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Professional Values of Corporate Nurses

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Walden University, 2018

AS, Minnesota State College Southeast, 2014

Dissertation Submitted in Partial Fulfillment

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Abstract

Healthcare is comprised of providers, who offer patient services, and payors, who manage the financial reimbursement of providers. Not much is known about registered nurses (RNs) in the corporate payor industry due to a lack of research. Strong professional values (PVs) are expected of all RNs, but research has shown this to vary across the field, meaning that RNs may require support in this area. As little is known about RNs in the payor industry, how these nurses sustain their PVs within the industry has not been evaluated, recognized, or supported. Therefore, the aims of this quantitative, descriptive, and correlational study were to (a) identify the PVs of payor industry nurses using the Nurses Professional Values Scale-3 (NPVS-3), (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs. Social media posts and emailed flyers were used to recruit 171 Midwestern United States participants from the payor industry. Spearman's rho and Kruskal-Wallis H tests were conducted to analyze the data. Nurses placed high importance on PVs, similar to past provider studies (M = 110.66, SD = 15.256). There were no significant relationships between PVs and years of experience in the payor industry. However, nurses with rare or no contact with patients placed statistically significantly higher importance than other groups on two items: peer review, $H(3) = 8.185$, $p = .042$, and collaboration, $H(3) = 9.654$, $p = .022$. Thus, leaders in the payor industry should identify and continue to support nurses' PV maintenance to increase awareness of nursing contributions, promoting social change by deserved recognition in the industry and in the nursing profession.

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Chapter 1: Introduction to the Study

Professional nursing values are the most basic, fundamental values of a profession and are used to provide guidance to members for decision-making and behavior (American Nurses Association [ANA], 2015). Such PVs are formed from political and social systems, professional nursing unions, and educational institutions (Kaya & Boz, 2019). Additionally, the nursing profession's ethical values are meant to comprise a minimum set of practical requirements (Fowler, 2015). In the United States, values of respect, commitment to patients, advocacy, accountability, responsibility, advancement of the profession, and promotion of global health are some of the foundational components of nursing (ANA, 2015). Globally, parallel nursing values exist (Schmidt & McArthur, 2018). For instance, the International Council of Nurses espouses additional, complimentary ideas of responsiveness, compassion, and integrity (ICN, n.d.). Furthermore, the concept of caring is synonymous with the profession of nursing (Lyneham & Levett-Jones, 2016), as are professionalism and activism (Weis & Schank, 2017).

In Chapter 1, I will discuss the background of the literature related to the scope and study of professional nursing values, the problem statement, the purpose of the study, research questions and hypotheses, the conceptual framework, and the nature of this study. I will also provide operational definitions for the variables, and discuss the assumptions, scope, and delimitations of the study. I will conclude by discussing limitations and significance.

PVs are important in research because they influence nursing practices (Arries, 2020). Highly regarded PVs positively correlate with better nursing work performance and caring behaviors (Geyer et al., 2018), quality of care (Geyer et al., 2018; Kaya & Boz, 2019), job satisfaction (Cetinkaya-Uslusoy et al., 2017), and patient satisfaction (Geyer et al., 2018; Kaya & Boz, 2019). However, various barriers prevent nurses from fully exhibiting their values in practice (Brown et al., 2015).

Although the norm for practice environments is overwhelmingly clinically based, with 80% of nurses working in hospitals in the United States (Kovner et al., 2016), other emerging practice environments should be included in the wider PV discussion. Healthcare organizations can be broken into two primary groups: providers, made up of clinically based organizations and professionals providing direct care, and payors, represented by organizations and professionals who take an administrative role in processing payments for providers (Hyland, 2019). Most nurses work in the provider industry giving direct care (Kovner et al., 2016), whereas nurses in the payor industry provide a valuable contribution to healthcare by "boundary spanning," that is, connecting providers, payers, services, and patients (Fraher et al., 2015). Of the three million nurses in the United States, less than 1% are employed in the payor industry (U.S. Bureau of Labor Statistics, 2020). Despite a small populous, the contributions of these nurses are crucial in health care. In the United States, the payor industry includes professional nursing roles that provide value by using evidence-based practices and promoting the cost-effective use of resources (Rowe, 2009). Additionally, the payor industry organizations are corporate in nature, providing a different practice environment than

most clinical nursing roles offer. This is due to the workforce composition. Nurses make up only 1% of the payor industry workforce, less than 3% of which are clinicians (U.S. Bureau of Labor Statistics, 2020). Together, these nurses and clinical professionals provide a patient-centered value focus to the payor industry.

Beyond this, roles in the payor industry can be considered both corporate and indirect because the industry is providing a service to support direct-care providers, leaving the payor organizations with indirect types and levels of interaction with patients. A study to identify the PVs of nurses in the payor industry in the United States can provide valuable insight into how much nurses impact this unique type of practice setting. This impact opens opportunities to identify potential support, education, and resources for professional development in atypical, indirect nursing roles. In this a priori study, I focused on the nature of the payor industry's environmental practice factors. The latter were determined to be substantially different from clinical practice roles. The first independent variable in this study was the level and type of patient contact. Level and type of patient contact were measured on a self-created scale that is representative of the types and amounts of patient contact that nurses had in their payor industry roles: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact. Additionally, this study included, as an additional independent variable, the years of nursing experience in the payor industry away from direct patient care. This was done to identify a possible relationship between the time in years of experience away from direct care and PV sustainability.

Social change means effecting positive change through the creation and application of ideas to promote the dignity of people, organizations, communities, and societies (Walden University, n.d.). Using this definition, the current study could promote social change because it generated knowledge on the understudied population of nurses employed in the corporate roles of the United States payor industry. Therefore, the social change impact of this study would be on the development and maintenance of PVs of nurses in these unique roles. Furthermore, the study could impact payor organizations in developing and promoting the worth of nurses' contributions to managed care. Lastly, this study could change the culture of the nursing profession by offering a look into these understudied roles, creating an opportunity to recognize their value in healthcare.

Background

Nurses must maintain high PVs to avoid potential quality consequences. Thus, researchers have explored PVs related to those taught in nursing programs (Gazaway et al., 2018; Knecht et al., 2020) and in various direct-care environments (Jahromi et al., 2018; Torabizadeh et al., 2019). For instance, nurses may uphold certain PVs more than others. Factors such as culture (Drayton & Weston, 2015), organizational culture or environment (Hayes et al., 2015), and nursing practice specialty (Fernández-Feito et al., 2019; Gallegos & Sortedahl, 2015) can cause variations in the importance nurses place on PVs. Time-related factors, such as age and years of experience, also cause variations in professional nursing values (Cetinkaya-Uslusoy et al., 2017; Monroe, 2019). Additionally, intrinsic values held by individual nurses impact the PVs established and sustained (Saito et al., 2018), although this study focused solely on PVs.

Notably, PV development is essential in a world of increasing ethical challenges (Weis & Schank, 2009). Conflicts can arise between the expectations in Code of Ethics for Nurses (ANA, 2015); nurses' personal ethical values; and the ethical principles of autonomy, beneficence, justice, and non-maleficence in practice (Haddad & Geiger, 2020). In all practice environments, nurses encounter challenges, which sometimes cause ethical dilemmas that impact the standard of care they provide (Torabizadeh et al., 2019). As a result, depreciated PVs in nurses can cause catastrophic damage to the quality of care provided. That is, nurses who have ceased to adhere to PVs are less equipped to respond to the ethical matters that arise daily from the complex, evolving nature of the current healthcare system (Torabizadeh et al., 2019). In turn, patients are affected by receiving care of lower quality, which often produces decreased patient satisfaction (Geyer et al., 2018). Consequently, organizations in the payor industry that rely on nurses and other clinicians to maintain the organization's focus on patients are then at risk of losing the crucial healthcare aspect of patient-centeredness (Hargan, 2020). This loss decreases the quality of the services provided, potentially driving cost higher.

When PVs are not sustained due to environmental or time-related factors, it can impact nurses' job satisfaction (Kaya & Boz, 2019). Unsatisfied nurses run the risk of burnout, which can lead to unpleasant physical and emotional consequences for them, absenteeism in the organization, and abandonment of the profession, potentially raising healthcare costs (Teixeira et al., 2014). This damage potential is evident in United States, where the hospital industry lost up to $6.02 million in 2016 due to a 16.5% nurse turnover rate (Yarbrough et al., 2017). Therefore, PVs in all practice environments,

especially in the dynamic health care environment of the United States payor industry, must be identified and supported. Clinical organizations take measures such as encouraging continuing education on ethics and professional development, in-service training, and mentorships (Drayton & Weston, 2015; Epstein & Turner, 2015; Monroe, 2019). However, there is no current data on whether these interventions are being used or could be beneficial in payor organizations due to a research gap regarding this specific group of nurses.

Furthermore, most professional nursing value research, regardless of methodology, has been conducted among nurses in clinical practice environments or without delineation between types of practice environments. For instance, Şenyuva (2018) examined the differences in the personal and PVs of nurses in a hospital setting in Istanbul according to generation. This researcher found that nurses in all generations had similar PVs, which may have been due to the shared culture and organization in which these nurses practiced. Additionally, Torabizadeh et al. (2019) conducted a cross-sectional study on operating room (OR) nurses and nurse anesthetists in Iranian university hospitals to explore the effects of the nurses' demographics on their PVs. The OR nurses' overall PVs scores were not found to correlate significantly with their professional experience, ages, education, or attendance at ethics workshops. However, these scores did significantly differ between male and female nurses. Again, the similarities may have arisen from the culture of the organization from which the sample was taken.

In another study, Jahromi et al. (2018) found that age, gender, and marital status did not impact hospital nurses' perceptions of PVs. These results indicated that external factors in the practice environment, like culture and organizational culture, may impact PVs. Thus, these authors concluded that the nurses would benefit from an organizational education program to increase their PVs.

Studying clinical nurses in Korea, Kim et al. (2015) added to the body of knowledge on nurses' perceptions of PVs as it relates to job satisfaction and ethical dilemmas. They discovered that both internal and external factors can cause burnout. This research also revealed a correlation between a low level of PVs and burnout. This finding suggested that organizations could provide continuing education in the work environment to enhance the PVs held by nurses, thus decreasing their risk of burnout.

In the same vein, Fernández-Feito et al. (2019) conducted a cross-sectional study on the PVs of nurses in Spain in the subspecialties of primary care in a clinical setting and in hospital care. They found significant differences in the importance the nurses in different practice environments placed on aspects of their PVs. These variations indicated that environment impacted these nurses' ethical behaviors.

Another research team, Gallegos and Sortedahl (2015), conducted a descriptive PV study on nurses in the specialized practice environment of a pediatric hospital in the United States. The results of this study showed that the lowest PVs were found among nurses with 3–10 years of experience. Nurses with fewer than 3 years and nurses with more than 10 years of experience had significantly higher scores. Lower PVs scores were also reported in roles where direct-care nurses indicated significantly lower PVs than

managers and educators. These figures demonstrated that role differential and culture of the practice environment impacted PVs. This research sample demonstrates that demographic variables, including experience, age, and role, influence PVs in nurses providing both direct and indirect care.

Problem Statement

The PVs of nurses are the fundamental ideals that guide them in making ethically sound, informed patient-care decisions. Professional standards, such as the Code of Ethics for Nurses, represent the PVs of nurses across the United States. These nurses vow to adhere to the values, morals, and ideals of their profession, embodying responsibility, dignity, respect, accountability, and competence (ANA, 2015). The sustainability of these values is essential for the success of the profession (Kaya & Boz, 2019; Knecht et al., 2019). As the largest group of healthcare providers (Torabizadeh et al., 2019), nurses play a key role in infusing value where high-quality, patient-centered care must lead to lower health care spending (Hargan, 2020).

By the same token, strong PVs in nurses have also been shown to correlate with high-quality nursing care (Kaya & Boz, 2019), higher job satisfaction among nurses (Kantek & Kaya, 2017), and higher patient satisfaction (Geyer et al., 2018). The Code of Ethics for Nurses requires nurses to consistently demonstrate and maintain all of the values espoused by the profession in their decision-making and behavior (ANA, 2015). However, both environmental and time-related factors can impact the importance that nurses place on the profession's values.

Perceptions of professional nursing values vary across the literature due to several factors. For instance, PVs can change when nurses are exposed to new practice environments (Şenyuva, 2018). Such exposure can impact the PVs of nurses in differing practice environments or subspecialties (Fernández-Feito et al., 2019). Beyond this, the importance placed on PVs has a direct relationship with education level (Erkus & Dinc, 2018; Kavradım et al., 2019) and is also higher in leadership roles (Gallegos & Sortedahl, 2015). These relationships indicate that nurses in leadership positions who generally have less patient contact than bedside nurses have stronger PVs orientations (Gallegos & Sortedahl, 2015). Additionally, variance can exist in the hierarchical importance placed on different PVs across the profession (Brown et al., 2015; Skela-Savič et al., 2017; Torabizadeh et al., 2019), although all values ought to be consistently upheld by nurses (ANA, 2015). There is evidence that nurses within one organization share similar PVs orientations (Brown et al., 2015), possibly constituting an environmental influence on value congruency. However, the environmental impact on the PVs of corporate nurses in the payor industry was not known at the time of this study.

Time is another important variable in the formation and maintenance of strong PVs. Nurses' PVs can change or disappear over time (Weis & Schank, 2009; Şenyuva, 2018; Torabizadeh et al., 2019) with factors such as years of experience and age correlating with stronger or lower PV orientations among nurses across different cultures. Thus, environmental and time-related factors associated with PVs can jeopardize the crucial, interlinked aspects of health care quality, cost, and patient-centeredness.

The payor industry in the United States offers a contemporary example of indirect-care organizational roles in which nurses collaborate with business stakeholders to provide services of varying types and levels of patient contact. These collaborations differ from the standard, clinical, direct-care practice environments. Much like direct-care nurses, corporate payor nurses participate in promoting evidence-based care and cost-effective uses of resources (Rowe, 2009). These unique practice environments create nursing roles infused with aspects of the business profession. However, this infusion may pose a risk to upholding the altruistic values of the nursing profession. Often the ethics of health care and the ethics of business are considered oppositional, causing ethical dilemmas (Ocak et al., 2020). Due to this conflict, nurses' obligation to maintain PVs in business-infused nursing roles requires further examination.

Changes in nursing PVs have resulted in primarily business-led, corporate environments, which may pose challenges for nurses, the quality of care they provide, and the valuable contributions they add to payor organizations. Additionally, the payor practice environment is substantially different in composition from a typical clinical setting. The United States payor industry relies on a total clinician population of only 3% of its total employees, only 40,000 of whom are professional nurses (U.S. Bureau of Labor Statistics, 2020), to create patient-centeredness for the entire industry. Thus, the health contribution in the health insurance industry is created by a small number of clinicians with an enormous responsibility. That is, they contribute to the management of the $3.6 trillion U.S. health care industry (CMS.gov, 2020).

Furthermore, nurse leaders in the health insurance industry can be a catalytic force in the movement toward increased value in care and decreased costs (Drayton &Weston, 2015). For this reason, the expectations of the professional nurse include that their PVs hold steady regardless of practice environment (ANA, 2015). However, little research has been conducted in corporate, indirect-care practice environments to ascertain how these nurses develop, demonstrate, and maintain their PVs. It has been said that if something cannot be named, it cannot be controlled, practiced, taught, or financed (Rutherford, 2008). The contributions from nurses in indirect-care organizations in the health insurance industry remain largely unknown. Therefore, it is impossible to properly evaluate how these nurses (a) are educated and prepared for roles, (b) continue to develop their professional identities, and (c) demonstrate and sustain their PVs in this practice environment. Additionally, these nurses are not supported or recognized like they are in other nursing environments. For this reason, all organizations that employ nurses must take actions to ensure that nurses' PVs are sustained. In order to identify, evaluate, and sustain these values, it is necessary to study how nurses in the payor industry perceive PVs. Beyond this, studies should explore whether there are variations in PV perception related to factors of time. That is, this research should investigate the amount of time spent away from direct clinical care roles in indirect-care organizational roles and the types and levels of patient contact these nurses have, and their PVs.

Purpose of the Study

The purposes of this quantitative, descriptive, and correlational study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships

between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs. The dependent variable was professional nursing values based on the Code of Ethics for Nurses (ANA, 2015). These values were further categorized as Caring, Activism, and Professionalism (Weis & Schank, 2017). The independent variables were the factor of time, which, in this study, was the number of years of nursing experience in a corporate role in a Midwestern U.S. payor organization, and the corporate environmental factor of patient contact level and type. I recruited from the Midwestern U.S, which contained over 730,000 registered nurses (U.S. Bureau of Labor Statistics, 2020).

Questions and Hypotheses

The following three research questions guided this study:

RQ1: What are the PVs of corporate nurses in the Midwestern United States employed in the payor industry using Weis and Schank's (2017) NPVS-3?

RQ2: What is the relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and the professional nursing values measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United

States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

RQ3: What is the relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

Conceptual Framework

The conceptual framework for this study was Kaya and Boz's (2019) professional values model (PVM). This model was established in Turkey and was developed from a literature synthesis of professional nursing values and related concepts from 1996 to 2017. In this model, nursing behaviors are guided by professional nursing values and patient individual values, which together, impact the quality of care that nurses provide. The concepts of professional nursing values, individual values, and quality of care are fully interdependent. As individual patient and nursing PVs increase, the quality of care that nurses provide increases. Conversely, weaker values decrease the quality of care provided (Kaya & Boz, 2019). This model fit this study because it explained the relationship between professional nursing values and the quality and value of the nursing

care provided. Because this model is relatively new, Kaya and Boz (2019) encouraged research to test its applicability in a variety of cultures and practice environments.

Nature of the Study

This quantitative study used a descriptive and correlational design—a method for determining the relationships between variables (Howell, 2013). Accordingly, this study determined whether relationships existed and the nature of the relationships between environmental variables and time and PVs of corporate nurses in the payor industry of the Midwestern United States. The instrument used to measure professional nursing values was Weis and Schank's (2017) NPVS-3. This is a psychometrically sound instrument that measures the summarized and labeled PV dimensions of Caring, Activism, and Professionalism using a 28-item Likert scale (Weis & Schank, 2017). Participants were asked to include the demographic factors of age, gender, race, total years of nursing experience, years of nursing experience in the U.S. payor industry, education level, level and type of patient contact, role in the payor organization, and job satisfaction. Furthermore, years of experience in the payor industry and level of patient contact were the two independent variables in the study. The dependent variable was professional nursing values, further broken down into the factors of Professionalism, Caring, and Activism in the NVPS-3 (Weis & Schank, 2017).

Definitions

American Nursing Association's Code of Ethics with Interpretive Statements: The guide that provides the outline for professional behavior by all nurses in the United States. Subsequently referred to as "the Code of Ethics for Nurses" in this study, this

guide outlines the ethical obligations of the profession, encompassing all of the practical and theoretical nursing commitments and values for the protection, promotion, and restoration of health in all patients and practice settings (American Nursing Association, 2015). The Code is considered to be the gold standard of PVs for professional nurses (Gallegos & Sortedahl, 2015).

Corporate: Something related to a business corporation (Merriam-Webster., n.d.). This adjective is used in the study to provide an overall description of the practice environment of the payor industry organizations to differentiate them from conventional direct-care nursing practice environments.

Corporate environments: Environments characterized by their competition, challenges, and pressure that are associated with individuals who most value self-enhancement, representing individual values for personal gain rather than ethical or organizational guidelines (Arciniega et al., 2019).

Environmental factors (IV): Factors that could impact nurses' ability to develop and maintain their PVs due to variability in the physical practice environment, including nature of the role, collaborators, and physical environment (Bijani et al., 2020; Torabizadeh et al., 2019).

Factors of time (IV): Factors that could impact nurses' ability to develop and sustain PVs due to variability in time (Erkus & Dinc, 2018). In this study, factors of time include years of experience as a registered nurse and specifically as a payor industry nurse.

Level of patient contact (IV): In this study, the "environmental factors" IV is further differentiated into level and type of patient contact. This factor includes the amount and type of contact between the payor industry nurse and the patients or members: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact. Virtual or telephonic contact, sometimes referred to as "telehealth," is the coordination of health services through electronic information integration (Steingass & Maloney-Newton, 2020).

Midwestern United States: According to the U.S. Bureau of Labor Statistics (n.d.), the Midwest Census Region consists of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

Nursing PVs Score-3: The NPVS-3, created by Weis and Schank (2017) was the instrument selected to measure nursing PVs. The factors or subscales of the values in the tool are Caring, Activism, and Professionalism.

Patients: As the Code of Ethics for Nurses (ANA, 2015) and the PVM (Kaya & Boz, 2019) refer to people that receive services from nurses as patients, this study refers these people as patients. Payor industry professionals may refer to these people or groups of people receiving services as clients, customers, or members, but for this document's continuity, they are referred to as patients.

PVs in nursing (DV): The structure for ethical decision-making and professional behavior contributing to professional commitment (Torabizadeh et al., 2019). In this study, PVs are measured using the NPVS-3.

Payor or Health Insurance Organization: Organizations, also referred to as "payors," provide administrative management for processing patient eligibility, enrollment, claims, and payment for patients, direct-care organizations, or both (Hyland, 2019). In this practice setting, nurses promote evidence-based care and cost-effective uses of resources (Rowe, 2009).

Assumptions

Four assumptions made in relation to this study. First, it was assumed that nurses had been exposed to the profession's values during their formal education (Jun & Lee, 2016) and were currently aware of the PVs of their practice. Second, it was assumed that nurses aimed to behave and make decisions in ways that were consistent with nursing professionalism as it pertains to the ethical standards in the Code of Ethics for Nurses. This assumption was made because ethical and practice standards are introduced to nurses during their formal education as nonnegotiable for any nurse in any practice setting (ANA, 2015). Third, I also recognized the potential for participants to answer the NPVS-3 survey questions in a way they believed they should rather than truthfully (Frey, 2018). I assumed that nurses honestly reported their perceived PVs because they were asked to do so before taking the survey.

