resources | |
| 1. I feel very confident in providing my mentee with honest, direct, and respectful feedback. | 5 |
| 2. I am completely satisfied with the mentor training materials provided including coaching materials, SMART objectives, and mentor coordinator resource. | 4.6 |
| 3. I am very satisfied with the frequency of the meetings in the mentorship program. | 5 |

Note: Responses for each item based on a Likert scale: 5. Completely agree; 4. Somewhat agree; 3. Neither agree nor disagree; 2. Somewhat disagree; 1. Completely disagree

# Appendix O

## Table 7

*Topics Discussed During Weekly Mentorship Meetings*

| Topic of Discussions | Number of times discussed per mentEE/mentOR pair | | | | | Total |
|---|---|---|---|---|---|---|
| *Suggested Plan Items* | 101/102 | 201/202 | 301/302 | 401/402** | 501/502 | |
| Get to know each other, share information about professional and personal life. | 1 | 1 | 1 | 1 | 1 | 5 |
| Plan future meetings, develop a schedule of how and when meetings will continue | 1 | 1 | 1 | 1 | 1 | 5 |
| Set goals for mentoring relationship, and create a personal plan | | 1 | 1 | | 1 | 3 |
| Tranisition to the advance practice role | | | 1 | | | 1 |
| Patient visit work flow (*including ordering labs and lab results) | 1 | 1 | | | | 2 |
| Dealing with adversity / conflict (*patient-related including anger, demanding medication, refusing to pay) | 3 | 2 | 3 | 2 | 2 | 12 |
| Customer service | 1 | | 1 | | | 2 |
| Wait room management | 1 | 1 | 2 | | | 4 |
| Time management (*including work flow) | 1 | 1 | | | 1 | 3 |
| Antimicrobial stewardship | | | 1 | | | 1 |
| Metrics: (HEDIS, CQI, NPS, etc) | | 1 | 1 | | 1 | 3 |
| How to take ownership of your clinic | 1 | | | | | 1 |
| Marketing | | | | | | 0 |
| Relationship development | | | | | | 0 |
| Communication with clinic partner | | 1 | 1 | | | 2 |
| Cultural diversity | | | | | | 0 |
| Patient visit work flow | 1 | | 1 | | | 2 |
| Email etiquette | | | | | | 0 |
| Operational support questions | 1 | | 1 | | 1 | 3 |
| EPIC documentation tips and tricks | 1 | 2 | 1 | 3 | 1 | 8 |
| Peer mentor panels: DOT, Travel Health, STI, Chronic Care | | | 1 | | | 1 |
| Precepting | | | | | | 0 |
| Collborating Physicians | 1 | 1 | | | 1 | 3 |
| Involvement and professional development within company | | 1 | | | | 1 |
| Career ladder program advancement | | | | | | 0 |
| Pursuit of formal education (DNP, PhD, MBA) | | | | | | 0 |
| *Topics Added by Mentee* | 101/102 | 201/202 | 301/302 | 401/402 ** | 501/502 | |
| Prior authorizations | 1 | | | | | 1 |
| Specific protocols: STI treatment, DOT, Diabetics, OSA, sports physicals, pinworms, nPep, one-time medication renewals | 3 | 6 | 1 | 1 | | 11 |
| Internal policies: call out procedures, PTO, raises/reviews, CME, Skills validations | 2 | 3 | | | 3 | 8 |
| Administrative questions: supply ordering, equipment repair or replacement, document storage, cash drawer, daily HUB tasks, expired vaccines/tests | 1 | 1 | 1 | 4 | 1 | 8 |
| Questions about specific vaccines | | 3 | | | | 3 |
| Chart review information | | | 1 | | 1 | 2 |
| Clinical guidelines questions - how to utilize | | | 1 | 1 | 1 | 3 |

** Data provided by mentEE only in mentee/mentor cohort 401/402

*Acronyms:*

HEDIS = Healthcare Effectiveness Data and Information Set
CQI = Continuous Quality Improvement
NPS = Net Promoter Score
DOT = Department of Transportation (exams)
STI = Sexually transmitted infections
OSA = Obstructive sleep apnea
nPep = non-occupational Post exposure prophylaxis (HIV)
PTO = Paid time off
CME = Continuing medical education
HUB = Name of internal system for daily administrative tasks