Scope and Delimitations

The scope of this study covered the perceived PVs of nurses contributing to the Midwestern U.S. payor industry. Thus far, limited information exists on the nature of the roles and subsequent value of nurses in payor organizations. Therefore, the most basic tenet of being a nurse, PVs, was selected to explore this population of professional

nurses. Because PVs are expected to be highly regarded and embodied by professional nurses in any practice setting, these values provided a certain level of reliability in examining this specific subgroup of nurses. Moreover, the target population of nurses was selected due to the uniqueness of these roles among business professionals, who are sometimes regarded as having values in opposition to nursing values. Beyond this, uniqueness is also present due to the indirect nature of care provided in corporate payor industry roles.

The results of this study may be generalized to nurses in the Midwestern U.S. payor industry, but may not be generalizable to nurses across the United States in similar roles or in other cultures. Additionally, the results may be generalizable to similar corporate-type roles, such as those in other indirect-care organizations, as well as to direct-care organization nurse leaders.

Limitations

This study was subject to six limitations. First, a limitation of this study was that data collection involved gathering the nurses' perceptions of their PVs. The Hawthorne effect, in which people respond to research questions with answers they believe to be ideal (Frey, 2018), may have impacted the way the nurses responded to the survey items. That is, nurses were asked to respond honestly prior to receiving the survey, but controlling for the aforementioned effect is not inherently possible. Also, the survey collected the nurses' perceptions of the profession's values; actual behavior was not recorded and cannot be measured by a survey on perceptions. Thus, the theoretical understanding of PVs may not indicate practice behavior (Lyneham & Levett-Jones,

2016). In addition, the COVID-19 pandemic affected every part of the healthcare system (Jackson et al., 2020) not excluding the payor industry, which may have impacted how nurses responded to the idealistic NPVS-3 survey items.

As the study is a quantitative survey study, it can describe only the variables and their relationships, but not why a relationship may have existed between variables or which variable may have produced another (Burkholder et al., 2016). Although the minimum sample size was met based on G*Power analysis for a multiple analysis of variance (MANOVA) prior to data collection ($N = 88$), no clear trend appeared among the three NPVS-3 factors in the 144 collected responses. Therefore, a greater sample size may have yielded different results, with a higher statistical power (Faul et al., 2014). Time and funding constraints for this project limited the pursuit of continuing to recruit additional participants.

Finally, although the internal validity of the selected instrument for this study has been shown, at the time of this study this validity had not been tested on populations of nurses specifically practicing in payor organization roles. To address this limitation, internal validity using Cronbach's alpha coefficient was described based on the relevance of the tool's internal validity. Other nursing PV studies that used the NPVS-3 were not available at the time of this study, leaving comparison with the exact scale impossible. However, variations of the PV scales created by the NPVS-3 authors Weis and Schank (2017) had been extensively tested in nursing literature in the past decade, facilitating certain conceptual conclusions on professional nursing values.

Significance

The results of this study provided key insights into the PVs held by corporate nurses employed in the payor industry. Notably, these types of nursing roles, in which nurses share both patient ethics obligations and business responsibility, are becoming more common (Zupančič, 2015). PVs drive attitudes and behaviors (Fernández-Feito et al., 2019), so discovering the PVs of this nursing environment revealed components of the nurses' mindsets toward PVs. This insight provides the foundation for further exploration into how nurses maintain their PVs in corporate practice environments.

Moreover, this research was intended to offer a significant contribution to the literature and practice of nursing, as evidenced by this quantitative study aligning with Walden University's definition of social change (Walden University, n.d.). This study may promote social change because it generated knowledge on the understudied population of nurses in the U. S. payor industry. In turn, this information provided insight into these nurses' professional worth by identifying their professional nursing values, which they incorporate into promoting the dignity of their patients or clients. This is done by collaborating with business stakeholders and making patient-centered decisions, improving the quality of care provided, and driving down healthcare costs. This knowledge may promote social change in the professional development of individual nurses in these roles and provide indications of where corporate nurses may benefit from tailored support. The latter may inspire the development of education and other supportive programs to ensure that nurses have the opportunity to identify and enhance their PVs in any nursing role. This knowledge may also impact the culture of the nursing

profession by offering a glimpse into these roles and thus creating an opportunity for recognizing their importance in health care.

Summary

PVs as the most basic tenet of nursing professionalism must be maintained in all nursing practice environments. These values have been significantly correlated with important aspects of the profession, outcomes, and health care in general. Thus, organizations should support nursing professional development, and such education should provide a basis for the preparation of decision-making in the field and behaviors in a variety of environments. The payor industry employs nurses who provide their clinical expertise in the payor rather than the provider sector in health care. The payor industry is unique because it assumes health management but involves a minority percentage of clinicians, including nurses. These nurses skillfully navigate the enormous responsibility of influencing the focus of the organization toward patient-centeredness each day. Studying their PVs validates their efforts in the nursing profession and creates knowledge about how environments may or may not impact their values over time.

This quantitative study, which used the NPVS-3 for descriptive and correlational data, identified the PVs of nurses in the U.S. payor industry. It accomplished this by sampling Midwestern United States nurses to identify the relationships between years of experience in the payor industry away from standard clinical practice, level of patient contact, and PVs. The research was guided by the PVM, which predicted the relationships between individual PVs in nursing and quality of care. Additionally, this study promoted social change by presenting new knowledge on the PVs of these

corporate nursing roles and supporting the professional development of individual nurses, recognition in the profession, and development and understanding of value in the organizations that employ these nurses.

Next, Chapter 2 provides an in-depth literature review of this topic, including the concepts of professionalism in nursing, nursing PVs as they appear in literature in the setting of education and in practice, and what was known about the corporate nurses' roles in the payor industry prior to this study.

Chapter 2: Literature Review

PVs are the foundational concepts of nursing (ANA, 2015). Nurses first begin to internalize the values of nursing in their formal education (Norman, 2015) and through professional socialization in their transition from education to practice (Gazaway et al., 2018). Furthermore, they are expected to maintain the profession's values in all environments throughout their careers (ANA, 2015). However, PVs can change or disappear over time (Weis & Schank, 2009; Şenyuva, 2018; Torabizadeh et al., 2019). In addition to the impact of time on PVs, nurses have placed various degrees of importance on PVs based on differing environments (Cetinkaya-Uslusoy et al., 2017; Kim et al., 2015, Şenyuva, 2018). Detracting from any of the profession's values—including truth, integrity, altruism, autonomy, equality, human dignity, and esthetics—can cause a decrease in nursing care quality (Kaya & Boz, 2019). In a practice environment, where adoption of colleagues' PVs may diminish altruistic nursing ethical values, it is essential to examine PV sustainability.

PVs have been shown to impact quality of nursing care in various ways. These include patient satisfaction (Geyer et al., 2018); nurse job satisfaction (Kantek & Kaya, 2017); career development (Yarbrough et al., 2017); attitudes toward collaborating with other professionals (Brown et al., 2015); ability to navigate ethical dilemmas (Kim et al., 2015); and consistent, evidence-based practice (Cetinkaya-Uslusoy et al., 2017). These concepts are important in maintaining the interlinked concepts of health care quality, cost, and patient-centeredness.

The PVM, created by professional nursing value researchers Kaya and Boz (2019), provided a conceptual framework for this study. It predicted the relationships between professional nursing value dimensions and patient individual values on the quality of nursing care. Nurses who are employed in the U.S. payor industry practice in a unique setting due to the corporate nature of the environment. That is, the majority of employees are nonclinical (U.S. Bureau of Labor Statistics, 2020), and the indirect nature of their caring contributes to health care in this environment. Nurses in this industry provide crucial work in infusing value in healthcare (Rowe, 2009), much like direct-care nurses. Furthermore, Kaya and Boz (2019) encouraged testing of the PVM in diverse practice environments, which I found had not been tested on payor industry nurses at the time of this study. Thus, the knowledge gap explored here was the absence of research describing the PVs of nurses in the insurance industry. The purposes of this quantitative, descriptive, and correlational study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs.

Thus, this chapter presents the literature search strategy, the conceptual framework of the study, relationships among the variables of the PV dimensions, professionalism, and quality of nursing care. The research also explores PVs in nursing education and in practice, as well as outlining the significance of studying these concepts in the health insurance industry.

Literature Search Strategy

I completed an exhaustive search of the literature on my phenomena of interest both in both professional nursing literature and multidisciplinary literature. I used the research databases of Google Scholar, CINAHL & MEDLINE Combined Search, CINAHL, ProQuest Nursing & Allied Health, ABI/INFORM Collection, Embase, Ovid, SAGE Journals, PsycInfo, Science Direct, Medline, and Academic Search Complete. The Boolean operator "and" expanded the search results by connecting the target variables with nurses. Next, the searches conducted were appropriately narrowed using the Boolean operator "or." The inclusion criteria that comprised this search strategy were those of peer-reviewed articles, written in English, and full-text published between 2015 and 2020. Beyond this, articles published as early as 1992 were included due to their relevance to the study. In total, 105 articles were identified for inclusion in this study's literature review.

The search terms used to locate literature related to *PVs*, the independent variable in this study, were *professionalism*, *professional identity*, *professional values* (multidisciplinary), *nurse professional values*, *nurse ethical decision-making*, and *Professional values model*. To identify research done on the indirect-care organizations, I also used the terms *indirect care*, *managed care*, *health insurance, health plan*, *insurance organization*, *managed care organization*, *healthcare economics*, *payor*, *business and healthcare ethics*, *stakeholders*, and *health insurance industry*. Additionally, these searches employed the Boolean operator *or*, in combination with the Boolean operator *and* with *clinician*, *nurse*, or *nursing role*.

Although the topic of reducing health care cost is a primary tenet of the health insurance industry, as discussed in the literature, few peer-reviewed articles were identified describing any aspect a nurse's role in this endeavor. For this reason, search inclusion criteria were expanded by removing the peer-reviewed criteria. In doing so, I located an Institute of Medicine Roundtable Workshop in which Rowe (2009) discussed aspects of the role of clinicians in cost savings in the health insurance industry. Additionally, the America's Health Insurance Plans (AHIP) organization website was located by expanding the search inclusion criteria. The AHIP organization is a national professional organization that provides resources for all professionals in the health insurance industry. This organization conducts and publishes research relevant for industry professionals and provides educational materials to its members (AHIP, n.d.-b). However, the resources available at the time of this study did not contain material on the role of the nurse in the insurance industry. Other websites pertinent to the phenomena of interest included the ANA and the U.S. Bureau of Labor Statistics. To ensure this search was exhaustive, appointments with the Walden librarians were utilized in the payor industry and PVs study searches.

Conceptual Framework

The branches of philosophy, ethics, and moral theology have long been discussed and debated due to their important implications on the understanding of value judgements and behavior. Ethics is a theoretical domain of knowledge that addresses the nature and morality of actions (ANA, 2015). This morality is an essential concept for a functioning individual, profession, and society. Additionally, the philosophies of ethics inform

people's abilities to participate peacefully and productively in society (Epstein &Turner, 2015). Furthermore, the concepts of doing what ought to be done, what is right, and what is good create value structures. Every individual has a value structure that is formed in childhood and influenced by the society and culture with which they interact as well as their family, education, and professions (Moyo et al., 2016). Nursing is a profession that is underpinned by the disciplines of ethics and moral theology and guided by value structures based on these concepts. The ethical principles of nursing values are autonomy, beneficence, justice, and non-maleficence in practice (Haddad & Geiger, 2020).

Moreover, the profession of nursing is underpinned by both applied and normative ethics. Applied ethics questions what is good, evil, right, or wrong in a profession, whereas normative ethics is based on what people "ought" to do (ANA, 2015). A combination of moral and normative ethics provides professional nurses with the philosophical structure by which they are expected to make decisions. Additionally, they are thus expected to behave in a manner following the profession's ethical code in terms of what nurses "ought to do, be, and seek" (ANA, 2015, p. xii). The needs for knowledge and understanding regarding ethical and moral ideologies to explain or guide decision-making and human behavior have led to the creation of many theories related to these values.

Like the profession of nursing, other professions in the health sciences, such as psychology, social work, and medicine, are also guided by the philosophy of ethics and moral ideological concepts. Additionally, each profession defines its professional ethics based on aspects unique to that discipline (Barry & Ohland, 2009). In this vein, the

general discipline of ethics informs individual and PV structure formation. However, the value structures within the professions of business, health, law, and engineering have developed over time in isolation, each recognizing aspects of that discipline that are different from others (Barry & Ohland, 2009). In this way, many PVs theories and conceptual frameworks based on general human values theories exist. These may describe or predict behaviors of professionals according to each profession's hierarchical value structure.

General values theories play a role in the formation of individual and PVs structures. Rokeach's values theory (1973) explained how individuals can place varying hierarchical value importance based on their priorities. This has been used in professional contexts to describe the moral judgments and behaviors of business professionals (Farcane et al., 2019; Tuulik et al., 2016; Vitale, 2018) and topics regrading education (Blyznyuk, 2017). Additionally, values theory (1973) has been used to guide research on values in the nursing profession (Arries, 2020; Rassin, 2008). Although this theory is well-developed in describing basic value structures of individuals or groups (Blyznyuk, 2017), it does not address the complexity of moral judgments in providing care to people, as is done in nursing. Complex ethical problems exist in nursing (Woods et al., 2015), requiring an advanced, modern understanding of value structures and competition between values. The theory of basic human values, created by Shalom Schwartz (1992), is most often used in psychology research (Arciniega et al., 2019) and is useful in nursing PVs research (Erkus & Dinc, 2018; Luciani et al., 2020). This theory suggests values are interrelated, and some values, such as power and benevolence, conflict (Schwartz, 1992).

Additionally, value conflicts, especially those related to the concept of benevolence, are important for understanding values in the caring profession of nursing. The nature of nursing sometimes means nurses must make decisions against their PVs (Blomberg et al., 2019), making Schwartz's (1992) theory a logical guide to nursing ethics and values research. Even so, this study sought to build off such theoretical value knowledge using a specific conceptual model to explain the specific concepts of nurses' PVs, taking into account the individual patients' values regarding the quality of nursing care.

The purpose of a conceptual model in a quantitative study is to explain relationships among variables (Creswell, 2014). One conceptual model specifically based on the PVs in the nursing profession explains the relationships between nurses' PVs and the quality of care they provide. I selected the PVM created by Kaya and Boz (2019) to use in this study. The PVM contains specific nursing PVs, building on value and ethics theoretical underpinnings of the nursing profession previously discussed. At the time of this study, this model was the only known model that specifically highlighted the role of professional nursing and PV dimensions as they pertain to quality nursing care. Furthermore, this model fit this study well because of its relational predictions between key variables of PV dimensions and quality of care. Additionally, the PVM was used as the conceptual framework for the study because it most specifically described the variable relationships within the nursing profession.

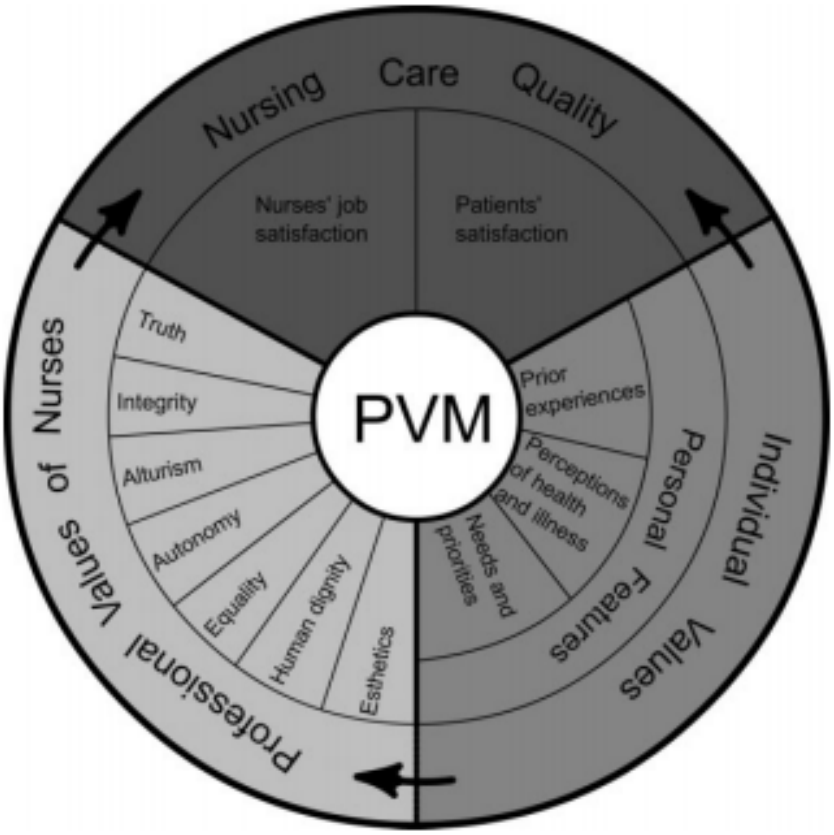
Creation of the Model

Turkish researchers Kaya and Boz identified a lack of ability for classic value theories and conceptual frameworks to address the specific, interrelated concepts of PVs

of nurses and their impact on patients, other nurses, organizations, and the nursing profession. Thus, they synthesized research conducted around the world on nursing PVs and related concepts from 1996 to 2017 to create the PVM. This model is a conceptual framework that depicts the relationship between nurses' PVs and quality of care, accounting for how patients' individual values affect quality of care (Kaya & Boz, 2019).

Figure 1

The PVM



Note. From "The Development of the PVs Model in Nursing" by Kaya, A., & Boz, İ., 2019, *Nursing Ethics*, *24*(6), pp. 916 (https://doi.org/10.1177/0969733017730685).

Purpose of the Model

The purpose of this model is to explain the relationships between the variables of individual patients' values and the PVs of nurses regarding the quality of the care the nurses provide (Kaya & Boz, 2019). Additionally, respect for patients' individual values involves maintaining a patient-centered care environment. The latter entails involving patients in their own care, providing them with information, and supporting them in making informed decisions (Van Humbeeck et al., 2020). Furthermore, this model also serves the actionable purpose of helping nurses and nurse leaders identify potential reasons for deficits in quality of care. Whether the results of a care deficit audit revealed a patient satisfaction or nurse job satisfaction deficit, identification of the cause would facilitate the creation of solutions for change.

Framework of the PVM

The PVM contains primary concepts of "individual values," "Professional values of nurses," and "nursing care quality." Individual values represent patient values and are subcategorized into "personal features," where "prior experiences," "perceptions of health and illness," and "needs and priorities." Beyond this, PVs of nurses are subcategorized into "truth," "integrity," "altruism," "autonomy," "equality," "human dignity," and "aesthetics." The third concept of nursing care quality is subcategorized into the concepts of "nurses' job satisfaction" and "patient satisfaction" (Kaya & Boz, 2019).

The three primary concepts of nurses' PVs, individual values, and the outcome of nursing care quality are interrelated in the PVM. The relationships in this model signify

that individual values affect the nurses' abilities to obtain and maintain PVs in their clinical practices. Both PVs and individual values affect the quality of care provided. Additionally, the interrelatedness of these concepts allows conclusions to be drawn on nurse, patient, and organization outcomes.

Individual Values

Values are a set of beliefs that are determinants of behavior (Arries, 2020). In this model, individual values represent those of the individuals receiving care from professional nurses (Kaya & Boz, 2019). Every person has a set of values. For instance, personal values are derived from the socialization process that occurs early in life through family learning, community, and education (Moyo et al., 2016). Next, individual values are important in health care and in the nurse–patient relationship. Patients' individual values influence decisions in which they participate with nurses on actions related to their care (Kaya & Boz, 2019).

Because everyone has a value set, it is important to note that the individual values of the nurses influence their own PV formation, although this is not distinctly indicated in the model. Instead, the model includes the individual values of the nurse within the "professional values of nurses" section because nurses' individual and PVs are integrated so that their personality and profession become one (Kaya & Boz, 2019). This process is supported by the ANA (2015) which indicates that nurses must embody and not simply adhere to the Code of Ethics for Nurses from when they become nurses. Additionally, the code informs all aspects of nurses' lives (ANA, 2015). Individual values are important in this model because nurses can best practice with highest ethical consideration when they

understand the meaning of the phenomenon a patient is experiencing (Kaya & Boz, 2019). For the purpose of this study, the "individual" may represent either a person receiving care or entire populations of individuals served by a U. S. payor industry organization.

Personal Features. "Personal features" make up the subcategory under "individual values" in the PVM (Kaya & Boz, 2019). Such features are further divided into physical, psychological, and social components. Physical characteristics are those of gender, age, education level, or other such factors. Psychological characteristics comprise intrinsic individual qualities, including motivation, perception of abilities, and self-respect. Additionally, social characteristics include such variables as individuals' culture and socioeconomic status (Kaya & Boz, 2019).

"Prior experiences" is a subcategory of "personal features" in the model. Kaya and Boz (2019) indicate this part of the model represents individual interpretation of their past experiences, including how individuals work to determine their priorities and needs. "Perceptions of health and disease" is another subcategory under "personal features." The former represents the value individuals place on their own health care. In turn, individuals who perceive health as the absence of disease have difficulty getting involved in their own care. The third subcategory, "needs and priorities," represents the individuals' prioritized needs, in which nurses can align nursing care approaches to impact the health outcomes of the patients (Kaya & Boz, 2019).

PVs of Nurses

The governing bodies of ethics in nursing, such as the American Association of Colleges of Nursing and the ANA, have resources for ethical guidelines that were taken into account by Kaya and Boz (2019) in selecting the "PVs of nurses" subcategories of "truth," "integrity," "altruism," "autonomy," "equality," "human dignity," and "esthetics" (Kaya & Boz, 2019). Kaya and Boz (2019) noted that researchers have added suggested additional values, although their model summarizes the basic categories of such concepts. For example, in response to a changing world that includes the rise of a global economy, world consumerism, and rapid advancements in technology and science, Bruce (2018) recommended that nursing values should include diversity and social justice. Until research supports a need for change, and the governing bodies of nursing make official such recommendations, the model remains a solid summary in which these new recommended variables exist as sub concepts.

Truth. The dimension of truth represents the adherence to fact or reality (Kaya & Boz, 2019). A devotion to such concepts is important in nursing because nurses have an obligation to responsibly practice and promote optimal healthcare (ANA, 2015). For this reason, truth is taught in formal nursing education. Furthermore, truth in the forms of rationality and responsibility was demonstrated to be a PV that increased in students more in the first year as it was a newly acquired value than the third year of formal nursing education (Kavradım et al., 2019). Thus, truth is necessary for the profession of nursing and is justifiably included in the PVM model.

Integrity. The PVM includes the PV of integrity, which is demonstrated when nurses act in accordance with the appropriate standards of practice (Kaya & Boz, 2019).

The inclusion of this concept aligns with Provision 9 in the Code of Ethics for Nurses that indicates the duty of nurses is to maintain the integrity of the profession by articulating nursing values and participating in professional organizations (ANA, 2015). Integrity is a PV shared with other professions, including accounting (International Code of Ethics for Professional Accountants, n.d.), due to its importance in maintaining strong moral principles. Additionally, integrity is commonly discussed in nursing values literature (Schmidt & McArthur, 2018; Shahriari et al., 2013). Therefore, the PV of integrity is essential to the profession, so including this concept in values discussions is necessary.

Altruism. In their model, Kaya and Boz (2019) defined altruism as a regard for the welfare or wellbeing of others. As nursing is a caring profession, the first provision in the Code of Ethics for Nurses is appropriately one of compassion and respect, which align with altruistic values (ANA, 2015). Altruism is an important concept in the profession of nursing and represents respect for individuals (Kantek & Kaya, 2017). Beyond this, including altruism in the nursing model is well supported in the literature. In fact, it was one of the most common attributes found in PV literature for nursing (Schmidt & McArthur, 2017) and in health practitioner PVs research (Moyo et al., 2016). However, although altruism may be widely accepted as a necessary PV, nurses do not always report altruism as a high value priority (Erkus & Dinc, 2018; Rassin, 2008). Even so, this value is a primary tenant of the caring profession of nursing and is strongly supported in the literature for inclusion in the model.

Autonomy. Autonomy as a PV in the PVM represents the ability of a nurse to make decisions or take action (Kaya & Boz, 2019). That is, nurses must maintain the

ability to make decisions that will positively impact patient outcomes. Nurses must be accountable, responsible, and competent in their ability to make independent, evidence-based judgments (Fowler, 2015). Although autonomy in the sense of the latter responsibility is not debated, this concept in light of individualism is valued differently across cultures. For example, individual autonomy is not as highly valued compared with family and social relationships in collectivist cultures (Erkus & Dinc, 2018). However, this responsibility to make possible the best, most consistent actions and decisions should be unwavering, facilitated through continuing, lifelong education (Fowler, 2015). Like other PVs, autonomy may waiver in importance among professional nurses over time. Regardless, autonomy is a value of great importance in professional nursing practice due to its role in nurse decision-making.

Equality. The PV of equality involves nurses' valuing the same basic rights and privileges for all (Kaya & Boz, 2019). Caring for all patients with the same approach has been a core value in the nursing profession since the beginning. For instance, patient advocacy and equal accessibility and privilege of care were among the primary beliefs of Florence Nightingale, the founder of the profession (Selanders & Crane, 2012). Equality is essential for respectful care of diverse populations and therefore must be considered in PV discussions.

Human dignity. The value of human dignity represents the inherent worth of individuals (Kaya & Boz, 2019). This concept is a primary tenant of the humanistic nature of nursing because nurses have a responsibility to all people to provide care according to basic human rights. As human dignity is the heart of the nursing practice,

this the most commonly discussed nursing value in the literature (Schmidt & McArthur, 2018; Shahriari et al., 2013). Nursing students and practicing nurses alike have reported dignity in providing respectful patient care as the most important PV (Cetinkaya-Uslusoy et al., 2017; H. Kaya et al., 2017; Şenyuva, 2018). Thus, human dignity must be included in any model representing values in nursing, making it a correct choice for inclusion in the PVM.

Aesthetics. Kaya and Boz (2019) described the PV of esthetics as the fundamental value nurses place on what is proper, tasteful, stylish, or pleasant. In this sense, caring for individuals in the nursing practice is an art (Siles-González & Solano-Ruiz, 2016). Florence Nightingale first recognized that nursing was more than just scientific application, that it also upheld human values (Rassin, 2008). Esthetics essentially represents the relationship between the environment and the perceptions of the people in it. Thus, exercising sensitivity in approaching patient care and supporting nursing colleagues are ways nurses can practice the PV of esthetics (Mannix et al., 2015). This value can impact the perceptions of patients, organizations, nurses, and the nursing profession as a whole.

Nursing Care Quality

In the PVM, nursing care quality is indicated by the two subcategories of nurse job satisfaction and patient satisfaction. PVs are an important component of nursing and allow nurses to deliver high-quality care (Torabizadeh et al., 2019). For instance, nurse job satisfaction positively correlates with strong PVs (Hui et al., 2020; Kantek & Kaya, 2017). Additionally, quality nursing care includes patient satisfaction with the care they

receive in the model. In addition to impacting job satisfaction, strong PVs in nurses can also positively impact patient satisfaction (Fernández-Feito et al., 2019; Monroe, 2019). Furthermore, patients are satisfied when their expectations and care needs are fulfilled (Kaya & Boz, 2019). As this is paramount in the purpose of nursing, both nurse job satisfaction and patient satisfaction create quality nursing care in the PVM.

Relationships Among Variables

The model describes relationships between the three primary variables of individual values, nurses' PVs, and high-quality nursing care. "Nursing care quality" appears at the top of the wheel and is impacted by both individuals' and nurses' PVs. This quality of care is the focus of the model, as it is also the focus of the entire nursing profession. The primary goal of this profession is to provide a high quality of care through the promotion, protection, and restoration of health (ANA, 2015).

Individual values impact quality of care and the PVs of nurses. People who are aware of their own values are better able to participate in their own care, and this decisiveness provides clear insight for nurses to apply their PVs to generate quality patient outcomes (Kaya & Boz, 2019). Beyond this, the PVs of nurses affect nursing care quality as well, so an increase in the importance nurses place on PVs positively affects care quality. Conversely, placing low importance on PVs negatively impacts the quality of care, demonstrating the importance of creating and maintaining high value perceptions among professional nurses. Overall, the model indicates that high PVs increase nurse job satisfaction, patient satisfaction, and quality of care (Kaya & Boz, 2019).

Framework Use in Literature

At the time of this study, the PVM had been cited in new PV literature but not tested, so Kaya and Boz (2019) recommended that this model be tested in various cultures and practice settings. The model is based on cross-cultural professional nursing values research and is supported by years of peer-reviewed studies. Thus, this model should be tested in unique practice environments, such as in this study, on nurses employed in the payor industry of the Midwestern United States.

Literature Review Related to Key Variables

Professionalism

Every profession has a set of values that require its members to do certain things and act certain ways to achieve quality contributions to society. These standards constitute professionalism, an important concept in this study because it is an antecedent to the study's dependent variable of PVs. That is, PVs as used in the PVM are individual components that contribute to the whole of professionalism. Professionalism represents a set of values constructed through interpersonal interactions, relationships, and societal and situational contexts representing responsibility, respect, altruism, and honesty (Hoffman et al., 2017). These value structures create congruency among members in the profession with the goal of a congruent, high-quality output. Additionally, professions function best when members conform to PVs structures (Moyo et al., 2016). All professions, including law, business, accounting, medicine, and nursing, have various educational and skill requirements, as well as best practices developed through extensive research. The profession of nursing achieves a definition of what is good and what ought

to be done through the Code of Ethics for Nurses (ANA, 2015); the scope of practice with the Nursing Scope and Standards of Practice (ANA, n.d.-c); global professionalism and advocacy via the professional organization of the International Council of Nurses (ICN, n.d.); and nursing education standards using the American Association of Colleges of Nursing (AACN, n.d.). Together, these standards guide nurses in internalizing the PVs of caring, dignity, and compassion (O'Connor et al., 2019). Moreover, conformity to professional standards must be maintained by the members of the occupation to fulfill their duty to society and produce high-quality outcomes.

All professions, including nursing, have an obligatory responsibility to society, and this relationship between profession and society is symbiotic. That is, society grants the profession permission to provide a service, and the profession is obligated to provide that service with altruistic intentions (Sills, 2000). Members of the profession must adhere to the profession's values to participate in the practice in a manner that fulfils the profession's responsibility to society. For instance, nurses internalize the values of their profession and are obligated to contribute to society by providing high-quality, competent care, whereas patients rely on nurses to give them high-quality care.

Furthermore, professionalism necessitates a commitment and conformity to a profession's values. Nurses first learn what constitutes professionalism during their education, and through professional socialization, they ultimately internalize and act in accordance with their profession's values (Norman, 2015). The challenge of nursing education is motivating nurses to fully internalize the meaning of nursing values to impact their practice because professionalism is an abstract concept. The concept of

professionalism is a multidimensional phenomenon that can be ambiguous in nature (Hoffman et al., 2017). Part of this ambiguity is that professionalism is a noun that represents the ideals of a profession in which members adhere to specific standards of practice. As a verb, exhibiting professionalism indicates members must behave in a way that maintains the profession's integrity. In nursing, professionalism includes continuing education and research to maintain an autonomous practice (Skela-Savič et al., 2017). The ambiguity makes it necessity for professionals to promote a more detailed approach to professionalism in the form of an operationally defined set of values. Additionally, nurses must actively promote the integrity of the profession by participating in professional nursing organizations and integrating social justice into health policy (ANA, 2015). In the PVM, integrity requires nurses to act in accordance with the appropriate standards of practice (Kaya & Boz, 2019). The commitment to achieving and maintaining professionalism requires the profession of nursing to maintain a clear, patient-centered PV structure.

Every profession has a set of PVs. For instance, in addition to nurses, physicians, attorneys, engineers, accountants, and construction workers also share profession-specific professional identities (McCabe et al., 2016). More specifically, other healthcare practitioners in medicine, dentistry, physical therapy, occupation therapy, and paramedicine, also maintain altruism as core values in their professions (Moyo et al., 2016). The business profession typically does not include altruism stated as such but does include similar concepts such as respect for persons, responsibility, fairness, and trustworthiness (South University, 2017). Other aspects of the business profession such

as competition are why some consider the values of business and of health care oppositional (Ocak et al., 2020).

Although modern nursing is considered its own profession due to its consistent educational frameworks, professional codes of conduct, and standards of practice (Sills, 2000), it was not always considered a profession. There was a period of time where nursing was regarded as only semi-professional because the knowledge used was not classified as unique, and the field did not require a university education (O'Connor et al., 2020). Thus, the nursing profession must continuously evaluate the field's values to maintain the integrity of the profession.

In summary, the concept of professionalism requires nurses to internalize the values of their profession and act in accordance with its outlined standards of practice and ethical codes of conduct. Professionalism is an antecedent of PVs, and the individual PVs make up the concept of professionalism. That is, PVs are individual concepts that fall under the overarching concept of professionalism that must be followed to achieve intended outcomes and fulfill a duty to society. As PVs compose the foundation of professionalism, these values are necessary to study in all practice settings within the nursing profession.

PVs in Nursing

The Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) is the primary ethical guide and PV structure for all nurses in the United States. Because this code establishes ethical standards for the nursing profession, it serves as a practical guide for ethical decision-making (ANA, 2015). All professional nurses in all practice settings

must adhere to these guiding principles to maintain morally acceptable, competent, and professional practices. Additionally, nursing PVs allow nurses to establish a common culture in which they can unite under a guiding ideology to add meaning to their practices (Cetinkaya-Uslusoy et al., 2017). As nurses are exposed to clinical practice, they further internalize these PVs through a process called professional socialization (Gazaway et al., 2018). Students and practicing nurses alike must be familiar with the PVs in the Code of Ethics for Nurses so that they form professional identities that embody the profession's values to consistently provide high-quality care.

The Code of Ethics for Nurses is a living document, revised to accommodate changes such as advancements in technology, changes in health care delivery, and new nursing roles (Epstein & Turner, 2015). Due to these inherent changes in society and health care, the PV structure of nurses must adapt. Thus, it is critical that professional codes be reviewed and modified approximately every decade (Fowler, 2015). For instance, the Code of Ethics for Nurses was first created in 1950 and subsequently modified in 1956, 1960, 1968, 1976, 1985, 2001. It was most recently updated in 2015 with specific consideration for the increasingly complex, expanding roles of nurses (Fowler, 2015). However, these modifications maintained the nine provisions of the 2001 Code, meaning that only minor revisions were made in 2015 (ANA, 2015).

Contents of the Code

The Code of Ethics for Nurses is separated into nine provisions, which can be conceptualized according to ethical or moral concepts or sections of provisions. The first three provisions of the code outline the values and commitments of the nurse. Next,

Provisions 4–6 illustrate the nurse's duty and loyalty, and the last three provisions identify the duties of the nurse outside of patient care (ANA, 2015). These ethical, morality-based values have been discreetly named and categorized in various ways throughout the literature. Weis and Schank (2009) developed the Nursing Professional Value Scale-Revised version based on the Code of Ethics for Nurses 2001, listing the dimensions of professionalism, caring, activism, trust, and justice. However, their 2017 NPVS-3 contained only the three broader concepts of Caring, Professionalism, and Activism (Weis & Schank, 2017). Elsewhere, Kaya and Boz (2019) described the values of truth, integrity, altruism, autonomy, equality, human dignity, and esthetics. Skela-Savič et al. (2017) argued that professional nursing values fall into two primary dimensions of (1) caring, trust, and justice and (2) activism and professionalism. The essence of nursing comprises promoting and restoring health, alleviating suffering, and caring for all people (ANA, 2015) regardless of the discrete naming or categorization of the value concepts. The Code of Ethics for Nurses remains the gold standard for outlining the value structure of the nursing profession in the United States.

As nursing is a profession centered on caring for people, the most basic tenant of providing high-quality care is the concept of respect, the maintenance of human dignity. The latter was found to be the most common attribute in PVs literature based on a sample from 1973 to 2016 (Schmidt & McArthur, 2018), which is similar to Weis and Schank's (2017) Caring dimension. Additionally, altruism, justice, and integrity were commonly discussed attributes of professional nursing values in the literature (Schmidt & McArthur, 2018).

The PVs in the Code of Ethics for Nurses represent abstract concepts that are to be applied in practice to real-life decision-making. Thus, nurses are expected to be aware of PVs and apply them in their work (Poorchangizi et al., 2017). However, because PVs are abstract concepts defined in an idealistic way, there can be differences between what is ideal in theory and in reality. For instance, during nursing school, students may struggle to close the theory–practice gap, which encompasses the distance between what is expected and what is reality (Palese et al., 2019). Beyond this, practicing nurses experience this gap, as they sometimes struggle to apply PV concepts in practice (Jahromi et al., 2018). Although the PVs are individually abstract, they serve a clear purpose in nursing practice.

The purpose of professional nursing values is to provide a guide for nurse decision-making and behavior (Jahromi et al., 2018; Şenyuva, 2018; Torabizadeh et al., 2019). Micro-decisions are those small but not insignificant decisions made many times in a day (Karlsen et al., 2020), representing a large portion of the decision-making of nurses on a daily basis. Other decisions, such as those involving ethical dilemmas, require more resources but fall in the realm of nursing decision-making employing guidance from ethical codes. In such cases, the Code of Ethics for Nurses serves as a guide rather than a source of definitive answers (Kim et al., 2015). This illustrates the importance of activating other PVs, such as advocacy and collaboration. The culmination of caring behavior and competent, timely decision-making is what makes nursing not only a science but also an art (Siles-González & Solano-Ruiz, 2016).

A nurse can face challenges in adhering to PVs when making a decision among confounding variables, such as a choice involving individual patient values, complex medical situations, ethical dilemmas, and individual values (Kaya & Boz, 2019). Furthermore, environmental constraints on nurses' ethical decision-making, such as availability and accessibility of information, evolving technology, and the complexity of modern health issues, can cause ethical conflicts in nursing practices (Woods et al., 2015). Additionally, nurses who cannot effectively navigate ethical issues encountered in their practice daily do not meet expected standards of care (Torabizadeh et al., 2019). Thus, PVs are not only essential to the foundation of nursing practice, but they also must continually evolve as the practice evolves.

PVs Impact on Practice

The levels of internalization and manifestation of these values impact nurses, patients, and organizations. Again, the ultimate goal in nursing is to provide high-quality nursing care, resulting in positive patient outcomes. There is a clear positive correlation between strong PVs and good behavior in practice (Fernández-Feito et al., 2019), where nurses' good behavior implies the likelihood of high-quality care. Geyer et al. (2018) found in their PVs study on hospital nurses in South Africa that a robust values orientation facilitated up to a 90% chance of positively affecting work performance. Even so, a primary aspect of PVs is that nurses must recognize their own perceptions of the profession's values to understand how these values affect their professional behavior (Kantek & Kaya, 2017).

Impact on Nurses

The level of importance nurses place on individual PVs has direct implications on nurses as individuals. For instance, nurses with strong PVs often display high job satisfaction (Cetinkaya-Uslusoy et al., 2017; Yarbrough et al., 2017). Satisfied nurses are more likely to provide high-quality care and less likely to leave their jobs (Kantek & Kaya, 2017). PVs also impact nurses' abilities and propensities to collaborate with other professionals (Brown et al., 2015; Cetinkaya-Uslusoy et al., 2017; Kantek & Kaya, 2017). Additionally, PVs inform nurses' routine behavior as well as their actions in ethically challenging situations. Moral distress resulting from experiencing an ethical dilemma occurs when nurses experience a situation in which they must make a decision between two unsatisfactory options (Kim et al., 2015). This leads to stress, which stems from the belief that they must do what is best for the client even if it means sacrificing their personal beliefs (Stones & Klein, 2015). This type of stress can lead to emotional burnout, which can cause staff turnover; that is, nurses may leave organizations or abandon the profession entirely (Kantek & Kaya, 2017). Nurses are each responsible for their own practice (ANA, 2015) and therefore have an individual responsibility to reflect on their practice, noticing if they are unable to practice safely and take appropriate actions. Regardless of the reasons nurses leave their profession, they are unlikely to return once they have exited (Black et al., 2010). Thus, the importance of identifying value deficits is crucial to retain nurses. Consequently, efforts should be made to identify issues and provide support to nurses to strengthen their PVs because nurses with strong PVs are less likely to experience burnout (Kim et al., 2015).

Impact on Patients

Patients are directly affected by the level of importance nurses place on their PVs. Beyond affecting the quality of care provided, nurses' PVs are correlated with caring behaviors in the eyes of patients. Geyer at al. (2017) found that strong PV orientation had a positive correlation with work performance and with patients' perceptions of nursing care. Patients are affected by the PVs of their nurse caregivers, making clear the importance of sustaining PVs in nursing practice.

Impact on Organizations

Professional nurse retention is critical for organizations and the healthcare industry (Dotson et al., 2014). Turnover, in addition to other job stress, can cause issues such as absenteeism, decreased productivity, and medical insurance or legal costs for employers in the United States resulting in a cost of over 300 billion dollars every year (Nguyen, 2016). In 2016, the U.S. hospital industry lost as much as 6.02 million dollars due to a 16.5% nurse turnover rate (Yarbrough et al., 2016). Although variables such as job satisfaction and strong PVs can be predictors of nurse burnout and intent to leave organizations, behavior cannot always be predicted. Therefore, organizations must focus on items they can control, such as offering a variety of resources to strengthen nurses' PVs. Such practices can increase job satisfaction and quality of care and decrease the likelihood that nurses will leave organizations, helping the latter avoid the subsequent costs. Like nurses as individuals, organizations that employ nurses also have a responsibility to ensure resources are available to support nurses in their efforts to maintain their PVs. Nurses who report higher job satisfaction are often those with higher levels of value congruence or values that align with those of the organizations in which

they are employed (Dotson et al., 2014). According to Dotson et al. (2014), value congruency between organizational values and nursing PVs could provide insight into the high turnover rate in addition to factors that address nursing task burnout, such as nurse–patient ratios. Therefore, organizations that employ nurses should seek to understand their employees' moral, ethical, and PV obligations to enhance resource allocation.

PVs in Organizations

Organizations are also interested in PVs to predict and mitigate unethical behavior by professionals within their organizations (Arciniega et al., 2019). Nurses' behavior is ideally influenced by the profession's values, but work settings also affect behavior (Fernández-Feito et al., 2019), and even supportive organizations can cause nurses stress. Monroe (2019) discovered that one of the lowest scored PV items was that of conscientious objection, which could indicate nurses were uncomfortable with taking such action at work. To display this type of objection, a nurse would respond to an unethical circumstance by refusing to participate (Lamb et al., 2019). Thus, nurse leaders and organizations must ensure the practice environment is supportive, encouraging nurses to feel confident in their decisions. Organizational policies and procedures should not constrain nurses' abilities to make decisions and behave in a morally acceptable way (Woods et al., 2015). In order to ensure this type of workplace, an organization must seek to acknowledge and support the PVs of nurses.

PVs in Nursing Education

There is an extensive body of literature on the professional development of nursing students during their formal education and on nurses immediately after they enter

the workforce. The goal of nursing education is to create professionally prepared, competent nurses who must be prepared for progressively more complex and varied work environments (Knecht et al., 2020). PVs offer an important study in education because unveiling the perceptions and ethical ideologies of nursing students can provide educators with strategies to shape their curricula. In doing so, they can address potential shortcomings and promote strategy creation to help students critically reflect on their approaches to professionalism (Arries, 2020). Prior to becoming a practicing professional, a nursing student must demonstrate the internalization of PVs that guide their behavior. During nursing education, nursing students first internalize these values, developing their professional roles (Jun & Lee, 2016). Additionally, nursing students are expected to act on these values in their daily patient care (Arreis, 2019). To consistently develop nurses who embody the profession's values, many studies around the world have focused on PVs in nursing education.