## Appendix P

### Checklist 1

*University of Massachusetts, Boston QI Checklist*

### CLINICAL QUALITY IMPROVEMENT CHECKLIST

| | | |
|---|---|---|
| Date: November 20, 2020 Project Leader: Judith Thigpen | | |
| Project Title: Formal Mentoring Program, Region 44 | | |
| Institution where the project will be conducted: "The Organization" | | |
| Instructions: Answer Yes/No to each of the following statements about QI projects | YES | NO |
| The specific aim is to improve the process or deliver of care with established/accepted practice standards, or to implement change according to mandates of the health facilities' Quality Improvement programs. There is no intention of using the data for research purposes. | X | |
| The project is NOT designed to answer a research question or test a hypothesis and is NOT intended to develop or contribute to generalizable knowledge. | X | |
| The project does NOT follow a research design (e.g. hypothesis testing or group comparison [randomization, control groups, prospective comparison groups, cross-sectional, case control]). The project does NOT follow a protocol that over-rides clinical decision-making. | X | |
| The project involved implementation of established and tested practice standards (evidence based practice) and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards. | X | |
| The project involves implementation or care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience. | X | |
| The project has bee discussed with the QA/QI department where the project will be conducted and involves staff who are working at, or patient/clients/individuals who are seen at the facility where the project will be carried out. | X | |
| The project has NO funding from federal agencies or research-focused organization, and is not receiving funding for implementation research. | X | |
| The clinical practice unit (hospital, clinic, division, or care group) agrees that this is a QI project that will be implemented to improve the process or delivery of care. | X | |
| The project leader/DNP student has discussed and reviewed the checklist with the Course Faculty. The project leader/DNP student will NOT refer to the project as research in any written or oral presentations or publications. | X | |
| ANSWER KEY: If the answer to ALL of these questions is YES, the activity can be considered a Clinical Quality Improvement activity that does not meet the definition of human research. UMB IRB review is not required. Keep a dated copy of the checklist in your files. If the answer to ANY of these questions is NO, the project must be submitted to the IRB for review. | | |

Quality Improvement Project Checklist
Version Date: August 13, 2018

## Appendix Q

### Checklist 2

*"The Organization" Checklist*

**DNP Project Approval at "The Organization" and Checklist**

"The Organization" Projects Committee would like to give you some helpful information regarding completing your DNP Project at "The Organization".

| | DNP Project Checklist |
|---|---|
| ☐ | 1. Contact your SPM and "designated company email" to let us know of your desire to conduct your DNP project with "The Organization". |
| ☐ | 2. Please navigate to the following page and read through the documents posted: "the company intranet site" --> Professional Practice Page --> Process for Conducting your DNP Project at "The Organization" |
| ☐ | 3. Decide if you will use a Colleague as a preceptor.<br>• If yes, and you need help finding a preceptor, please contact your SPM as they may have candidates in mind for you.<br>• If you decide to use a "The Organization" preceptor please send your blank preceptor agreement (before obtaining any signatures) to "designated company representative" for review at: "designated company email" |
| ☐ | 4. Read and sign the required attestation (you'll send it to us in a later step) located on the Professional Practice Page on the Intranet. |
| ☐ | 5. Decide on a project that will not use or analyze patient data at "The Organization". We are unable to pull stats, data, or any other related information from any of our systems or databases at "The Organization" for use in a DNP Project. |
| ☐ | 6. Complete the DNP PICOT Project Proposal located on the Professional Practice Page on the Intranet. |
| ☐ | 7. Please have your University's Academic Preceptor and your Project Preceptor review your DNP PICOT Project Proposal and any other supportive documents (surveys, educational material, etc.) prior to sending that information to "The Organization" Projects Committee. |
| ☐ | 8. After your preceptors have reviewed and approved your DNP PICOT Project Proposal, please send your completed DNP Checklist, proposal, surveys/educational materials (if prepared already), and completed attestation to: "designated company email" and **copy your University's Academic Preceptor/Project Preceptor**.<br>☐ All emails, surveys, and educational materials that you plan on using/sending while working on your DNP project must be formally approved by "The Organization" Committee prior to being sent/used with our "Organization" Providers. |
| ☐ | 9. After your project has been approved by "The Organization" DNP Project Committee please confirm if your university requires a contract be in place with "The Organization". If yes, please email "designated company representative" at: "designated company email" |

**Please note: After you submit your project to the** "The Organization" **Committee you can expect a response back from us in 3 to 4 weeks. We will let you know if your project is approved or denied. If your project is denied we will give you feedback so you can resubmit it to us at a later time.** If you have any questions during this process please contact us at: "designated company email"

Thank you,

The "The Organization" Projects Committee

## Appendix R

### Attestation 1

*"The Organization" Attestation*

**DNP Candidate Attestation for DNP Projects Conducted at "The Organization"**
Effective Date: 5.11.2017

"The Organization" is committed to supporting providers in their pursuit of professional advancement and achieving continued education. "The Organization" also considers research and innovation as key components of the organization's mission and is therefore prepared to facilitate and support research at "The Organization".