Specific practices to encourage the internalization of professional nursing values during nursing education include ethics courses. Knecht et al. (2019) found that courses that focus on PVs and ethical practices produce nursing students with stronger value orientations. In addition to courses, mentorship has proved to impact PV orientation. Furthermore, nursing faculty greatly influence their students' educational experiences (White et al., 2020). In a longitudinal, master-level, pre-licensure educational study, Gazaway et al. (2018) found that students who participated in a formal mentorship had placed more importance on PVs after graduation than their peers. Nurses who experienced informal or no mentoring displayed no change or a decrease in the

importance they placed on PVs nine months after graduation (2018). In mentorship, it is crucial that nursing students do not observe uncivil behavior in their mentors. For instance, Kim (2018) conducted a study on student PVs in a four-year nursing program in South Korea, finding that experiences of incivility were the most influential factors in shaping the students' PVs. These results further supported the need for educators to help students internalize PVs.

The PV "Trust" was found to be of the most important values to nursing students compared with the other professional nursing values described by Weis and Schank (2009). The latter values included Activism, Trust, Justice, Professionalism, and Caring in several nursing education PV studies, whereas Caring was found to be slightly less important (Arries, 2020; Feller et al.,, 2019; Jasemi et al., 2020). Additionally, the caring aspects of nursing as a PV have been reported in qualitative studies with nursing students, aligning with quantitative studies on the topic (Schmidt, 2016). Beyond this, values relating to professionalism and activism are typically valued lower than those related to caring and trust (Arries, 2020; Bijani et al., 2019; Feller, n.d.; Jasemi et al., 2020). There is a similar trend among practicing nurses with experience in various practice environments (Brown et al., 2015; Poorchangizi et al., 2017; Torabizadeh et al., 2019). These findings present the need for educators to focus on activism and professional behaviors to enhance the positive effects of PV sustainability.

PVs in Nursing Education: Environmental Factors

Furthermore, the environment impacts students' PVs, with aspects such as culture impacting professional nursing values during formal education. Lin et al. (2016)

conducted a comparative study on the PVs of undergraduate nursing students in Taiwan compared with those in China. Although the PVs mean scores were not significantly different, there were noticeable discrepancies in the importance the students placed on 11 of the 26 NPVS-R items. These results indicated that culture impacts student perceptions of PVs. Another cross-cultural study, this one between American and Taiwanese nursing students, found that the mean overall PV scores were not significantly different and were high, but the values prioritized varied between the two cultures (Alfred et al., 2013). On the one hand, the collectivist cultural tradition of Taiwan meant that these nursing students placed greater value on advancing the profession, professional nursing association participation, continuing education, and patient privacy. On the other hand, the individualist cultural tradition of the United States caused those nursing students to value patient advocacy. As a result, these students maintained that competency, self-evaluation, and responsibility to care for a culturally diverse population were the most important values (Alfred et al., 2013). Thus, culture is an example of a factor that impacts PV development in nursing education.

PVs in Nursing Education: Time Factors

In addition to environment, factors of time such as age impact PVs in nursing students. In regard to generational differences' effects on PVs, Jiménez-López et al. (2016) found that nursing students and young nurses had decreased value orientation for the core nursing values, including altruism, justice, freedom, and equality, compared with older nurses. Additionally, a qualitative study revealed that after being exposed to a practice environment later in their formal education, students reported changes in their

senses of self and reflections on their values (Callwood et al., 2019). In a Canadian study, no statistically significant differences arose between year of study age or gender, but nursing students ranked activism as the least essential PV dimension (Arries, 2020). Moreover, differences in time-related factors such as age and environmental factors such as culture have presented differences in PV priorities and orientations in students. The importance of nursing education in developing PVs is well established (Alfred et al., 2013; Arries, 2020; Gazaway et al., 2018; Jiménez-López et al., 2016; Kim, 2018), supporting the need to research PVs in practice.

PVs in Practice

PVs are to be held in high regard and used to inform a nurse's practice. In the United States, nurses must realize the vital importance of respect; commitment to patients; advocacy; accountability; responsibility; duty to self and others; contributions to health care environments; advancement of the profession; and promotion of community, world health, and the nursing profession (ANA, 2015). No PVs are negotiable. A primary limitation in PV studies is that they typically measure value perceptions, which are not measurements of actual behavior. However, strong PV perceptions are important to study because they correlate with good professional behavior (Fernández-Feito et al., 2019); patient satisfaction (Geyer et al., 2018); nurse job satisfaction (Kantek & Kaya, 2017); career development (Yarbrough et al., 2017); attitudes toward collaborating with other professionals (Brown et al., 2015); ability to navigate ethical dilemmas (Kim et al., 2015); and consistent, evidence-based practice use (Cetinkaya-Uslusoy et al., 2017). Such

studies were conducted either within clinical direct-care organizations such as hospital and clinics or did not separately list nurses in indirect-care organizational roles.

In my literature review, most PVs studies referenced were conducted in countries reflecting high overall PVs orientations (Brown et al., 2015; Cetinkaya-Uslusoy et al., 2017; Erkus & Dinc, 2018; Fernández-Feito et al., 2019; Gallegos & Sortedahl, 2015; Jahromi et al., 2018, Poorchangizi et al., 2017; Skela□Savič et al., 2017) using various values tools, most commonly the Nursing PV Scale (NPVS) or NPVS-R (Weis & Schank, 2015). This research revealed that nurses are being guided by the ethical values of their profession. Ideally, all of the profession's values would be perceived as highly important to one's practice, but this is not evident in nursing research. In studies utilizing the NPVS-R, items in the PV dimension of Caring are the most valued by nurses across cultures (Brown et al., 2015; Erkus & Dinc, 2018; Geyer et al., 2018; Jahromi et al., 2018; Monroe, 2019; Poorchangizi et al., 2017; Skela□Savič et al., 2017). Although environment, specifically culture, can introduce different value priorities (Kaya & Boz, 2019), the importance placed on caring was the highest among the values examined in these studies. Caring in nursing involves providing attentive, responsible, competent, and responsive care (Fowler, 2015). Additionally, the caring aspects of nursing have been reported in qualitative studies among nursing students as well, supporting quantitative studies (Schmidt, 2016). Next, PVs related to trust are most often the second highest PV factor in clinical nursing studies (Brown et al., 2015; Geyer et al., 2018; Jahromi et al., 2018; Poorchangizi et al., 2017).

On the other end of the spectrum, the values of justice and activism in the form of professional associations and public policy are often perceived cross-culturally as the least important by professional nurses (Brown et al., 2015; Fernández-Feito et al., 2019; Monroe, 2019; Skela□Savič et al., 2017). However, this finding is contradictory in that valuing professional activities and advocacy behaviors is essential to maintaining the core practice of nursing. That is, to continually achieve high-quality care, evidence-based activities requiring peer review and research must also be valued (Monroe, 2019).

To identify value priorities and understand their impact on practice in this study, I gathered the demographic variables of age, years of nursing experience, role, and education level. Time-related variables, including age, generation, or years of experience, were important factors that have been found to impact PV orientation in practicing professional nurses. Thus, these factors were included in some form in all of the studies reviewed here.

PVs in Practice and Time Factors

Evidence suggests that PVs change over time. In a nursing PV study conducted in Spain, nurses with less experience in a primary care group were found to have stronger PVs than their more experienced colleagues, and nurses with intermediate amounts of hospital experience (11–20 years) had the strongest PVs in a hospital group, compared with nurses with more or less experience in hospital care (Fernández-Feito et al., 2019). In addition, some nursing PVs studies have identified a mid-range phenomenon that may occur as the ideals of nursing school wear off, replaced by the reality of practice. Nurses with 3–19 years of experience had the lowest PV scores, whereas nurses with less than 2

years or more than 20 years of experience had similar, significantly higher scores in pediatric hospitals (Gallegos & Sortedahl, 2015). The study was conducted in only one organization, which may have been a limitation. However, a similar phenomenon occurred in a Turkish hospital study that found nurses with 11–20 years of experience to achieve the lowest PV scores compared with both their less experienced and more experienced colleagues (Erkus & Dinc, 2018).

Contradicting the previous studies in this section, several researchers have found that nurses with greater years of experience and age have higher PV orientations due to their broader experiences. For instance, in Turkish hospitals, as level of experience and age increased, PV scores also increased (Cetinkaya-Uslusoy et al., 2017). Poorchangizi et al. (2017) found a similar trend among Iranian nurses at four university hospitals. Similarly, in a study on nurses in all roles via a convenience sample in the state of Washington, Monroe (2019) found that nurses with 10 or more years of experience had significantly higher PVs scores using the NPVS-R than other age groups (less than two years of experience; 2–5 years of experience; 5–9 years). In a professional nursing values study in Turkish hospitals, Erkus and Dinc (2018) found positive correlations between nurses with higher PV orientations and higher levels of education. Nurses with master's degrees attained the highest PVs scores. However, Fernández-Feito et al. (2019), found that nurses with more than 20 years of experience had weaker PVs in both primary care and hospital environments. In these studies, time-related variables were valuable in identifying value differentials and trends used to support nurses' ethical decision-making.

Elsewhere, in a quantitative nursing PV study conducted on a sample in one tertiary hospital in the United States, Brown et al. (2015) found no correlation between the demographic values of age, experience, education level, role, or amount of time spent in that role providing direct care. Notably, these researchers did find a significant relationship between nurses with strong PV orientations and positive attitudes toward physician collaboration (Brown et al., 2015). Even so, due to not finding any significant correlations between demographic variables in this study, Brown et al. (2015) concluded that PVs are consistent throughout nursing careers. Additionally, this team recommended promoting competence, knowledge, and skills, which may more effectively promote changes in practice over PVs since these attributes are consistent. However, this sample was taken from a single hospital, possibly indicating that the PVs reported were not intrinsically static for nurses. Instead, the extrinsic factors of the organization's culture may have influenced these PVs in a way that was consistent across the sample, despite demographic and role differences.

Therefore, researchers have been able to clearly identify the most important professional nursing values, as evidenced by guidelines developed by organizations, such as the ANA's Code of Ethics for Nurses (ANA, 2015). However, the current body of literature indicates a global lack of consistency between upholding PVs over time and upholding them in different environments. These differences in PVs must be influenced by outside factors, such as extrinsic environmental factors. Additionally, culture plays a role in the hierarchy of individual values, such as how Eastern cultures are more collectivistic, whereas the United States is more individualistic (Erkus & Dinc, 2018).

Cross-culturally, differences remain in PV perceptions over time. This suggests that resources must still be allocated to enhance the PVs of nurses at all experience levels, tailored to both the culture of each society and the organization's culture. Furthermore, attention should also be paid to factors in each organization that could be affecting perceived value importance among nurses.

PVs in Practice and Environmental Factors

Aspects of the practice environment have been found to influence nurses. The nature of environments, colleagues, roles, and available resources all influence nurses. Furthermore, the integration of values into professional nursing practice is affected by the nurses' intrinsic factors and experiences of nursing activities and the extrinsic factors that make up the practice environment (Fernández-Feito et al., 2019). The nature of the practice environment, the other professionals in the environment, the various nursing roles, and the professional development resources available to the nurses are all extrinsic factors that affect the nurse's ability to apply PVs in practice. For example, the environment directly impacts a nurse's desire to stay at or leave an organization (Yarbrough et al., 2017).

Additionally, differences can exist across PV orientations because of varying specialties or practice environments. In a quantitative cross-sectional study by Fernández-Feito et al. (2019) in Spain, significant differences were noted between nurses in primary care facilities and hospitals. Although both groups of nurses highly valued ethics, caring, and autonomy, 58.9% of the hospital nurses, compared with only 22.9% of the primary care nurses, rated their participation in nursing research as "very important" on the

NPVS-3 (Fernández-Feito et al., 2019). This difference in value importance between these two specialties is concerning because all nurses are expected to uphold the same high PVs, regardless of practice environment. Thus, the nature of their roles in these different specialty environments is a contributing factor to this variation.

An important part of an environment conducive to maximum PV orientation maintenance is when nurses are comfortable taking advocacy actions like conscientious objection. In this study, however, as mentioned earlier, conscientious objection was perceived as less important than other values (Fernández-Feito et al., 2019; Monroe, 2019). This is an important disparity to note, because nurses use conscientious objection to speak up and take action against unethical circumstances (Lamb et al., 2019). This disparity could be related high levels of self-esteem and self-confidence, which enable nurses to stand up to others, which is not something that was historically common in the profession when it was still considered a subordinate occupation (Fernández-Feito et al., 2019). In practice environments where nurses maintain caring PVs among primarily non-health care professionals, various implications of conscientious objection could arise. Thus, identifying how nurses in the payor industry value advocacy using the NPVS-3 is the first step toward recognizing nurses' contributions to these organizations and to their profession.

Colleagues. Nurses are expected to represent and preserve the scope of nursing practice in collaborative situations (ANA, 2015), and their colleagues in their practice environments make each environment distinct. That is, the professionals with whom nurses interact in their practice impact the nurses' perceptions of their environments and

their PV orientations. For instance, nurse managers play a role in practice environments, working to ensure these environments are healthy and conducive to safe practices and satisfying work experiences (Kantek & Kaya, 2017). Additionally, nurses who have nonclinical or indirect roles in organizations are expected to collaborate by influencing the direction of care (ANA, 2015). Like nurses influencing other professionals in support of patient care, other professionals also can influence nurses. Colleagues including other nurses, other medical professionals, and other non-clinical professionals can influence the PV perceptions of nurses in the work environment (Fernández-Feito et al., 2019). At times, this can cause conflict or stress (Kim et al., 2015; Torabizadeh et al., 2019). For instance, perioperative nurses reported in a qualitative study that conflict with other professionals affected them in that value conflicts impacted their ability to be present for patients (Blomberg et al., 2019). However, new practice environments are rapidly appearing, and new roles are being undertaken by nurses (Fraher et al., 2015). Thus, nurses are working alongside professionals with whom they have not worked before, professionals who might not place the same importance on the concept of caring, like nursing. These nurses are essentially navigating new territory with their core nursing values, which may or may not guide their decision-making in their changing roles.

Roles. In clinical PVs research, roles within clinical organizations involving a more indirect patient care environment indicate a higher PV orientation. In one study, PVs were lowest in nursing providing direct patient care, whereas nurses with indirect-care roles in the clinical organizations, including managers, directors, and educators, scored the highest in PVs (Gallegos & Sortedahl, 2015). Similarly, in Turkey, Cetinkaya-

Uslusoy et al. (2017) found that non-inpatient ward nurses (nurse directors, educator nurses, operating nurses, and those in other positions) scored significantly higher in this area than inpatient ward nurses. Therefore, nurses in these roles value the basic core values of caring but more highly value supporting the profession and advocacy. Since nurse leaders have influence over the practice environment (Kantek & Kaya, 2017), nurses in leadership roles should take great care to motivate nurses. The latter practice will enhance these nurses' perceptions of advocacy and the development of their PV strength.

Organizational Resources. Previous studies have examined the professional development resources organizations provide to reveal whether resources strengthen nurses' PVs and ethical attitudes toward patient care. In a sample of Turkish hospital nurses, 72.5% reported taking in-service ethics training, and these nurses achieved higher PV scores than those who did not attend this training (Cetinkaya-Uslusoy et al., 2017). These results supporting the idea that resources provided by an organization make a positive impact. Similarly, Monroe (2019) found a modest, positive correlation between strong PVs orientation and ethics education in practice via a convenience sample of all registered nurses in Washington State. Conversely, Torabizadeh et al. (2019) found no significant PV differences after nurses took ethics workshops among OR nurses and nurse anesthetists. Based on this evidence, one could conclude that ethics and professional development training may have an effect on PVs. However, the context in which such courses are offered and the value the nurses place on the training, among

other possible variables, affect the nurses' attitudes toward the training and thus how impactful it is.

In clinical research, professional nursing values have varied in relation to a number of extrinsic environmental factors, including organizational culture, colleagues, roles, and organizational resources. As with time factors, inconsistencies have further supported the need to understand organizational culture's influence on nurses' PVs. As nursing roles expand, and organizations seek guidance from nurses to patient-center their organizations, nurses are experiencing new practice environments. Therefore, as in clinical nursing, these nurses may need resources to support them as they face new challenges related to time and environmental changes. However, few studies have specifically measured the values of nurses in payor rather than provider organizations. With the continuous expansion of nursing roles, the values held by those in unique or less common roles should be studied to expand PV knowledge in nursing.

Indirect-Care Nurses in the Health Insurance Industry

The extent to which clinical PV nursing studies are generalizable to payor rather than provider environments, specifically professional nurses in the payor industry, is not known. However, since nurses in all practice environments are expected to maintain all of the profession's values (ANA, 2015), and the PVM should be tested in a variety of practice environments (Kaya & Boz, 2019), studying payor industry practice environments could provide useful knowledge to the profession. Additionally, physical environmental differences between provider and payor environments include a corporate nature and an indirect practice methodology. Thus, this section justifies how the payor

industry environment is unique based on these two characteristics, indicating the significance of testing the PVM in this environment.

The traditional image of the caring nurse has been evolving since Florence Nightingale first recognized the profession was not only scientific but also inextricably linked to human dignity (Rassin, 2008). In part, the evolution of the nurse can be seen in contemporary roles that bridge boundaries between patients and services (Fraher et al, 2015). Thus, the sample from this study focuses on nurses in the health insurance industry, including boundary-spanning nursing roles that are both corporate and indirect. I did not find literature on nurses in the health insurance industry as they pertain to PV dimensions or impact quality of care.

Societal Changes on Nursing

The rise of a global economy, world consumerism, and rapid advancements in science and technology have created a global society that must continually adapt (Bruce, 2018). For example, in the field of public administration, societal changes in the fields of economics and consumerism have in turn caused changes in professional identity, so new roles have emerged (McCabe et al., 2016). Additionally, such societal changes affect health care. The ultimate goals of U. S. health care include forming a system that provides personalized, patient-centered, affordable care (The U.S. Department of Health and Human Services, 2020). As the largest group of health care professionals, nurses play an important role in driving the value of care (Fraher et al., 2015).

In recent years, there has been a growing recognition of nurses' contributions to value in health care (Platt et al., 2019). Value-based care entails better care and lower

health care costs (Hargan, 2020). Payors like the Centers for Medicare and Medicaid Services (CMS) are shifting away from fee-for-service payments that reward volume to instead emphasize value reimbursement and overall population health. Such changes lead to professional role changes. Furthermore, these healthcare reform changes have caused both providers and payor organizations to create new roles, shifting their focus from acute care to preventative care (Fraher et al., 2015). From health care reform, more nursing roles have emerged in population health, coaching, informatics, and other managed care positions (Fraher et al., 2015).

As new roles in care management appear through healthcare reform, education should shift resources to specifically address expanding, diverse nursing roles (Fraher et al., 2015). Although it is necessary to prepare nurses during the formal education process for a constantly changing, diverse healthcare system (Bruce, 2018), almost 80% of new nurses work in hospitals (Kovner et al., 2016). Even so, preparation for diverse and evolving aspects of roles in nursing should not be overlooked.

One way to address this need to prepare nursing students for diverse roles is by offering education in healthcare economics. Infusing healthcare economics into BSN curricula would help future generations of nurses, but it would not impact currently practicing nurses (Platt et al., 2019). However, after concluding their formal education, nurses continue to develop their professional identities in their professional environments (Gazaway et al., 2018; Shao et al., 2018) and through continuing education (Skela□Savič et al., 2017). Regarding the latter, 84.4% of nursing administrators rated health care reform and health insurance skills as useful or very useful (Platt et al., 2019). However,

the profession is not currently prepared to officially develop nursing competencies in this area. Therefore, a clear gap exists in continuing education concerning adding value, cost containment, financial, and health care economics courses for nurses. This shortage is evidenced by the very few courses offered by Lippincott, the ANA, or the National Council of State Boards in Nursing (Platt et al., 2019). For this reason, nurses are not formally trained to prepare for adding value in healthcare economics, though the expansion of their roles in a changing society occasionally thrusts some nurses into these roles. As health care continues to shift from a non-profit to a for-profit business model (Ocak et al., 2020), knowledge of health care economics will become more valuable for nurses and other clinicians to adapt their practices in an increasingly competitive environment.

Infusing Clinical Value into Health Insurance

Value is defined by economists as the worth of a product or service minus the cost (Lindrooth et al., 2015), and the health care industry in the United States is expensive. Specifically, in 2019, the cost of health care in the United States was $3.6 trillion, with a projected spending growth of an additional 5.4% for 2019–2028, reaching $6.2 trillion by 2028 (Centers for Medicare & Medicaid Services, 2020). Of the nearly 3 million professional nurses in the U.S. at the time of this study, 39,650 were employed in all sectors of finance and insurance services (U.S. Bureau of Labor Statistics, 2020). Alongside 1,000 medical doctors (U.S. Bureau of Labor Statistics, 2020) and other non-clinical professionals, nurses drive value in the payor industry (Drayton & Weston, 2015). Thus, nurse leaders in the health insurance industry can be a catalytic force in the

movement toward increasing the value of care and decreasing cost (Drayton & Weston, 2015). Nurses in these roles also infuse value into organizations and are primarily responsible for navigating interactions between patients and providers because of their valuable skills in negotiating these relationships (Fraher et al., 2015). Furthermore, nurses in the payor industry serve as good stewards of patients and employers, ensuring high-quality, accessible care is provided (America's Health Insurance Plans, n.d.-a). Fraher et al. (2015) describes such roles as professional nursing "boundary spanners," connecting patients and services. In essence, professional nurses are a catalytic force in helping manage the $3.6 trillion dollars of American medical cash flow per year. Even so, there is little research available from these practice environments regarding how these nurses develop, demonstrate, and maintain their PVs, functions, and ideals in the payor environment.

Data typically used to measure nursing values in health care pertaining to cost in and of itself is not easily extrapolated. Economists refer to value as the value of a product or service with a benefit that results minus the costs (Lindrooth et al., 2015). In the same vein, value associated with nursing care has historically been measured by costs and outcomes associated with acute care rather than from data points capturing the unique, complex attributes of nursing care (Moon, 2019). However, the complexity that creates the aesthetic of nursing as a profession is described with regard to known costs and outcome data points and through other measurable variables. The latter include the impacts of nursing job satisfaction (Hui et al., 2020; Kantek & Kaya, 2017) and patient satisfaction (Geyer et al., 2018), which produces nursing care quality according to the

output of the PVM (Kaya & Boz, 2019). Using patient satisfaction as a data point, nurses were ranked the most trusted profession in Gallup's ethics survey in 2019 for the seventeenth year in a row (American Hospital Association, 2019). The value is really organizational and patient outcomes (Garcia & Jenkins, 2018). Studies that have attempted to quantify costs related to clinical nursing settings have revealed that nurses drive up value in health care. For example, they accomplish this aim through evidenced-based care by decreasing length of care (Yakusheva et al., 2014) and acute care hospital readmissions (Weis et al., 2011). With an average annual salary of $76,170, the payor industry invests over $3 billion each year in nurses (U.S. Bureau of Labor Statistics, 2020). This investment in nurses drives value by assisting their organizations with patient-centeredness by helping to promote evidenced-based practices and cost-effective uses of resources (Rowe, 2009).

A Distinct Practice Environment

The payor industry comprises a unique practice environment for nurses for two reasons: (1) Organizations that employ nurses have corporate natures, and (2) Roles include patient interaction conducted indirectly via means of digital technology.

Corporate Environment. The transformed health care system has created various new collaborative relationship opportunities (Fraher et al., 2015). Collaboration is a key part of nursing professionalism in all practice environments, outlined in Provision 2 (ANA, 2015), which contributes to the PVs of equality and altruism (Kay & Boz, 2019). Furthermore, nurses in the payor industry advocate for accessibility to high-quality nursing care (America's Health Insurance Plans, n.d.-a). The environment of the health

insurance industry differ from that of clinical organizations because there is a unique clinical-to-nonclinical colleague ratio, creating a corporate environment. In the health care insurance industry, only 3% of all employees are health care-trained practitioners, 40,000 of whom are nurses (U.S. Bureau of Labor Statistics, 2020). This ratio is drastically different from more typical clinical environments. That is, the healthcare industry is made up of 61% healthcare-trained professionals, 2.6 million of whom are professional nurses (U.S. Bureau of Labor Statistics, 2020). Due to differing collaborative opportunities, these environments provide situations unlike direct-care environments, where more collaborative opportunities exist among non-clinical, business professionals. Therefore, the latter is equivalent to a corporate practice environment.

Moreover, the health care industry has gradually become a large corporate business, dominated by managers (Ocak et al., 2020). Corporate environments are characterized by their competition, challenge, and pressure and are also associated with individuals focused on self-enhancement, often meaning prioritizing personal gain over ethical or organizational improvements (Arciniega et al., 2019). Although such practice environments offer unique opportunities for nurses, the ethics of business, and the ethics of health care are viewed there in opposition (Wicks, 1995). For this reason, Sellman (2011) encouraged nurses to endure the "corrupting influences" of the competitive, money-driven organizations that claim to be aiming for value in care. Despite this austere, cautionary advice, data have shown that nurses are contributing to business environments. The top four highest-paying industries for nurses are business support services, the federal executive branch, pharmaceutical and medicine manufacturing, and

aerospace product and parts manufacturing. In 2019, these environments employed nearly 85,000 nurses in the United States (U.S. Bureau of Labor Statistics, 2020). These business environments, as well as the health insurance industry, arguably make the overall environment more corporate than clinical due to their higher proportions of non-clinical professionals.

Beyond this, organizations aim to reduce the negative impacts of losing employees when they ensure their employees' values fit well with the organizational values (Wei, 2015). That is, to fit with an organization, professional and individual values and organizational values must align. Thus, this type of environment produces a potential conflict with nursing PVs such as integrity, equality, truth, and altruism. In recent years, the topic of corruption as it pertains to ethical issues in organizations and the health care industry has gained scholarly interest from both the business and health care professions (Ocak et al., 2020). This phenomenon further supports the need for nurses to explore roles in health care that are mixed with the business sector.

There is potential for conflict among nurses regarding business and caring. To begin, decision-making in health care assumes beneficence (Prestia et al., 2017). In clinical research, chief nursing officers who interact with stakeholders to prioritize human and financial resources attribute some of their moral distress to relationships found to be counterproductive. That is, they become stressed working with professionals who center their goals on enhanced personal or organizational gains (Prestia et al., 2017), confirming that supporting some collaborative business relationships can conflict with nursing values. The Code of Ethics for Nurses encourages those dealing with potential conflicts

between economic self-interest and professional integrity to withdraw from these situations or environments (ANA, 2015). Regarding the potential for businesses to differ from nurses in health care goals (Ocak et al., 2020; Platt et al., 2019), nurses should theoretically present with especially strong value orientations in the PV dimension of activism. As previously discussed, activism sometimes calls for respectful refusal to participate in certain collaborative decisions or actions in the form of conscientious objection, requiring confidence, autonomy, and strong advocacy skills (Lamb et al., 2019). Therefore, on the one hand, nurses in environments that contain many clinical and non-clinical professionals must espouse the PVs of truth and autonomy in their collaborative decision-making with their colleagues. However, on the other hand, a stronger orientation around this PV may not exist among nurses. Since extrinsic environmental factors affect PV orientation (Fernández-Feito et al., 2019; Şenyuva, 2018), this orientation may differ in practice from that found in studies conducted in clinical settings.

Technology. Although technology can be a source of ethical concern in health care (Bruce, 2018), it has also brought opportunity for the expansion of the profession, the capacity in which nurses practice, and the roles and settings in which nurses practice (Fraher et al., 2015). Virtual health care, also known as digital health, digital care, or telehealth, offers opportunities for reducing fragmentation in care and eases accessibility (Steingass & Maloney-Newton, 2020). For instance, in 2020, the COVID-19 pandemic caused the rapid development of technological health care innovations to reduce transmission of the virus. All aspects of nursing were impacted by the rapid progression

of the pandemic (Jackson et al., 2020), so technology provided an opportunity to make changes in nursing education and patient care. As a result of these changes, technology integrated clinical software to utilize information technology, harness automation in incident reporting, effect changes in emergency communication, and transition nonessential health care workers to telework from their homes emerged (Maben & Bridges, 2020). Similarly, mental health organizations quickly converted their supportive services to use an indirect, televirtual approach. At the same time, nursing educators hastily converted formal nursing education programs to virtual formats (Jackson et al., 2020). Due to the pandemic, it is more important than ever to develop an understanding of nurses who routinely interact with patients and providers indirectly through technology.

Digital or physically indirect patient care has been reported by both patient and nurses as providing positive outcomes (Schuelke, et al., 2019), although direct physical patient care is still viewed as the best way to provide care in clinical settings (Steingass & Maloney-Newton, 2020). In the latter environments among managers, supervisors, and other more hands-off positions, PVs have been measured to be stronger than those of direct-care nurses (Cetinkaya-Uslusoy et al., 2017; Gallegos & Sortedahl, 2015). Nurse leaders were employed in clinical organizations providing direct care, which this study established as a different type of practice environment than the payor industry. However, I did not locate current literature on the relationship between PVs and level or type of patient contact, which inspired this study's research question on this relationship.

The foremost nursing concept of caring is at risk in the twenty-first century (Bruce, 2018), and the unprecedented times caused by the COVID-19 pandemic could increase such risk. This risk has increased because the nursing profession has become task-focused, busy, and technologically dominated, moving away from being a genuinely caring profession (Adams, 2016). Additionally, increases in the use of technology in nursing care are expected to increase because of the pandemic, requiring the rapid evolution of nursing care (Jackson et al., 2020). Such changes in the way nursing care is provided will require ongoing efforts from organizations, researchers, nurses, and educators to continue developing the fundamental values of nursing professionalism. Thus, nursing roles in must evolve and be enhanced through technology, despite the risk that such action could negatively impact the value of caring.

The concept of caring, like the historical concept of what it means to be a nurse, is ambiguous in nature, as it is both a noun and an abstract concept infused with the current nursing metaparadigm (Adams, 2016). Because caring is described as a physical sense of compassion, displaying compassion and taking physical action to enhance human connectedness (Adams, 2016), caring may be absent in practice environments where patients are not physically present. Caring in the form of human dignity is a vital value in the nursing profession (ANA, 2015), so a distinctive shift away from this value in any practice environment could potentially cause a decrease in nursing care quality according to the PVM (Kaya & Boz, 2019). Caring is truly part of the nursing metaparadigm, epistemology, and ontology, and thus it remains of upmost importance to all nurses as a

PV (ANA, 2015). However, it is not currently known if practice via the use of technology only without direct patient contact correlates with the factors of PVs.

Nurses' Role in the Insurance Industry

The nursing role in the insurance industry is one that is necessary and underutilized. Additionally, nurses are also underprepared for this role. Nurses in leadership roles could enhance value-based care efforts but are often mistaken as functional "doers" rather than strategists contributing to changing the industry (America's Health Insurance Plans, 2020a). In the same vein, the payor industry nurses who are employed in U.S. health insurance organizations may be underutilized, which could mean they are also under-supported due to a known lack of formal and continuing education on financial and economic topics for nurses (Platt et al., 2019). Furthermore, nurses in all environments must still adhere to the profession's values (ANA, 2015). Different practice environments could mean that PVs will differ in priority, as has been demonstrated in previous clinical practice environment comparison studies (Fernández-Feito et al., 2019). Beyond this, the preparedness of the industry to employ more nurses to infuse value is not confirmed (America's Health Insurance Plans, 2020a). At the same time, these nurses' preparedness for participation in economically focused professional are unsupported (Platt et al., 2019). To recognize and support nurses in such roles, a first step would be to identify how this group of nurses perceives the importance of PVs.

Moreover, these new and expanded roles may include value-based ethical challenges. Even now, nurses in all settings encounter ethical challenges (Chisengantambu-Winters et al., 2019; Woods et al., 2015), sometimes related to

financial constraints (Prestia et al., 2017). However, decisions regarding values become inherently more challenging for nurses and non-clinical providers alike when a more costly treatment produces better outcomes than a less costly one (Lindrooth et al., 2015). Thus, difficult ethical decision-making is guided by the PVs in the Code of Ethics for Nurses calling nurses to espouse values based on patient advocacy, care, justice, and equality (ANA, 2015). Because nurses often lack formal education regarding health care economics (Platt et al., 2019), these nurses must apply PVs in new situations. Despite years of efforts by the U.S. federal government, employers, insurers, nurses, and physicians to improve access to quality, low-cost, and innovative health care, disparities persist (America's Health Insurance Plans, n.d.-a). In such situations, nurses must utilize strong activism and advocacy skills.

PVs are the fundamentals of nursing (ANA, 2015). Therefore, when beginning to explore a unique practice environment such as the payor industry, PVs are a good place to begin exploring that new environment. The impact of PVs and their applicability in making positive practice changes is clear in clinical settings, despite variance among the importance nurses place on different PVs.

Summary and Conclusions

This literature review has demonstrated that nursing PVs tend to change or disappear over time (Weis & Schank, 2009; Şenyuva, 2018; Torabizadeh et al., 2019). Additionally, nurses place different importance on each PV based on differing practice environments (Cetinkaya-Uslusoy et al., 2017; Kim et al., 2015, Şenyuva, 2018). Furthermore, factors of time can cause differing PV priorities (Fernández-Feito et al.,

2019, Gallegos & Sortedahl, 2015), and devaluing any PV puts nursing care quality at risk (Kaya & Boz, 2019). Therefore, nurses and organizations should make every effort to identify their PV orientations to identify how to best sustain them across time and in various environments. Beyond this, the U. S. payor industry provides a unique practice environment for nurses that differs from clinical settings due to the corporate and indirect nature of such a practice. Due to these differences, clinical PV studies may not be generalizable to these practice settings. To explore the under-recognized payor industry nurses, one could conduct a study specifically on these nurses rather than provider industry nurses.

In Chapter 3 I will discuss the research methodology most appropriate to answer my research questions. I will discuss in-depth the selected population, the planned sampling procedures, operationalization of variables, instrumentation details, data analysis plan, threats to validity, and ethical procedures.

Chapter 3: Research Method

The purposes of this quantitative, descriptive, correlational study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs. In this Chapter, I present the study's research design and rationale, methodology, sampling procedures, recruitment procedures and provide validity and reliability information to support the selected instrument (NPSV-3). I also provide operationalized definitions of each variable in the study. I then discuss the methodology, data analysis plan, threats to validity, and the ethical considerations as they pertain to this study.

Research Design and Rationale

The dependent variable in this study was professional nursing values as they pertained to nursing ethics. PVs as a whole impact the quality of nursing care in the conceptual PVM (Kaya & Boz, 2019). The NPVS-3 contained 28 items grouped into the subscale factors of Caring, Activism and Professionalism (Weis & Schank, 2017). The independent variables that impact the ability of the nurse to retain professional nursing values corresponded to years of nursing experience in the payor industry and the level and type of patient contact in their payor industry role. The three research questions were as follows:

RQ1: What are the PVs of corporate nurses in the Midwestern United States employed in the payor industry using Weis and Schank's (2017) NPVS-3?

RQ2: What is the relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and the professional nursing values measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

RQ3: What is the relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

A quantitative, descriptive, correlational design was used to answer the research questions. PVs could be measured both qualitatively through use of interviews and

quantitatively through use of a validated survey instrument. Because professional nursing values are to be known and demonstrated by all nurses (ANA, 2015), I decided to focus on analysis of the numerical data to identify patterns in the sample group and describe relationships between characteristics of corporate payor industry nursing and how nurses perceived the profession's values. Quantitative survey research is useful is to collect data on behaviors, characteristics, or attitudes (Burkholder et al., 2016). Nurses are expected to adhere to the values of the profession (ANA, 2015); therefore, there was utility in gathering quantitative data that measured the significance of PVs in nurses with varying amounts of experience in the insurance industry, as there are environmental factors that make insurance practice environments different from clinical environments where PV research has been focused. Quantitative methodology had been most often used in global studies of PVs due to the established nature of the profession's values. A descriptive, correlational design was selected to identify the association between years of indirect experience, level of patient contact, and PVs. A descriptive, correlational design is appropriate when assessing the strength of the relationship between numerical constructs (Howell, 2013). To measure the relationship between Weis and Schank's (2017) PV factors (Caring, Activism, Professionalism) and nurses in the practice environment as well as nurses with varying amounts of experience in the health insurance industry environment, correlations were calculated.

This quantitative, correlational study is consistent with research designs needed to advance knowledge in the nursing discipline. Quantitative studies advance knowledge in disciplines by generating knowledge through measuring variables in a valid and reliable

way (Houser, 2018). Descriptive design is useful when little is known about the question or population being studied (Houser, 2018). Little is known about nurses that work corporate, indirect-care nursing roles in the payor industry, which makes descriptive statistics in this study useful. Correlational design allows researchers to quantify the strength and direction of relationships between variables (Houser, 2018). It is imperative to explore the relationships between fundamental professional nursing values and factors indicative or nurse contribution to corporate environments.

There were minimal anticipated time and resource constraints with this quantitative, correlational study. The impact of the COVID-19 virus impacted all aspects of healthcare (Jackson et al., 2020); however, this quantitative study used a digital survey that was not obstructed by physical social distancing restrictions. The target population of nurses was minimally constrained in that some indirect-care nurses may have entered direct-care roles in clinical organizations to assist with COVID-19 impacts on their communities. Corporate payor industry nursing roles in assisting to manage resource allocation are also critical, so it was anticipated at the time of this study that most insurance nurses were still employed in their payor organization. Due to this, there was a possibility that some nurses that typically had indirect-care organization roles were excluded by the study criteria due to working in direct-care organizations, reducing the availability of potential participants.

Methodology

Population

In the United States, professional nurses have a registered nursing license (ANA, n.d.-c). Aligning with professional nursing values in the US, the population I targeted was registered nurses in the Midwestern United States. This region is home to over 730,000 of the nearly two million total registered nurses in the United States. There are around 40,000 registered nurses employed in the U.S. health insurance segments, but the exact geographic dispersion of insurance nurses by region is unknown (U. S. Bureau of Labor Statistics, 2020). This is in part due to corporate nursing not being recognized at the time of this study as a nursing subspecialty, which would provide nurses with resources and professional networking specific to their specialty as well as data on the population of nurses nationwide (ANA, n.d.-b). I was not able to identify any professional organizations specific to health professionals or nurses in the payor industry at the time of this study, which also could contain geographic data for a more specific target sample. For this study, the target sample was not precisely known, but recruitment in the Midwestern states was expected to contain a greater amount of insurance nurses than required by the study's minimum sample size.

Sampling and Sampling Procedures

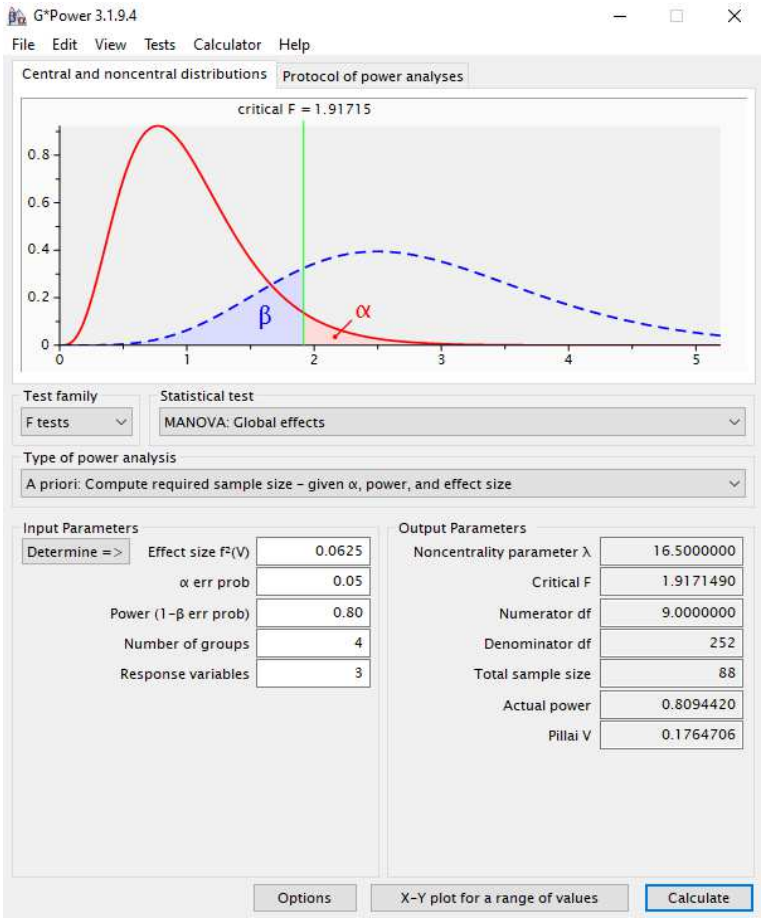
Convenience sampling was utilized to sample the Midwestern U. S. payor industry nurses. Convenience sampling targets participants due to their proximity to the researcher or ease of access (Creswell, 2014). The convenience sample included nurses with registered nursing licenses in the Midwestern US. The convenience sampling

method comes with an inherent risk, little opportunity for bias control (Creswell, 2014), but this was addressed in this study by taking measures to improve participant representation via sufficient recruitment to obtain equal groups. The inclusion criteria were nurses with active registered nursing licenses currently employed in any type of payor organization in the Midwestern US. The sample included nurses in any position or role and in any division of insurance including federally regulated, state regulated, and private. Nurses that did not have a registered nursing license or who were actively working in additional employment roles in a direct-care organization were excluded. Sampling occurred between January 2021 and March 2021.

A power analysis was performed in G*Power version 3.1.9.4 to determine the minimum sample size requirement for this study (Faul et al., 2014). The statistical analyses for this study involved the use of descriptive statistics, and planned Pearson correlations, and MANOVA if the assumptions of the tests were not violated. The MANOVA had the largest sample size requirement and was utilized in the power analysis calculation. The MANOVA incorporated three dependent variables (Caring, Activism and Professionalism), and one independent variable with four groups: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact. In addition, a power of .80 was utilized, a medium effect size (f^2 = .0625), and an alpha level of .05. With the described parameters, it was determined that a minimum of 88 participants would be sufficient for the data collection, with approximately 22 participants in each of the four indirect patient care groups (Figure 2).

Figure 2

*MANOVA G*Power calculation*



Procedures for Recruitment, Participation, and Data Collection

The NPVS-3 was electronically distributed to the sample registered nurses via method of convenience sampling. To recruit participants, social media public postings and individual emails were posted and sent to nurses respectively with Midwestern state nursing licensure. Nurse contact information was publicly accessible via board of nursing websites. Participation was anonymous and no personally identifiable information on the participants or the specific organizations in which they are employed was collected.

Demographic information was collected for the purpose of creating the comparison groups:

1. Age in years
2. Gender identity: (a) male, (b) female, or (c) not specified
3. Race: (a) African American, (b) Asian/Pacific Islander, (c) White, (d) Hispanic, (e) Native American or (f) Two or More Races
4. Years of registered nursing experience
5. Years of experience employed in the health insurance industry
6. Highest level of education: (a) Associate's, (b) Bachelor's, (c) Master's, or (d) Doctoral
7. Role in the payor organization: (a) Non-manager, (b) Manager, or (c) Director or higher
8. Level of patient contact: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact
9. Job satisfaction: (a) yes, (b) no, or (c) not certain

The demographic questions were supported in the literature with the uniqueness of this study being in the requested number of years of nursing experience and years in the health insurance industry. The question of job satisfaction was supported by the PVM (Kaya & Boz, 2019), and was previously used in a yes or no format with valid results in a professional nursing value study (Kantek & Kaya, 2017). With the 28 NPVS-3 Likert-scale items, the total number of questions participants must have answered for a complete

survey was 37. Participation was voluntary, and participants were able to exit the survey at any time by closing the survey or the internet browser window they were using. Recruitment posts and emails were reposted three times with reminders to participate.

I obtained lists of registered nurses' email addresses via board of nursing website list requests. I created a Survey Monkey account and included the participation to consent as an introductory webpage prior to participants being able to access any survey questions. Social media posts with recruitment information, including inclusion criteria and a link to Survey Monkey, were also employed simultaneously in addition to the emails to help narrow the recruitment focus. In order to proceed to the demographic and instrument questions, participants had to consent by selecting the "Next" button or else exit the survey. By employing both direct recruitment via social media where payor organization nurses may have been interacting, and a general email listing, I increased the potentiality of obtaining a more than sufficient sample size.