In an effort to assist providers, ensure consistency and fairness, and maintain "The Organization's" high quality standards, "The Organization" DNP Project Committee (comprised of doctorally prepared providers and legal, compliance and quality consultants) has been created to review and approve all "The Organization" provider DNP Projects conducted at "The Organization" or an entity managed by "The Organization" (together, "The Organization"). "The Organization" providers seeking to work on a DNP Project at "The Organization" ("DNP Candidates") cannot conduct a DNP Project unless and until the project has been reviewed and approved by the "The Organization" DNP Project Committee.

**Any use of** "The Organization" **data for research purposes is not authorized unless express, written approval from the** "The Organization" **DNP Project Committee is provided.**

"The Organization" DNP Project Committee's role is to determine if the DNP Candidate's proposal is appropriately tailored to a project that can be conducted at "The Organization". All DNP Projects will be assessed based on the soundness of the DNP Project proposal, congruence with "The Organization" priorities and resources, and conformance with privacy and regulatory requirements.

"The Organization" DNP Project Committee does not assume any responsibility for facilitating the DNP Candidate's work within "The Organization" organization. "The Organization" DNP Project Committee does not serve as an ad hoc advisory committee to answer specific research/clinical-related questions or assist the DNP Candidate with his or her DNP Project.

This document provides DNP Candidates with an explanation of the criteria, requirements and process for conducting DNP Projects at "The Organization". Any DNP Candidate wishing to conduct their DNP Project at "The Organization" must adhere to these requirements and attest to their understanding and willingness to follow the processes outlined below by signing this document.

It is the DNP Candidate's responsibility to allow for sufficient time for the "The Organization" DNP Project Committee to review all DNP Project proposals. The DNP Candidate must plan accordingly given the timeframes and processes outlined below. Project proposals will not be

reviewed by the “The Organization” DNP Project Committee unless this document has been signed by the DNP Candidate and submitted with the proposal.

1. Eligibility:
    a. The DNP Candidate must be a fulltime “The Organization” provider
    b. The DNP Candidate must have been a “The Organization” provider for at least two years at the time of submission of the DNP Project proposal
    c. If the DNP Project is conducted in connection with the pursuit of an advanced degree, the academic program must be accredited
    d. The DNP Candidate must be employed by “The Organization” at the time the Project is completed and submitted to the DNP Candidate’s University and/or at the time the DNP Candidate requests “The Organization” DNP Project Committee to review the Project for publication.
    e. If DNP Candidate’s employment with “The Organization” is terminated prior to completion of the Project and submission to the DNP Candidate’s University and/or request for publication, the DNP Candidate must return all research materials to “The Organization” and cannot continue to pursue any Project incorporating or related to “The Organization” data
2. Total Number of Projects:
    a. “The Organization” DNP Project Committee will be able to approve a limited number of projects each year
    b. When assessing DNP Projects for approval, “The Organization” DNP Project Committee will consider the number of Projects currently being carried out in the same state and/or area so as to avoid placing unnecessary strain or burden on “The Organization” providers who may participate in the research work. “The Organization” DNP Project Committee will also consider the amount of “The Organization” resources required to support the DNP Project research and will evaluate proposals in light of “The Organization” resources currently devoted to supporting research initiatives
3. Requirements for projects conducted in pursuit of academic degree:
    a. Research must be conducted for DNP Project work outside of working hours
    b. No “The Organization” provider who has any managerial responsibilities with respect to a DNP Candidate may serve as the DNP Candidate’s preceptor
    c. Any DNP Candidate who chooses to ask a “The Organization” provider to serve as his or her preceptor must ensure that “The Organization” provider satisfies the specific requirements imposed by the DNP Candidate’s University, although it is “The Organization” preference that the preceptor be doctorally prepared. The DNP Candidate acknowledges the preceptor role is voluntary and any preceptor work will be conducted outside of scheduled work hours
4. Project Proposals
    a. All “The Organization” providers are representatives of “The Organization” organization and shall consider the professional values and reputation of the organization when drafting DNP Project proposals
    b. DNP Candidates are required to submit to the “The Organization” DNP Project Committee an initial project overview or research question (“Initial Project Proposal”) for approval. If the Initial Project Proposal is approved, the DNP

Candidate is required to submit a full research proposal ("Full Proposal") to the "The Organization" DNP Project Committee for final approval.