Instrumentation and Operationalization of Constructs

The NPVS-3 is an instrument based on the American Code of Ethics for Nurses with the purpose of measuring nurses' PVs (Weis & Schank, 2017). The tool was developed by Darlene Weis, PhD, RN and Mary Jane Schank PhD, RN of the Marquette University College of Nursing in Milwaukee, Wisconsin in 2017. The NPVS-3 is a revised version of the NPVS-Revised based on the changes to the Code in 2015 (ANA, 2015). The NPVS-R was based on the 2001 version of the American Nurses Code of Ethics. The Nursing PV Score (NPVS) was the original instrument based on the 1985 version of the American Nurses Code of Ethics for Nurses. The NPVS contained 11

provisions compared to the NPVS-R's nine provisions labeled under five PV dimensional factors of Caring, Activism, Trust, Professionalism, and Justice. The most recent NPVS-3 version of the instrument contains three factors: Caring, Activism and Professionalism.

At the time of this study, the NPVS-3 was the only instrument that measured nursing PVs based on the Code of Ethics for Nurses. The conceptual model selected for this study supports use of the instrument. Kaya and Boz (2019) indicated in their seminal study on the development of the PVM that the NPVS is appropriate for evaluation of the PVM. Permission was granted by Weis and Schank to use the NPVS-3 for my dissertation study on 10/09/2020 (see Appendix A).

Upon development of the NPVS-3 in 2017, psychometric analyses established the instrument's reliability and validity. Content validity was established on each of the 28 instrument items through review by three judges with expertise on the Code of Ethics for Nurses. Cronbach's alpha was used to measure the internal consistency of the instrument items compared to the whole (Weis & Schank, 2017). The instrument was tested for reliability and validity on a sample of nursing students ($N = 243$), nursing graduate students ($N = 237$), and practicing nurses ($N = 659$). Cronbach's alpha coefficient is a test that measures an instrument's reliability where a value approaching one indicates a shared covariance and probability that the instrument is measuring the same concept (University of Virginia Library, 2015). Results displayed good reliability of the instrument with an overall Cronbach's alpha coefficient value of ($\alpha = .944$) as well as for the three PV factors of Caring ($\alpha = .885$), Activism ($\alpha = .912$), and Professionalism ($\alpha = .799$).

Validity of the instrument was established using factor analysis. The number of factors was determined via use of three prior rules which when met, were retained on the instrument: (a) Cattell and Vogelmann's (1977) scree test, (b) factors with eigenvalue of one or greater, and (c) results that made theoretical sense (Weis & Schank, 2017). A minimum of .30 was used as the minimum factoring loading criterion for each item. Principal components analysis with varimax rotation and Kaiser normalization was used because items on the instrument were not thought to correlate each other, as they are not thought to correlate in the Code (Weis & Schank, 2017).

The previous Nurses PVs Scales have been used globally with various populations of nurses consistently reporting reliability of the instrument. The NPVS-R, the previous version of the instrument to the current, was seen to be consistently reliable—in the U. S., practicing nurses in a magnet hospital environment $\alpha = .93$ (Brown et al., 2015) and in Washington State nurses $\alpha = .92$ (Monroe, 2019), for example. The consistent reliability of the instrument in various cultures and practice environments supports the continued use of the instrument to measure nurses' PVs. For this study, internal consistency of the NPVS-3 were validated by use of Cronbach's alpha coefficient, where a value close to one indicated internal consistency of the tool with my study's sample population of payor industry nurses in the Midwestern United States.

The NPVS-3 ascertains the development and sustainability of nursing PVs (Weis & Schank, 2017). The NPVS-3 was appropriate for this professional nursing values study and sufficient for use in answering the research questions as it was the only known instrument at the time of this study that measured nursing PVs.

Operationalization

The dependent variable was professional nursing values measured by the interval scale NPVS-3 instrument. Professional nursing values in this study guiding by the PVM and operationalized by the NPVS-3 instrument were separated into categories highlighting primary values of the profession: Caring, Activism and Professionalism. The independent variables are factors of time and level of patient contact.

Factors of Time

The time-related factor variable was the nurses' total years of experience employed in the payor industry in any role or type of payor organization. There was little published information detailing the role types of nurses currently employed in the U. S. payor industry at the time of this study. Although the payor industry in general offers indirect-care services, the potentiality of nurses being employed by the payor organization but having aspects of roles including direct patient contact were included as a sampling group option.

Environmental Factors

The environmental factor in this study was labeled level and type of patient contact. Level and type of patient contact included type and amount of contact, divided into four subgroups: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact.

The NPVS-3 is a 5-point Likert scale with 28 total items. Each item contains a short phrase with interpretative wording based on the Code's 2015 provisions. Each item

ranges from 1 (not important) to 5 (most important). The items are all positively directed and there are no reverse scored items. Total scores were obtained by summing the totality of the responses, and the range of scores is 28 to 140. The variable was treated as a continuous variable, with higher scores indicating stronger PVs.

Data Analysis Plan

The data were downloaded from Survey Monkey and uploaded into SPSS version 25.0. The data was first examined for partial and missing responses. Surveys with mostly incomplete responses were removed from further analysis. Frequencies and percentages were used to identify trends in the nominal level variables, such as gender or education level. Means and standard deviations were examined for the interval level data, such as years of experience.

RQ1: What are the PVs of corporate nurses in the Midwestern United States employed in the payor industry using Weis and Schank's (2017) NPVS-3?

To address RQ1, exploratory data analysis was used to identify the trends in the PVs of nurses, using the NPVS-3. Composite scores were generated from a sum of the respective items in the NPVS-3 to measure the three dependent variables of interest: Caring, Activism, and Professionalism (Weis & Schank, 2017). Cronbach alpha was calculated to identify the internal consistency of the measures. The alpha values were interpreted through guidelines identified by George and Mallery (2016) where $\alpha > .9$ Excellent, $\alpha > .8$ Good, $\alpha > .7$ Acceptable, $\alpha > .6$ Questionable, $\alpha > .5$ Poor, $\alpha < .5$ Unacceptable.

Exploratory data analysis involved the examination of descriptive statistics, such as minimum, maximum, mean, standard deviation, and range. Kolmogorov-Smirnov tests were used to identify whether the three variables of the NPVS-3 followed a normal distribution. The Kolmogorov-Smirnov test compared the test data to a true bell-shaped curve (Field, 2013). Significance in a Kolmogorov-Smirnov test indicates that the data do not follow a bell-shaped distribution. Nonparametric statistics were considered a back-up for the inferential analyses to address RQ2 and RQ3.

RQ2: What is the relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

To address RQ2, a Pearson correlation matrix was to be conducted to examine the association between years of indirect nursing experience and professional nursing values, as measured by the NPVS-3. A Pearson correlation is appropriate when assessing the two-way association between continuous-level variables (Pallant, 2013). Years of indirect

nursing experience was a continuous variable and was measured as a fill-in-the-blank response on the survey. The three NPVS-3 scales (Caring, Activism, and Professionalism) were also continuous measurements.

Prior to analysis, the assumption of linearity and normality was tested on the data. Linearity was assessed with a series of scatterplots between years of experience and each of the three NPVS-3 scales. An approximate positive or inverse trend indicated that the assumption of linearity is met. Normality was tested in RQ1 through using Kolmogorov-Smirnov tests.

After the assumptions were examined, the Pearson correlations were to be run. Correlation coefficients can range from 0 (no linear relationship) to ± 1 (perfect positive linear relationship) or -1 (perfect negative linear relationship). Positive coefficients identify a direct relationship, such that as one variable increases, the second variable also tends to increase. Negative correlation coefficients identify an inverse relationship, such that as one variable increases, the second variable tends to decrease. Cohen's standard (Cohen, 1988) was to be used to assess the strength of the correlation coefficients, in which coefficients between .10 and .29 represent a small association; coefficients between .30 and .49 represent a medium association; and coefficients above .50 represent a large associate or relationship. The nonparametric Spearman's Rho tests were considered the back-up in place of the Pearson correlations if the assumptions of the Pearson test were violated.

RQ3: What is the relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

To address RQ3, a MANOVA was to be conducted to assess for differences in PVs of nurses by level of patient contact. A MANOVA is appropriate when testing for differences in multiple continuous dependent variables between groups (Tabachnick & Fidell, 2013). The independent grouping variable corresponded to level of patient contact, with four possibilities: (a) routine, direct, physical contact, (b) some direct contact and some virtual or telephonic contact, (c) virtual or telephonic only, and (d) rare to no patient contact. The dependent variables corresponded to the three scales of the NPVS-3: Caring, Activism, and Professionalism.

Prior to analysis, the assumptions of a MANOVA were tested: normality and homogeneity of variance. Normality was tested in Research Question one through use of Kolmogorov-Smirnov tests. Homogeneity of variance was tested with Levene's test (Howell, 2013). Levene's test verifies that the spread of the NPVS-3 variables is approximately equal between the four groups of indirect patient care. Statistical

significance ($p < .05$) indicated that the assumption was not met. If homogeneity of variance is not met, the significance level for the individual ANOVAs will be cut in half (.05/2 = .025), which will make it more difficult to prove significant results (Tabachnick & Fidell, 2013).

Wilk's Lambda was to be used to determine whether there were multivariate differences in PVs of nurses by level and type of patient contact. If the multivariate test was significant, individual ANOVAs were to be conducted to examine the three scales of the NPVS-3 independently. If the individual ANOVAs were significant, post hoc analyses were to be conducted with Tukey comparisons to identify which groups for level of patient contact had significant differences. A nonparametric Kruskal-Wallis H test was considered to be the back-up if the assumptions of the MANOVA were not met.

Threats to Validity

External Validity

External validity is the extent to which results are generalizable to other settings and populations and different times (Gray et al., 2017). The extent to which my study's generalizability is valid for other indirect-care nursing settings or in other states is a threat to external validity. My strategy of recruiting from the Midwestern United States licensed registered nurses' database and posting public recruitment posts via professional social media websites as well as including any type of payor organization as inclusion criteria for nurses decreased the risk of selection bias. As this study was voluntary, there was the potential threat to external validity of volunteer bias. Volunteer bias poses a threat because the people that chose to participant may not be representative of the target

sample (Salkind, 2010). Using volunteers for a survey study was unavoidable. The Hawthorne effect is another threat to external validity characterized by participants responding in ways they believe are expected of them (Frey, 2018). As the NPVS-3 asked participants to indicate their perceptions, it is a possibility that the participants were untruthful in their responses to answer in a socially acceptable manner.

Internal Validity

Instrumentation poses a potential threat to internal validity. The threat to internal validity causes low reliability through instrumentation when there is inconsistency in the scores (Gray et al., 2017). To mitigate this threat to internal validity, I chose to use an instrument derivative that had proven reliability over time in various practice settings. The NPVS-R was validated in previous studies to have reliable internal reliability (Brown et al., 2015; Monroe, 2019).

Another threat to internal validity that may have occurred was my own bias as a researcher. I was previously employed in one type of payor organization in the US. I may have had preconceived notions about being a corporate, payor organization nurse, and how this experience may impact PVs. History was not expected to pose a threat to the internal validity of this study because I collected data via a onetime survey.

Construct Validity

Construct validity refers to the ability of something to measure what it was intended to measure (Mathison, 2005). No instrument has perfect validity; it is not possible to measure professional nursing values with no uncertainty. The NPVS-3 has been shown to be internally reliable in its factor testing on creation (Weis & Schank,

2017). The creators of the PVM listed the NPVS derivatives as instruments that could be used to test the model (Kaya & Boz, 2019), ensuring construct validity.

Ethical Procedures

An application for permission to access participants and collect data was approved by the Walden University Institutional Review Board under approval 01-15-21-0621229 on 1/15/21. Participants were recruited via social media public postings and individual emails. Email addresses were publicly accessible data obtained via board of nursing information website requests. Participants were then provided a weblink to the survey. Individuals who selected the link accessed a study information and a consent webpage that presented inclusion and exclusion criteria to participate. Individuals were asked to voluntarily participate if they (a) were currently employed by a health insurance industry organization in the Midwestern United States and (b) were not dually employed in a direct-care organization such as a hospital or clinic. Anyone who wished to continue with the survey was asked to select "Next" on the survey screen. The participant was then directed to demographic study questions followed by the NPVS-3 survey questions. If the participant chose not to proceed by selecting "Cancel," an exit screen appeared.

Participation in this study was voluntary. Personally identifiable information such as state of residence, participant name, or organization name were not collected. Participants' survey responses were assigned numbers as identifiers for data analysis. Data were secured by the Survey Monkey website as well as stored on a password protected computer in a locked file cabinet.

Summary

The purposes of this study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs. A quantitative, descriptive, correlational design was used to answer the research questions. Registered nurses in the Midwestern United States employed in payor organizations were selected as the target population. Participants were recruited through posts on social media websites and via individual emails. Participation was voluntary and anonymous. Surveys were offered through Survey Monkey. Descriptive statistics, Pearson correlations, and MANOVA tests were planned to analyze the data using SPSS. Nonparametric tests of Spearman's rho, if the assumptions of the Pearson test were violated, and the Kruskal-Wallis H test—if assumptions of the MANOVA were violated—were planned as back-ups.

The results of the data analysis are reported in Chapter 4.

Chapter 4: Results

Introduction

The purposes of this quantitative, descriptive, and correlational study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs. The three research questions were as follows:

RQ1: What are the PVs of corporate nurses in the Midwestern United States employed in the payor industry using Weis and Schank's (2017) NPVS-3?

RQ2: What is the relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and the professional nursing values measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3.

RQ3: What is the relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3?

H_0: There is no relationship between patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

H_1: There is a relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3.

In Chapter 4, I discuss the data collection procedures, including actual recruitment and response rates, discrepancies in data collection, demographic characteristics of participants, and basic univariate analyses. I then discuss the results of the study, including statistical analyses.

Data Collection

The online survey was opened for data collection from 1/16/2021 to 3/15/2021. The recruitment flyer approved by Walden University's IRB was used to recruit participants via email and by social media posts. The target population for this study proved to be challenging to recruit because there was no centralized location in social media. Few social media groups were found that included payor industry nurses. In anticipation of this challenge, both a broad recruitment strategy was used—including emails and social media posts—and a more targeted strategy was used, including employment data and private messages in LinkedIn.

Publicly accessible email addresses of registered nurses were obtained via requests to the Midwestern board of nursing website. Recruitment flyers were emailed to registered nurses on 1/18/21, 3/8/21 and 3/10/21. Reminder emails were sent to the same nurses 1/20/21 and 3/13/21. Of the 106,559 total emails sent to Midwestern registered nurses, 171 chose to anonymously participate in the survey.

Using the same email recruitment flyer, various social media platforms were used to recruit participants. Facebook, Reddit, LinkedIn, Instagram and Twitter were used with a combination of relevant hashtags (#nurse, #registerednursing, #insuranceindustry, #research). Post locations in relevant registered nurse and insurance social media groups, and advertisements in LinkedIn and Facebook were used. Each platform received an initial recruitment post and two reminder posts. Some participants chose to share the post with their colleagues, unprompted by the researcher.

On 2/2/21, a request for change in procedure was approved by Walden University's IRB to add an additional step to the recruitment strategy with the objective to boost response rates. I was approved to contact LinkedIn members employed in the payor industry directly via private message and request they share the recruitment flyer with their colleagues. Fifty registered nurses across the 11 Midwestern states in 21 different organizations and roles received the flyer text and were asked to share the recruitment flyer information with the organizations' registered nurses on my behalf. The person search feature was used in LinkedIn to identify nurses that were employed in the insurance industry, had RN licenses, and whose locations were listed in a Midwestern state. Twenty registered nurses participated by taking the survey across all social media

recruitment methods. By 3/15/2021, I collected 171 attempted responses across email and social media recruitment strategies, 144 of which were complete surveys.

The majority of respondents were white (*n* = 132, 91.7%), females (*n* = 135, 93.8%) between the ages of 22 and 74, with the majority of respondents between 50–59 years of age (*n* = 45, 31.3%). Eight participants (5.6%) did not provide their age. Of the ages that were provided (*n* = 136), the average participate age was 49.10 (*SD* = 12.217) years. The majority held bachelor's degrees (56.3%) and were non-managers (*n* = 111, 77.1%). Nurses with rare to no contact with patients made up the most populated level and type of patient contact group (*n* = 50, 34.7%) followed closely by nurses with routine direct (in-person) physical contact with patients (*n* = 46, 31.9%).

Respondents reported having between 0–52 years of RN experience with a mean of 20.80 (*SD* = 12.958) total years of RN experience. Two participants (1.4%) did not indicate their total years of RN experience but completed the survey otherwise (*n* = 142). Most nurses in the sample reported having more than 26 total years of RN experience (*n* = 54, 37.5%). Respondents reported having 0–40 years of experience in the industry with the majority of respondents having 0–5 years of experience in the payor industry (*n* = 59, 41.0%). Two participants did not indicate their years of experience in the payor industry (1.4%). The mean years of experience (*n* =142) in the payor industry was 9.99 (*SD* = 9.496) years (Table 1).

Table 1

Summary of Sample Demographics

Attribute	*f*	%
Age		
20-29	14	9.7
30-39	15	10.4
40-49	32	22.2
50-59	45	31.3
60+	30	20.8
Unlisted	8	5.6
Gender		
Female	135	93.8
Male	9	6.3
Race		
African American	3	2.1
Asian/Pacific Islander	1	0.7
White	132	91.7
Hispanic	4	2.8
Native American	1	0.7
Two or More Races	3	2.1
Education		
Associate's	36	25.0
Bachelor's	81	56.3
Master's	23	16.0
Doctoral	4	2.8
Role		
Non-manager	111	77.1
Manager	21	14.6
Director or higher	12	8.3
Patient Contact		
Routine direct (in-person)	46	31.9
Some direct, some virtual	26	18.1
Virtual/telephonic only	22	15.3
Rare to no contact	50	34.7
Years RN (total)		
0-5	18	12.5
6-10	16	11.1
11-15	30	20.8
16-20	14	9.7
21-25	10	6.9
26+	54	37.5
Unlisted	2	1.4
Years payor RN		
0-5	59	41.0
6-10	31	21.5
11-15	21	14.6
16-20	9	6.3
21-25	8	5.6
26+	14	9.7
Unlisted	2	1.4

Note. N =144. Two responses missing for each experience demographic (1) years of experience as an RN and (2) years of experience in the payor industry did not disclose this value (*n* = 142). Eight responses missing for age (*n* = 132).

Respondents were asked to report their current satisfaction with their corporate, payor role by indicating (a) yes, (b) no, or (c) not certain. Most participants (*n* = 111, 77.1%) reported they were satisfied with their job (Table 2).

Table 2

Satisfaction with Corporate Job

Response	*f*	%
Yes	111	77.1
No	13	9.0
Not Certain	20	13.9

The sample represented a population of licensed registered nurses in the Midwestern states. The recruitment flyers invited licensed registered nurses from any of the 11 Midwestern states to participate if they met the study inclusion and exclusion criteria. No geographic data was collected in the survey, nor was any personally identifiable or organizationally identifiable information collected. Email addresses were retrieved from publicly available board of nursing website requests without specification of state to mask data. There are approximately 40,000 registered nurses employed in the U. S. health insurance segments, but the exact geographic dispersion of insurance nurses by region of the United States is not known (U. S. Bureau of Labor Statistics, 2020). Thus, the completed survey participation of 144 responses in this study represents 0.36% of the U. S. insurance industry nurses of the US.

Results

In total, there were 144 NPVS-3 responses. The MANOVA for Research Question three required a minimum of 88 responses via G*Power calculation which was exceeded by the 144 responses received. Seven respondents failed to answer between one and three of the NPVS-3 items. The percentage of items missing was reviewed and interpreted as having minimal impact on the data analysis (n = 7; 4.86% respondents missed responses on NPVS-3). As only 0.19% (9 missing responses) of the total NPVS-3 data was missing across seemingly random survey items, a sum of means procedure was conducted in SPSS to provide values for missing NPVS-3 items.

Internal consistency of the NPVS-3 on the studied population of corporate nurses was validated using Cronbach's alpha coefficient, where a value closer to one indicated internal consistency of the tool. All three factors presented either excellent or good internal consistency based on guidelines by George and Mallery (2016) (Table 3). Descriptive statistical tests were conducted to determine the mean, standard deviation, range, and Cronbach's alpha coefficient overall and by NPVS-3 factors. The total possible composite scores possible were between 28 and 140 (Weis & Schank, 2017). In this sample (N = 144), the mean composite NPVS-3 score was 110.66 (SD = 15.256), indicating relatively high overall PVs by the corporate nurses. Considering 100% PV scores by factor as all responses scored "most important" and factor means across this sample, nurses most highly valued the PV factor Caring (87.3%), followed by Professionalism (74.7%), and Activism (74.3%).

Table 3

Composite PV Scores

Factor	*M*	*SD*	Range	Cronbach's α
PV Total Score	110.66	15.256	58-140	.945
Caring	43.64	5.524	30-50	.916
Professionalism	29.89	4.865	17-40	.844
Activism	37.13	6.873	11-50	.898

Note. Total possible composite scores range from 28–140 overall, 10–50 (Caring), 10–50 (Activism), and 8–40 (Professionalism).

The individual item ranks indicated the factor of Caring obtaining the overall highest mean scores across the sample (Table 3). The top eight highest ranked statements (based on mean) were all under the Caring factor in the overall sample (Table 4). The item with the highest sample mean was "Act as a patient advocate" (*M* = 4.5625, *SD* = .67646) while the lowest scoring item was "Participate in peer review" (*M* = 3.1528, *SD* = 1.00571), part of the Professionalism factor.

Table 4

NPVS-3 Scores by Item

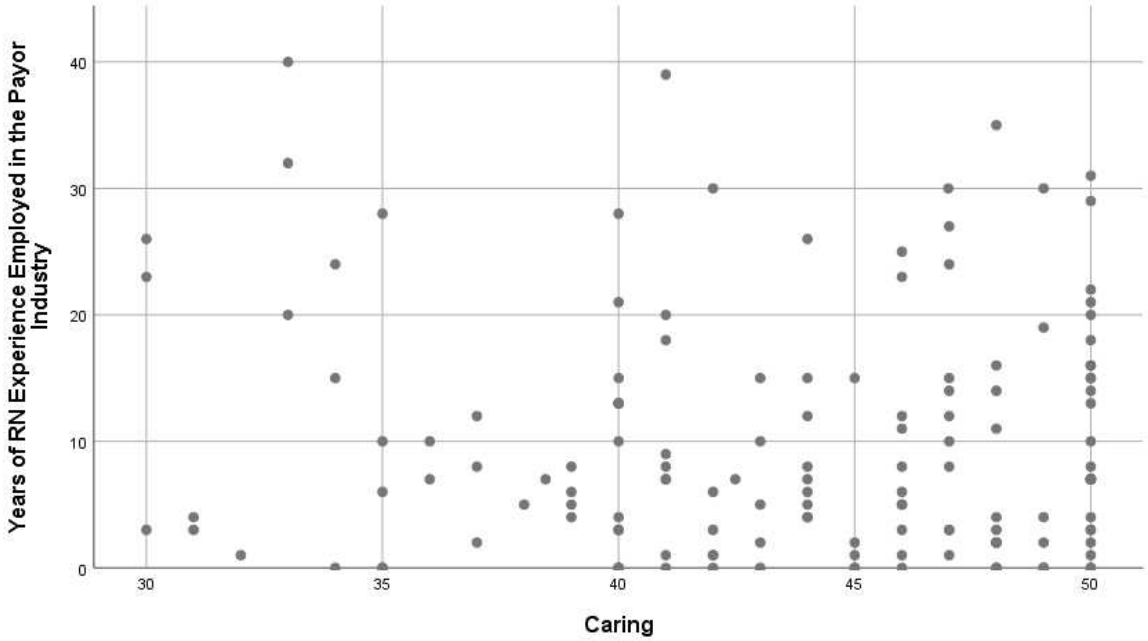
	Factor	Range	Min.	Max.	*M*	*SD*	Variance
Act as a patient advocate.	Caring	4.00	1.00	5.00	4.5625	.67646	.458
Provide care without bias or prejudice to patients and populations.	Caring	3.00	2.00	5.00	4.4965	.67807	.460
Protect health and safety of the patient/public.	Caring	2.00	3.00	5.00	4.4792	.65813	.433
Safeguard patient's right to confidentiality and privacy.	Caring	3.00	2.00	5.00	4.4718	.69658	.485
Protect moral and legal rights of patients.	Caring	3.00	2.00	5.00	4.4583	.70834	.502
Respect the inherent dignity, values, and human rights of all individuals.	Caring	3.00	2.00	5.00	4.4545	.68681	.472
Accept responsibility and accountability for own practice.	Caring	2.00	3.00	5.00	4.4236	.64320	.414
Practice guided by principles of fidelity and respect for person.	Caring	3.00	2.00	5.00	4.2708	.76842	.590
Actively promote health of populations.	Activism	4.00	1.00	5.00	4.1111	.80306	.645
Recognize professional boundaries.	Profess.	3.00	2.00	5.00	4.0694	.74470	.555
Assume responsibility for personal wellbeing.	Profess.	2.00	3.00	5.00	4.0559	.68731	.472
Assume responsibility for meeting health needs of diverse populations.	Activism	4.00	1.00	5.00	4.0417	.85995	.740
Confront practitioners with questionable or inappropriate practice.	Caring	4.00	1.00	5.00	4.0140	.81923	.671
Protect rights of participants in research.	Caring	4.00	1.00	5.00	4.0069	.93492	.874
Seek additional education to update knowledge and skills to maintain competency.	Profess.	4.00	1.00	5.00	3.9931	.77996	.608
Establish collaborative partnerships to reduce healthcare disparities.	Activism	4.00	1.00	5.00	3.9375	.94031	.884
Engage in consultation/collaboration to provide optimal care.	Activism	4.00	1.00	5.00	3.9167	.90453	.818
Establish standards as a guide for practice.	Profess.	4.00	1.00	5.00	3.7972	.89723	.805
Initiate actions to improve environments of practice.	Profess.	4.00	1.00	5.00	3.7847	.87036	.758
Promote mutual peer support and collegial interactions to ensure quality care and professional satisfaction.	Activism	4.00	1.00	5.00	3.7273	.89429	.800
Participate in professional efforts and collegial interactions to ensure quality care and professional satisfaction.	Activism	4.00	1.00	5.00	3.6736	.96679	.935
Advance the profession through active involvement in health-related activities.	Activism	4.00	1.00	5.00	3.5694	.97272	.946
Promote and maintain standards where planned learning activities for students take place.	Profess.	4.00	1.00	5.00	3.5347	1.08333	1.174
Engage in ongoing self-evaluation.	Profess.	4.00	1.00	5.00	3.5000	.89286	.797
Recognize the role of professional nursing associations in shaping health policy	Activism	4.00	1.00	5.00	3.4895	1.08304	1.173
Participate in nursing research and/or implement research findings appropriate to practice.	Activism	4.00	1.00	5.00	3.3403	1.00463	1.009
Take action to influence legislators and other policy makers to improve health care.	Activism	4.00	1.00	5.00	3.3264	1.03660	1.075
Participate in peer review.	Profess.	4.00	1.00	5.00	3.1528	1.00571	1.011

Note. Table depicts descending rank order by individual NPVS-3 item mean for total sample ($N = 144$).

To answer research questions two and three, Kolmogorov-Smirnov tests were used to identify whether the three factor variables of the NPVS-3 followed a normal distribution. A normal distribution is an assumption of both the Pearson correlation matrix (Pallant, 2013) for Research Question two, and the MANOVA (Tabachnick & Fidell, 2013) for Research Question three. The sample distribution for Caring (p = .000) and Professionalism (p = .027) were not normally distributed; however, Activism was normally distributed (p = .200). Scatter plots were created for each of the factors and years of experience in the payor industry to determine linearity. Linearity was an assumption of both the Pearson correlation (Pallant, 2013) and the MANOVA (Tabachnick & Fidell, 2013). The factors Activism and Professionalism demonstrated nonlinear nonmonotonic relationships (Figures 3 and 4). A weak positive linearity was noted on visual scatter plot of the factor Caring (Figure 2) and years of experience in the payor industry. After consultation with a statistician, and due to the inconsistency in the distribution and linearity of the data among the NPVS-3 factors which are assumptions of the parametric Pearson and MANOVA statistical tests, nonparametric tests were used to evaluate correlations between years of experience in the payor industry and level of patient contact and PVs.

Figure 3

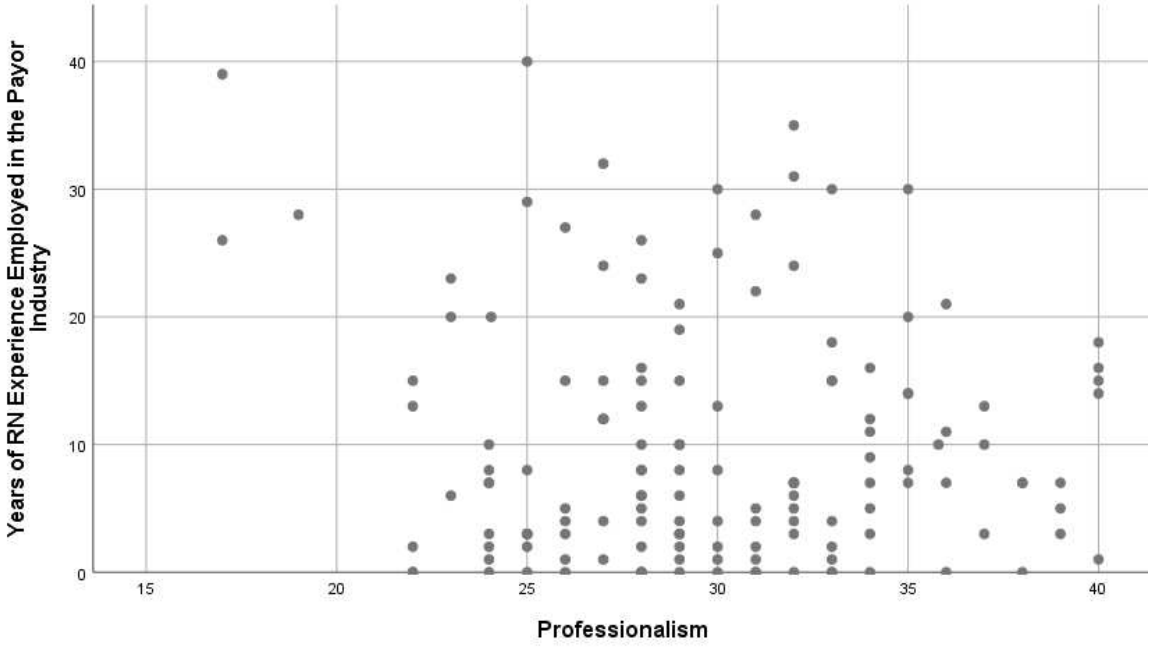
Scatterplot of years of RN experience in the payor industry by caring factor



Note. Factor Caring as part of the NPVS-3 included ten items with possible scores ranging from 10–50.

Figure 4

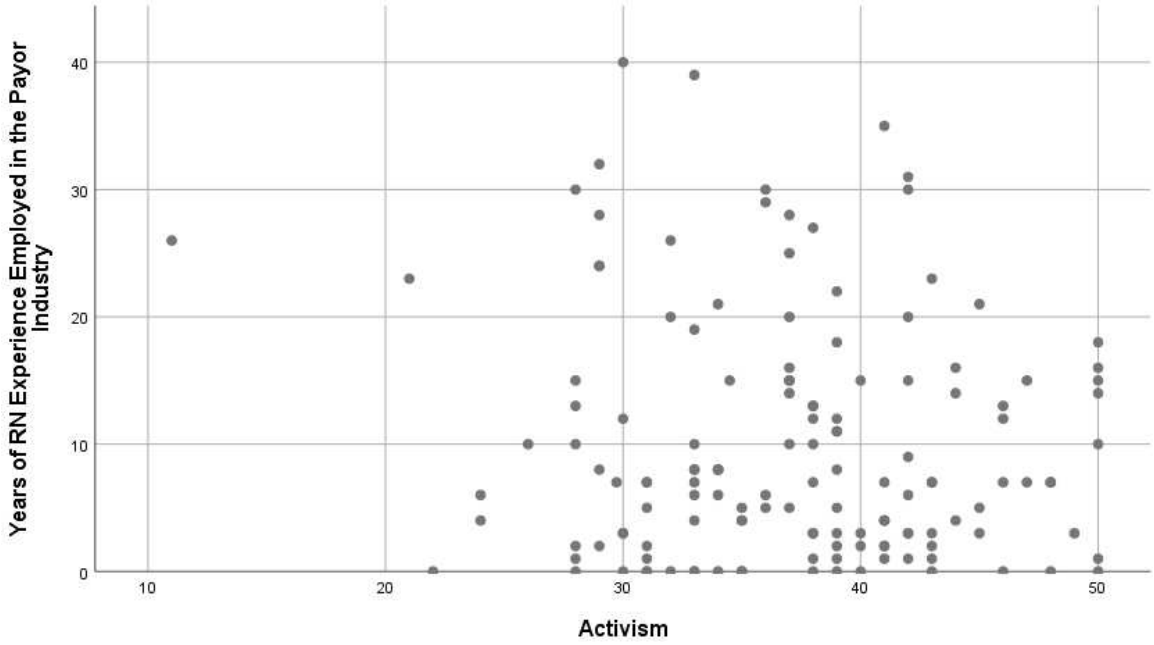
Scatterplot of years of RN experience in the payor industry by professionalism factor



Note. Factor Professionalism as part of the NPVS-3 included eight items with possible scores ranging from 8–40.

Figure 5

Scatterplot of years of RN experience in the payor industry by activism factor



Note. Factor Activism as part of the NPVS-3 included ten items with possible scores ranging from 10–50.

To answer RQ2, a Spearman's rho correlation was used to determine if there was significance between the continuous variable of years of experience in the payor industry and factors in the NPVS-3. The RQ2 hypothesis was as follows: there is a relationship between years of indirect nursing experience in corporate roles of the payor industry among nurses in the Midwestern United States and professional nursing values measured by Weis and Schank's (2017) NPVS-3. Years of experience in the payor industry did not significantly correlate with Caring (p =.797), Professionalism (p =.836) or the Activism (p =.604) factor in the NVPS-3 (Table 5). The null hypothesis for RQ2 was thus retained. When grouped, nurses with 16 to 20 years of experience had the highest PV composite

mean (*m* = 118.006, *SD* = 16.999), compared to nurses with 0–5 years (*M* = 110.390, *SD* = 13.866), 6–10 years (*M* = 110.7887, *SD* = 14.817), 11–15 (*M* = 114.928, *SD* = 14.452), 21-25 (*M* = 107.000, *SD* = 18.032), and over 26 years (*M* = 102.142, *SD* = 18.756). Spearman's rho tests were additionally run on each of the 28 individual NPVS-3 items for identification of statistical significance between years of experience in the payor industry and each item score (ranges of each item 1–5). No statistical significance was noted on any item.

Table 5

Spearman's Rho for Years of Experience and NPVS-3 Factors

			Years of RN experience in the payor industry
Spearman's rho	Years of RN experience employed in the payor industry	Correlation coefficient	1.000
		Sig. (2-tailed)	.
	Caring	Correlation coefficient	.022
		Sig. (2-tailed)	.797
	Professionalism	Correlation coefficient	.018
		Sig. (2-tailed)	.836
	Activism	Correlation coefficient	-.044
		Sig. (2-tailed)	.604

RQ3 addressed the four groups of level and type of patient contact and the three factors of the NPVS-3. The hypothesis surmised that there is a relationship between level of patient contact in corporate roles of the payor industry among nurses in the Midwestern United States and PVs measured by Weis and Schank's (2017) NPVS-3. Nurses with some direct contact and some virtual or telephonic contact had the highest composite PVs score (Table 6). Nurses with some direct contact and some virtual or

telephonic contact also had the highest Caring score (*M* = 44.58, *SD* = 5.486), and Activism (*M* = 38.81, *SD* = 6.499). Nurses that had some direct contact with patients and some virtual or telephonic contact also had the highest mean NPVS-3 composite scores (*M* = 113.6154, *SD* = 15.06274). Nurses with rare to no contact with patients had the highest Professionalism mean (*M* = 30.46, *SD* = 4.990) (Table 7).

Table 6

Composite NPVS-3 Scores by Level and Type of Patient Contact

Level and type of patient contact		NPVS-3 total		
	n (%)	Range	*M*	*SD*
Routine direct	46 (31.9%)	74-140	108.5695	15.83111
Some direct	26 (18.1%)	88-140	113.6154	15.06274
Virtual/tel. only	22 (15.3%)	86-130	109.3207	11.30823
Rare/none	50 (34.47%)	58-140	111.6345	16.37109

Table 7

Factor NVPS-3 Scores by Level and Type of Patient Contact

Level and type of patient contact		Caring			Professionalism			Activism		
	n (%)	Range	*M*	*SD*	Range	*M*	*SD*	Range	*M*	*SD*
Routine direct	46 (31.9%)	30-50	43.05	5.394	17-40	29.57	5.227	21-50	35.95	7.250
Some direct	26 (18.1%)	31-50	44.58	5.486	22-40	30.23	4.910	28-50	38.81	6.499
Virtual/tel. only	22 (15.3%)	31-50	43.95	4.990	24-39	28.87	3.691	24-45	36.50	5.837
Rare/none	50 (34.47%)	30-50	43.55	5.955	17-40	30.46	4.990	11-50	37.63	7.086

To answer RQ3, a Kruskal-Wallis H test was run to determine if there were differences in the three factor scores of the NPVS-3 between four groups of participants with different levels and types of patient contact: the routine direct, in-person contact (*n* = 46), some direct and some virtual or telephonic contact only (*n* = 26), virtual or

telephonic contact only (n = 22) and rare to no patient contact (n = 50) groups. Distributions of NPVS-3 subscales scores were similar for all groups, as assessed by visual inspection of a boxplot. Median NPVS-3 subscales scores were not statistically significantly different between groups (Table 8).

Table 8

Kruskal-Wallis H Test by Factor

Level and type of patient contact	*n* (%)	Caring *Mdn*	Professionalism *Mdn*	Activism *Mdn*
Routine direct	46 (31.9%)	43.50	29.00	36.00
Some direct	26 (18.1%)	46.50	30.50	40.00
Virtual//tel. only	22 (15.3%)	45.00	28.00	36.50
Rare to none	50 (34.47%)	44.50	30.00	38.00
Independent-samples Kruskal-Wallis		p = .628	p = .426	p = .296

Note. Kruskal-Wallis test *df* for each factor = 3.

Caring factor scores were highest among nurses with some direct (in-person) contact and some virtual or telephonic contact with patients (*Mdn* = 46.50), virtual or telephonic contact only (*Mdn* = 45.00), and lower in nurses with rate to no patient contact (*Mdn* = 44.50), and lowest in nurses with routine direct contact (*Mdn* = 43.50), although the differences were not statistically significant, $H(3) = 1.739$, $p = .628$. Nurses in the some direct (in-person) contact and some telephonic or virtual contact also had the highest median in the Professionalism subscale (*Mdn* = 30.50) and the Activism subscale (*Mdn* = 40.00), although the relationship was not statistically significant: Professionalism

$H(3) = 2.786$, $p = .426$; Activism: $H(3) = 3.695$, $p = .296$. Thus, the null hypothesis for RQ3 was retained.

Kruskal-Wallis H tests were also conducted on each of the 28 individual NPVS-3 items (scale range 1–5). A Kruskal-Wallis H test was conducted to determine if there were differences in item 5 ("Participate in peer review") scores between groups that differed in their level of patient contact: the routine direct, in-person physical ($n = 46$), some direct, some virtual or telephonic ($n = 26$), virtual or telephonic only ($n = 22$) and rare to none ($n = 50$) contact groups. Item 5 falls under the Professionalism ($\alpha = .844$) factor (Weis & Schank, 2017). Distributions of item 5 scores were similar for all groups, as assessed by visual inspection of a boxplot. Median item 5 scores were statistically significantly different between groups, $H(3) = 8.185$, $p = .042$. Although significance for item 5 was noted for the contact groups, there were not statistically significant pairwise comparisons between contact groups.

A Kruskal-Wallis H test also indicated differences in item 12 ("Establish collaborative partnerships to reduce healthcare disparities") scores between groups that differed in their level and type of patient contact. This item is part of the Activism ($\alpha = .898$) factor (Weis & Schank, 2017). Distributions of item 12 scores were similar for all groups, as assessed by visual inspection of a boxplot. Median item 12 scores were statistically significantly different between groups, $H(3) = 9.654$, $p = .022$. Subsequently for item 12, pairwise comparisons were performed using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons. Adjusted p-values were calculated. This post hoc analysis revealed statistically significant differences in item 12 scores between

the routine direct contact group (*Mdn* = 4.00) and rare to no contact group (*Mdn* = 4.00) (p = .014) but not between any other group combination.

Figure 6

NPVS-3 item 12 Kruskal-Wallis pairwise comparisons

Sample1-Sample2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj.Sig.
Routine direct (in-person) physical contact with patients-Virtual/telephonic contact with patients only	-14.420	10.210	-1.412	.158	.947
Routine direct (in-person) physical contact with patients-Some direct (in-person) contact and some virtual/telephonic contact with patients	-18.376	9.665	-1.901	.057	.343
Routine direct (in-person) physical contact with patients-Rare to no patient contact	-24.451	8.047	-3.038	.002	.014
Virtual/telephonic contact with patients only-Some direct (in-person) contact and some virtual/telephonic contact with patients	3.956	11.410	.347	.729	1.000
Virtual/telephonic contact with patients only-Rare to no patient contact	-10.031	10.077	-.995	.320	1.000
Some direct (in-person) contact and some virtual/telephonic contact with patients-Rare to no patient contact	-6.075	9.524	-.638	.524	1.000

Note. Significance values have been adjusted by the Bonferroni correction for multiple tests ($p < .5$).

Exploratory analyses were conducted on the remaining demographic variables to determine if there was significance between PV factors in the NPVS-3. Additional Spearman's Rho tests were conducted on participant age (n = 132) and total years of RN experience (n = 142) and Caring, Professionalism, and Activism. Significance at the $p <$

.05 level was not found among the continuous variables. Additional Kruskal-Wallis H tests were conducted on the demographic variables of education level (Associates, Bachelor's, Master's, Doctorates), role in the organization (non-manager, manager, director or higher), race (African American, Asian/Pacific Islander, White, Hispanic, Native American, Two or More Races), and job satisfaction (yes, no, not certain). No statistically significant findings among these demographic variables and the NPVS-3 dimensions were noted. There was not a statistically significant relationship between gender identity and PVs after conducting a Mann-Whitney U test.

I also conducted the planned parametric tests for research questions two and three on advice of a professional statistical consultant to verify the results although not all assumptions for these tests were met. A Pearson correlation matrix was created to answer RQ2 on the differences between years of experience in the payor industry and PV scores overall and by factor. A MANOVA was conducted for RQ3 on the same advice to determine correlations between level and type of patient contact and PV scores composite and by factor. Neither parametric test yielded statistically significant results, aligning with the results of the conducted nonparametric tests described in this chapter. Level of patient contact groups were experimentally transformed into only two groups from their original four groups: (1) routine or some direct contact and (2) telephonic or virtual contact or rare to no contact, without a different statistical conclusion.

To address abnormal factor distribution, data transformation using logarithmic 10 transformation in SPSS was applied to the factor distributions in the sample. Assumptions were retested, and parametric and nonparametric tests recalculated. The

data transformation did not yield statistically significant results. Again, by experimental advice from a professional statistician, the continuous variable of years of experience in the payor industry was transformed into six categories (0–5, 6–10, 11–15, 16–20, 21–25, and 26+ years) and subsequent one-way ANOVAs were run on each group against composite and individual factor scales of the NPVS-3, without significant results. Statistical significance was found between patient level and type of contact groups in Item 5 and Item 12 on the NPVS-3 only.