c. Project Proposal
    i. Each DNP Candidate is permitted two Project Proposals to "The Organization" DNP Project Committee. If "The Organization" DNP Project Committee denies both Initial Project Proposals, the DNP Candidate may not present further proposals for that topic.
    ii. Use of identifiable PHI will not be approved
    iii. "The Organization" is a public secular institution and therefore, Projects involving spirituality and/or religion will not be approved
    iv. The DNP Project topic must be consistent with "The Organization" goals and priorities
    v. The Project Proposal must include a clear timeline for Project
    vi. The Project Proposal must contain information regarding the extent and manner that the University makes student dissertations available
    vii. The DNP Candidate should anticipate up to 3-4 weeks for the "The Organization" DNP Project Committee to review and provide edits, recommended changes, or approval
    viii. The DNP Candidate is permitted three Full Proposal submissions. If the Full Proposal is not approved after the second submission, the "The Organization" DNP Project Committee will require written communication from the DNP Candidate confirming Project alignment with the DNP Candidate's academic advisor
    ix. If "The Organization" DNP Project Committee does not recommend approval after the third Full Proposal submission is made, the CNPO will be informed in writing and will have ultimate authority to approve or deny the Full Proposal
    x. No further requests regarding the Full Proposal under review will be considered after CNPO final review

5. Approved Projects:
    a. The DNP Candidate will receive written confirmation from "The Organization" DNP Project Committee that his or her Project has been approved ("Approval")
    b. The DNP Candidate must provide "The Organization" DNP Project Committee with all anticipated patient-facing and/or provider-facing survey instruments or communications for review and approval prior to use of such materials by DNP Candidate
    c. IRB Approval
        i. The DNP Candidate must obtain IRB approval
        ii. The DNP Candidate must provide "The Organization" DNP Project Committee with a copy of his or her IRB application and must await "The Organization" DNP Project Committee's review of application prior to submission to IRB. "The Organization" DNP Project Committee will review application to ensure consistency with the approved Project
        iii. DNP Candidate must provide a written copy of the IRB approval to the "The Organization" DNP Project Committee prior to beginning work on Project

6. DNP Candidate Acknowledgments:
    a. "The Organization" owns all data collected by DNP Candidate in connection with a DNP Project
    b. Project results may be used by "The Organization" for internal quality improvement purposes
    c. Any involvement from "The Organization" providers is on a voluntary basis
    d. If employment relationship with "The Organization" is terminated prior to completion of the DNP Project and submission to DNP Candidate's University and/or request for publication, the DNP Candidate must return all research materials to "The Organization" and cannot continue to pursue any Project incorporating or related to "The Organization" data
    e. "The Organization" may, in its sole discretion, require that DNP Candidate cease work on a previously approved Project
    f. If DNP Candidate wishes to seek publication of Project results (whether internally within "The Organization" or externally), DNP Candidate must submit proposal to the "The Organization" DNP Project Committee and must receive written approval before going forward with publication
    g. **Failure to obtain written approval from** "The Organization" **DNP Project Committee prior to publication of Project results may result in termination of employment**
    h. A copy of the final written project will be shared with "The Organization" DNP Project Committee

I have read and fully understand this *DNP Candidate Attestation for DNP Projects Conducted at* "The Organization" document and I understand that if I wish to complete any research at "The Organization", I must seek and obtain approval from the "The Organization" DNP Project Committee. While "The Organization" is committed to my professional development, I understand that approval of my Project proposal is at the exclusive discretion of "The Organization" DNP Project Committee and the CNPO.

**I understand that any use of** "The Organization" **data for research purposes is not authorized unless express, written approval from** "The Organization" **DNP Project Committee is provided. I further understand that I may not publish the findings of my completed Project without the express, written consent of the** "The Organization" **DNP Project Committee.**

_____
Name (print)

_____
Signature

_____
Date

## Appendix S

**Proposal 1**

*"The Organization" Project Proposal*

### DNP PICOT Project Proposal

**CRITERIA FOR APPLICATION**

- This document is to be completed by eligible DNP Candidate wishing to conduct their DNP Project at "The Organization".
- Requirements for DNP Project eligibility are outlined in the ***Attestation for DNP Projects Conducted at*** "The Organization" documented located on the "The Organization" Intranet > Professional Practice tab > Process for Conducting your DNP Project at "The Organization"

**DNP STUDENT INFORMATION**

**Name:** Judith Thigpen
**Position at** "The Organization"**:** Nurse Practitioner
**Date of Hire:** June 13, 2014
**Are you full-time?** Yes
**State/Region:** Georgia, 044
**Email Address:** judy.thigpen@"the organization".com
**Contact Phone #:** 404-966-6637
**School/Institute of Study:** University of Massachusetts, Boston
"The Organization" **Preceptor/Advisor (DNP/PhD required):** Aimee Kleppin, DNP

**DNP PROJECT PROPOSAL INFORMATION**

1. **What is the intended timeline for the DNP project?**
   Approximately 12 weeks beginning Summer, 2021

2. **Provide a brief summary of the practice issue (background, literature review):**
   BACKGROUND: Retail health can be a difficult transition for both new and experienced nurse practitioners (NPs). It is complicated by the isolated setting, demanding patients, lack of support staff, and the NPs' need to perform non-clinical administrative and business duties.

   LITERATURE REVIEW: Studies have demonstrated that mentorship can be beneficial for both mentee and mentor. This quality improvement project will be set in a region of the southeastern United States in an organization that has implemented a formal mentorship program nationwide, yet a gap was left in this region. Additionally, the formal mentorship program in this region will include newly hired, but experienced NPs who wish to participate along with newly hired new graduate NPs. Using Brown & Olshansky's Limbo to Legitimacy model to inform the improvement and Rogers' Diffusion of Innovation Theory to influence the change, the Plan-Do-Study-Act method

of quality improvement will be used (see Attachment for more details).

3. **Identify the project's PICOT elements?**

   **P**opulation: Nurse practitioners
   **I**ntervention: Formal mentorship program
   **C**omparison: Current transition process
   **O**utcome: Positive affect on transition
   **T**imeframe: Within the first 4 months of hire

4. **State the PICOT question:** Among nurse practitioners who transition to retail health (P), does implementation of a formal mentorship program (I) positively affect transition (O) in the first four months of practice (T) compared with the current transition process (C)?

5. **What is the proposed method of research (surveys, observation, etc)?** Surveys
   **If possible please attach a rough draft of your survey with your proposal. If you cannot provide a survey at this time please note that the DNP Project Committee will need to review your survey prior to implementation.**

6. **Please attest that you will not request** "The Organization" **to pull any data, reports, percentages, etc. for your DNP project at any time included de-identified PHI data.**

   **I attest I will not request** "The Organization" **to pull any data, reports, percentages, etc. for my DNP project at any time including de-identified data.**
   **Your initials:** __JT____

7. **Are there any ethical/privacy considerations? How will you de-identify the organization?**
   The organization will only be referred to as a national retail health chain or "the organization" or similar. At no time will the name of the organization be revealed or will any proprietary information be shared.

8. **How will you elicit participation?**
   A list of Region 44 providers (and other nearby regions if necessary) will be obtained for the knowledge of length of time with the organization. Those with the organization greater than 2 years will be called or emailed (either by company email or private email) to ask to volunteer as Mentors, and those with the organization less than 4 months will be called or emailed (either by company email or private email) to ask to volunteer as Mentees.

9. **Will consent be required for participation?** Formal consent will not be required. However, those who participate will be asked to complete the program for a 10-week cycle. Participation is voluntary and participants may withdraw at any time.

## Appendix T

**Approval 1**

*"The Organization"*

April 7, 2021

Dear Judy Thigpen,

Your DNP Capstone project, as outlined on your latest PICOT form, was approved by the DNP Research Committee on 4/5/2021.

You may proceed with your project however we ask that you please send us any survey questions, training materials, or emails to your population first for approval.

Please reach out to us with any questions you might have.

Thank you!
R.M., DNP Committee Chair

## Appendix U

**Table 8**

*Demographics*

| | Mentee (n=5) | Mentor (n=5) |
|---|---|---|
| Gender, n (%) | | |
| Female | 4 (80) | 5 (100) |
| Male | 1 (20) | 0 (0) |
| Age, n (%) | | |
| 30-39 | 3 (60) | 2 (40) |
| 40-49 | 2 (40) | 2 (40) |
| 50-59 | 0 (0) | 1 (20) |
| Education level, n (%) | | |
| Masters | 5 (100) | 5 (100) |
| Retail experience, n (%) | | |
| 0-2 months | 4 (80) | |
| 3-4 months | 1 (20) | |
| 18-23 months | | 1 (20) |
| 2-3 years | | 1 (20) |
| 4-5 years | | 0 (0) |
| 6-10 years | | 3 (60) |
| Had mentor in past, n (%) | | |
| Yes | 1 (20) | 1 (20) |
| No | 4 (80) | 4 (80) |
| Been a mentor, n (%) | | |
| Yes | 0 (0) | 1 (20) |
| No | 5 (100) | 4 (80) |
| Mentored in retail, n (%) | | |
| Yes | 0 (0) | 1 (20) |
| No | 5 (100) | 4 (80) |