Summary

A total of 144 completed survey responses were received via social media and email recruitment methods. Descriptive statistics were conducted to answer RQ1 where it was noted the composite NPVS-3 score for all participants was 110.66 (*SD* = 15.256). Nurses most highly valued the Caring dimension (87.3%), followed by Professionalism (74.7%), and Activism (74.3%). Nonparametric statistical tests were used to answer the correlational research questions as the Kolmogorov-Smirnov tests indicated non-normal distribution between Caring and Professionalism, and non-linearity was noted between all three factors.

A Spearman's Rho correlation to answer RQ2 to determine if there were statistically significant correlations between years of experience in the payor industry and the three NPVS-3 factors identified no significance. No statistical significance was noted among years of experience in the payor industry and any of the 28 NPVS-3 items. Kruskal-Wallis H tests were conducted to answer RQ3 to determine if there were statistically significant correlations between the three NPVS-3 factors and the levels and

types of patient contact (4 groups). Although no statistical significance was noted between the three factors and level and type of patient contact, there was statistical significance noted on the Professionalism item "Participate in peer review" ($p = .042$), and the Activism item “Establish collaborative partnerships to reduce healthcare disparities” between nurses with routine direct contact and nurses with rare or no contact with patients ($p = .014$).

The results indicate nurses in this sample had a relatively high PV orientation, consistent with PV research in other settings (Brown et al., 2015; Cetinkaya-Uslusoy et al., 2017; Erkus & Dinc, 2018; Fernández-Feito et al., 2019; Gallegos & Sortedahl, 2015; Jahromi et al., 2018, Poorchangizi et al., 2017; Skela□Savič et al., 2017). Nurses with various years of experience and types of practice environment based on their level of contact with patients indicated moderate to high value importance on all 28 of the NPVS-3 value statements, indicating value adherence as expected by the Code of Ethics for Nurses (ANA, 2015).

In Chapter 5, I interpret and discuss the findings of the statistical analyses presented in Chapter 4. Then, I describe the limitations that arose from the execution of the study. I conclude the study by offering recommendations for practice, further research, and implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Ethical decision-making, including how nurses maintain the profession's values in their practice, is important to all of nursing, especially in unique, corporate practice environments, such as in the payor industry. The majority of personnel in the U. S. payor industry are nonmedical professionals, leaving nurses and their medically licensed colleagues with the task of patient-centering payor organizations. In payor, rather than provider practice, environments, nurses are expected to collaborate by influencing the direction of care (ANA, 2015). Without formal preparation for influencing the direction of care among business professionals, nurses must avoid ethical corruption and may become part of compromising situations, increasing the risk for potential ethical strains and conflicts. The purposes of this quantitative, descriptive, and correlational study were to (a) identify the PVs of payor industry nurses using the NPVS-3, (b) identify relationships between years of experience in the payor industry and PVs, and (c) identify relationships between levels and types of patient contact and PVs.

Nurses in this study were found to place importance on all the PVs, indicating relatively high value importance from the corporate nurses collectively. Nurses most highly valued the Caring factor, which aligns with previous research conducted in clinical nursing environments (Brown et al., 2015; Cetinkaya-Uslusoy et al., 2017; Erkus & Dinc, 2018; Fernández-Feito et al., 2019; Gallegos & Sortedahl, 2015; Jahromi et al., 2018, Poorchangizi et al., 2017; Skela□Savič et al., 2017). No statistical significance was noted among years of experience in the payor industry and PVs. Although no statistical significance was noted among the three factors (Caring, Activism, Professionalism) and

level of patient contact, statistical significance was noted on the Professionalism item, "Participate in peer review," where nurses with rare or no patient contact in their roles valued this item more than all other groups. There was also significance in the Activism item, “Establish collaborative partnerships to reduce healthcare disparities,” where nurses with rare or no patient contact found this item more important than nurses with routine direct patient contact.

Interpretation of the Findings

Nurses in the payor industry overall had relatively high PV scores. Regardless of time, environmental, and demographic factors—such as level of education, gender identity, and job satisfaction—nurses placed a similar level of importance on all professional nursing values. Since there were no specific NPVS-3 studies for comparison at the time of this study, a percentage of the whole was calculated to demonstrate the PV orientation of corporate, payor industry nurses. If nurses answered all 28 items as “most important,” the percentage would be 100 (score of 140). As the mean was 110.66 (*SD* = 15.256), nurses in this sample collectively indicated they valued PVs at 79%. The importance of this primary finding is that even in practice environments that differ in routine activities, compared to standard direct-care nursing practice, nurses maintained the importance of their professional nursing values.

Although not statistically significant, nurses with some direct patient contact and some virtual or telephonic contact most highly perceived PVs in all three of the PV factors of Caring, Activism and Professionalism. It was also noted, though not statistically significant, that nurses with a medium amount of experience in the payor

industry (16–20 years) had the highest mean composite PVs score. Conclusions on these findings cannot be made although repeating the method in a larger sample size may clarify this potential pattern. However, previous studies have described a middle-range phenomenon contradictory to what was noted in this study, where nurses with a medium amount of experience had lower PV scores than nurses with less or more experience than them (Erkus & Dinc, 2018; Gallegos & Sortedahl, 2015).

The nurses employed in the payor industry in the Midwestern United States most highly valued the Caring factor, consistent with expectations in the Code of Ethics for Nurses (ANA, 2015) and the Scope and Standards of Practice (ANA, n.d.-c) as well as aligning with several other previous studies (Brown et al., 2015; Cetinkaya-Uslusoy et al., 2017; Erkus & Dinc, 2018; Fernández-Feito et al., 2019; Geyer et al., 2018; Jahromi et al., 2018; Kantek & Kaya, 2017; Knecht et al., 2020; Monroe, 2019; Poorchangizi et al., 2017; Skela□Savič et al., 2017). Eight of the top ranked PVs were based in the concept of caring. This finding suggests that nurses in the corporate environments of the payor industry highly value the aspect of caring in their practice. Caring means providing attentive, responsible, competent, and responsive care of people (Fowler, 2015). In literature on PVs, nurses most highly valued caring. As the profession was built around human value (Rassin, 2008), receiving such a result from nurses that have no direct patient contact (50% of the sample) speaks to the resilience of such fundamental concepts learned in nursing school and sustained throughout nursing careers.

Nurses in this study collectively found acting as a patient advocate most important. Being surrounded by peers that are primarily nonclinical professionals places

payor industry nurses in a unique collaborative environment. As discussed in Chapter 2, nurses in managed care roles are expected to practice by influencing the direction of care (ANA, 2015). Nurses in the payor industry participate in patient advocacy by advocating for solutions that expand accessibility to high-quality, affordable healthcare for all (Weston, 2018). Nurses in this sample strongly demonstrated their alignment with this aspect of their payor industry contributions through finding this the most important value statement. The item, "Act as patient advocate," in previous studies using the NPVS-R (Weis & Schank, 2015) has also been one of the top scoring items (Gallegos & Sortedahl, 2015; Jasemi et al., 2020; Monroe, 2019). Nurses in this study, alongside their provider industry colleagues, recognized the need to advocate for patients in the payor industry practice environments, indicating their embodiment of collaboration for patient advocacy in the payor industry.

In previous studies, PV items related to conscientious objection were perceived as much less important than other PVs (Bijani et al., 2019; Fernández-Feito et al., 2019) in comparison with this study that found that the item "Confront practitioners with questionable or inappropriate practice" as "important" (M = 4.0140, SD = .81923). Although this finding may seem to acknowledge the importance of such procedures in the payor industry, this survey item still ranked 13th for importance among the 28 NPVS-3 items, indicating conscientious objection was moderately valued compared to the other value statements. Conscientious objection is a necessary part of patient advocacy, but takes self-confidence (Fernández-Feito et al., 2019). The environment in which nurses feel comfortable advocating for their practice could still be evaluated and improved upon.

An environment of practice that encourages open communication may foster nurses' confidence in addressing serious issues.

The factors Activism and Professionalism were less valued by this population of nurses, which was also consistent with past studies of nurses with various roles (Jasemi et al., 2020; Poorchangizi, et al., 2017; Torabizadeh et al., 2019). Some researchers have hypothesized this phenomenon occurs because some of the PVs are supplementary to the nurse's role in practice, for example (Monroe, 2019). Some nurses perceive these activities outside of their role as less important than those used during care, including advancement of the health profession (ranked 22nd), role in professional nursing associations (ranked 25th), participating in nursing research (ranked 26th), influencing legislators (ranked 27th), and participating in peer review (ranked 28th) in this study. Whether the lesser perceived importance on these activities relates to not having enough time outside of employment (Monroe, 2019) or to other factors, this is a concern that the profession must overcome.

Regardless of experience, nurses in this study attached similar value to all the PV statements, aligning with similar results in studies by Brown et al. (2015) and Fernández-Feito et al. (2019). In this study, the data did not produce sufficient results to make a conclusion on correlation between years of experience away from direct-care nursing organization work and level and type of patient contact in the payor industry and nurses' PVs orientations. The statistically insignificant correlations between the number of years a nurse had spent away from direct-care organization work and their PVs, indicated that time was not a factor in nurses' ability to retain and sustain their PVs.

There was no statistically significant correlation between level of patient contact and the three factors of the NPVS-3 (Caring, Professionalism, Activism). A similar occurrence with nursing subspecialty differences occurred between PV scores using the NPVS-R (Torabizadeh, 2019). There was no statistically significant difference between the PV scores of OR nurses and nurse anesthetists (2019). However, in the current study, there was statistical significance in two of the NPVS-3 items between the level and type of patient contact groups. The first item was related to the importance of peer review ("Participate in peer review"), part of the Professionalism factor which presented good overall internal consistency in this sample ($\alpha = .844$). Nurses with rare to no patient contact more highly perceived the importance of this task compared to nurses in all other contact level and type groups. This NPVS-3 item was the lowest valued in the overall sample. Low importance placed on peer review items on NPVS survey derivatives is a common phenomenon in nursing literature (Gallegos & Sortedahl, 2015; Jasemi et al., 2020; Poorchangizi et al., 2017). The peer review process assesses the quality of scholarly articles that exemplify best practice prior to publication (Lloyd Searly Library, 2019). A contradiction exists between valuing highly some aspects of the profession of nursing, such as human dignity, but perceiving less importance in activities that are meant to enhance nursing practice. To adhere to the most recent evidence-based guidelines, literature peer review is necessary.

There was also a statistically significant relationship between nurses with rare to no patient contact and nurses with routine contact with patients regarding collaboration ("Establish collaborative partnerships to reduce healthcare disparities"). This item is part

of the Activism factor, which presented good overall internal consistency in this sample ($\alpha = .898$). Nurses with rare to no contact with patients perceived establishing collaborative partnerships as more important than nurses with routine direct contact with patients in the payor industry. Collaboration is a principal value in the nursing profession (ANA, 2015). As such, professional nursing values and the concept of collaboration have been studied collectively. Brown et al. (2015) found a positive relationship between higher professional nursing values and positive attitudes toward nurse-physician collaboration. The scope of this study did not allow for further conclusions on the concept of collaboration outside of the NPVS-3 value items, but further study of collaboration in the context of corporate nursing may be of value. Results in this study support the ANA, which posited nursing PVs should not waiver by any variable, including time or environmental factors (ANA, 2015). This study extends the knowledge of PVs in nursing as well as in a population of nurses that has not been previously isolated in the literature.

The PVM (Kaya & Boz, 2019) was not found to have been tested in literature available at the time of this study. The majority of nurses in this study indicated they were satisfied with their current employment in the payor industry, and no statistical significance was found between a correlation of job satisfaction and PV factor or total NPVS-3 scores. Thus, PVs were not correlated with job satisfaction among corporate, payor industry nurses in this sample, and the PVM did not accurately capture the circumstances of the studied population of nurses. A qualitative study exploring the reasons nurses enter and stay in or leave indirect-care organizations in the payor industry

may provide information on job satisfaction. Job satisfaction did not correlate with PV scores in this study as it has in other studies (Cetinkaya-Uslusoy et al., 2017; Kantek & Kaya, 2017). Factors other than the importance of PVs affected nurses' job satisfaction in this study, disproving the fit of the PVM. Qualitative research to further explore factors affecting nurse job satisfaction in this population of nurses may indicate necessary modifications to the model.

Limitations of the Study

There were five limitations in this study. As the study was a quantitative survey study, it described only the variables and their relationships, but not why a relationship may have existed between variables or which variable may have produced another (Burkholder et al., 2016). Prior to collecting data, the Hawthorne effect was noted to be an unavoidable limitation to conducting a study on perceptions. This may have impacted the way the nurses responded to the survey items. Nurses were asked to respond honestly prior to receiving the survey but controlling for this effect is not inherently possible. The survey collected the nurses' perceptions of PVs only. Actual behavior is not and cannot be measured by a survey inquiring on perceptions. As such, the theoretical understanding of PVs does indicate practice behavior (Lyneham & Levett-Jones, 2016).

The sociocultural events surrounding the time when data was collected were also expected to be a possible limitation prior to data collection. The survey was open for recruitment in the spring of 2021, during the height of the COVID-19 pandemic. The survey did not mention the pandemic, nor did it contain any items relating to the effects of the pandemic. However, the COVID-19 pandemic affected every part of the healthcare

system (Jackson et al., 2020) not excluding the payor industry, which may have impacted how nurses responded to and ranked the value of the idealistic NPVS-3 survey items.

An initially unanticipated limitation occurred on approval of the request to use the NPVS-R instrument from creators. They recommended a newer version of the tool that contained three (NPVS-3) instead of five (NPVS-R) PV factors. Previous quantitative professional nursing value studies used the NPVS or NPVS-R by Weis and Schank (2015). Other nursing PV studies utilizing the NPVS-3 were not available at the time of this study, making conceptual comparison with the same instrument impossible. However, variations of the PV scales created by the NPVS-3 authors Weis and Schank (2017) were extensively tested in nursing literature in the past decade, which made some conceptual conclusions on professional nursing values possible.

Sample size was an unanticipated limitation that may have contributed to statistically insignificant correlations. Although sample size was met based on G*Power analysis for the MANOVA prior to data collection ($N = 88$), there were emerging, but statistically insignificant trends among the three NPVS-3 factors in the 144 collected responses. A larger sample size may have yielded different results with a higher statistical power (Faul et al., 2014). Time and funding constraints during this project limited my efforts to recruit additional participants.

Recommendations

As the results of this quantitative, correlational study were not statistically significant, repeating the study on a larger sample size may yield a different result. Expanding the sampling method beyond the Midwestern United States may be a way to

gather a substantial sample for further exploratory statistics. In addition, qualitative research is needed in a population of nurses, such as corporate nurses, to gain their perspectives regarding their role identity in the corporate payor industry and how they navigate, uphold, and sustain nursing values in such settings. A qualitative study could gather valuable insight into what kind of measurements or qualitative questions could best capture the experiences of nurses in atypical practice environments such as in the payor industry. The manner nurses perceive and believe their value to be perceived in the payor industry could also be captured in a qualitative study to further the discussion of nurses' value contributions.

Another recommendation based on a review of the literature and in consideration of my study's finding of new graduate nurses entering the profession in indirect-care organizations is to enhance nursing school curriculum. Such enhancement would expose nurses to PV stressors from various environments, with consideration that various environments may provide different stressors. In this study, two nurses reported having no nursing experience prior to entering the payor industry. Three nurses had only one year of experience, meaning they entered an indirect-care role having never worked or only minimally worked directly with patients. In addition to preparing nurses to navigate clinical ethical challenges, nursing school should prepare them to navigate nonclinical challenges with the skills to overcome, adapt and advocate for patients at all levels of entry into the industry. There may be implications of nurses entering the field without direct-care experience that could be further explored by a qualitative study. In clinical research, chief nursing officers (CNOs) who interact with stakeholders to prioritize

human and financial resources attribute some of their moral distress to relationships they found to be counterproductive, working with professionals that centered their goals on enhanced personal or organizational gains (Prestia et al., 2017). As CNOs typically hold the highest nursing position in an organization (Prestia et al., 2017), it is probable that they are experienced nurses. A study on new graduate nurses entering indirect-care organizations could add to the body of knowledge about potential challenges nurses face when entering a practice environment where the majority of the collaboration is done with stakeholders, such as in the payor industry. The newly graduated payor industry nurses may provide great value, via qualitative interviewing, in identifying useful nursing school curriculum changes to best support this observed phenomena in payor industry employment post-graduation.

Additional studies with conceptual focus on collaboration are recommended. In this study, I noted statistical significance in an NPVS-3 item related to collaboration between nurses with little or no contact with patients, and those in the industry with routine direct patient contact. Additional research into the concept of collaboration and nurses in the payor industry may yield additional information to further identify the value of nurses in this industry.

Modifications to governing nursing organizations and documents to acknowledge and provide guidance for a wider range of nursing roles is recommended. The current Code of Ethics for Nurses provides little guidance on nurses' navigating relationships with professionals outside of healthcare, especially in terms of nurses and business. The current language recommends nurses "withdraw" from activities that provide a potential

conflict between economic self-interest and professional integrity (ANA, 2015). Nursing roles such as in the payor industry that require routine navigation of complex relationships involving topics such as economics could benefit from acknowledgement and clarity.

Maintaining PVs is crucial as nursing roles continue to expand. An understanding of nurses' perceived value of professional importance promotes the tailoring of resources to support professional identity development and value maintenance. Thus, individual organizations should be aware of the value importance hierarchy of the nurses in their organization to best support them. Likewise, nurses should be aware of how their practice environment impacts their PVs so that they may advocate for themselves by using resources to support them.

PVs must be maintained by intentional actions of nurses and organizations. Maintenance of professional nursing values is not accomplished passively. Although it was concluded in this study that PVs did not correlate with factors of time or of the environment, PV perception have been noted in literature to change or disappear over time (Weis & Schank, 2009; Şenyuva, 2018; Torabizadeh et al., 2019). PV maintenance requires action by nurses and by the organizations in which they work. Nurses, through organizations like the ANA, can expand their professional development by networking and accessing resources for certification, practice, advocacy, and education (ANA Enterprise, 2020). Professional development through earning continuing education credit is required for practicing nurses to maintain their licensure and varies by state. Nurses manage this task autonomously and can choose their continuing education topics to

include those in ethics, professional development, leadership, collaboration, and nursing specialty topics (ANA, n.d.-a).

Organizations can support nurses through in-service training on PV development (Geyer et al., 2018), value-based programs for practice development in which nurses can explore their individual values among their fellow nursing team members as well as develop a shared vision for their practice (Drayton & Weston, 2015). As PVs in nursing are morally and ethically centered, ethics resources to promote engagement to prevent moral distress are also targeted resources that can promote PVs while addressing specific stressors or situations. The PVs of freedom or autonomy, human dignity, justice and truth should be promoted to prevent emotional exhaustion (Altun, 2002).

Organizations should offer resources to help nurses address morally complex situations such as ethics committees or consultations (Epstein & Turner, 2015) and nurse ethics educators or mentors (Monroe, 2019). Even when organizations offer substantial resources, time must also be granted to nurses to use the resources, or they may feel they have no time to participate (Monroe, 2019). These resources must be identified as a need in organizations for implementation; therefore, any organization that employs nurses must attempt to provide nurses resources to maintain their PVs. The provision of organizational resources for changing aspects of the practice environment requires investment of the organization's resources, time and money (Shao et al., 2018). To make these investments, organizational leaders must understand the significance of the professional nurses in their organization as well as the importance of high PVs on the nurses and the quality of care they provide. Organizations that have proportionally

smaller numbers of nurses compared to nonclinical staff or minimal nursing leadership should recognize that identification and maintenance of PVs is key for successful nursing contribution and retention of personnel.

The nursing profession will continue to expand. Role and practice environment expansion may require a more elaborate and actionable direction for the new practice challenges that arise. Perhaps new methods of measurement must also be created to understand the robust value nurses provide in expanding practice environments.

Implications

This study promotes social change because it generates knowledge on the understudied population of nurses employed in the corporate roles of the U. S. payor industry. The results of this study did not support the conceptual PVM created by a thorough literature review of previous nursing PV studies around the world (Kaya & Boz, 2019). PVs did not correlate with nurse job satisfaction in this study, which was represented in the model as a predicted relationship. A conceptual implication of this study is to encourage further research to identify conceptual model changes or create a new model to capture the nature of payor industry roles and professional nursing value variable relationships.

The social change impact of this study lies in encouraging organizations that employ nurses to identify the importance of their nurses, including identifying the values the nurses enter their organization with from the profession of nursing. The social change also impacts payor organizations in developing and promoting the worth of nurses' contributions to managed care. Nurses in this study highly regarded professional nursing

values, despite environmental factors and their years of experience. This speaks to their ability to retain the core moral and ethical aspects of the profession and to their patient-centered contributions to organizations.

Nurse leaders in payor industry organizations are recommended to actively work to acknowledge and identify professional nursing values among their teams to promote recognition of the nurses' contributions. Recognition could spur discussions on the value of nurses in the industry and ensure that the talents of nurses are being maximized. Nurse leaders are also encouraged to participate in professional nursing organizations for enhanced recognition in the profession. Larger scale recognition accompanied by further research will allow for advancement of conceptual models specific to payor nursing, further advancement of roles in atypical nursing settings, and enhanced language in governing nursing doctrines specific to the inclusion of payor in addition to provider nursing resources. Amplified inclusion during nursing education of healthcare economics, resource utilization, enhanced collaboration skills—including mentorship in conscientious objection in a variety of practice settings—may benefit nurses entering the payor industry. Nurse leaders onboarding practicing nurses new to the payor industry are recommended to continue mentorship in sustaining the profession's values in the payor practice environment so that the observed sustaining of values noted in this study is preserved.

In this study, it was noted that nurses are entering the profession in corporate, payor industry roles, which may indicate a closer look into how schools prepare nurses for practice. As healthcare continues to move from a non-profit to for-profit business

models (Ocak et al., 2020), knowledge of healthcare economics will increasingly be valuable knowledge for nurses to include in their practice. The knowledge introduced in this study may also impact the culture of the nursing profession by offering acknowledgment and encouraging recognition of nurse contributions in less common roles. Through this acknowledgment, this study impacts social change by encouraging governing bodies to enhance guidance recommendations for practicing nurses of all experience levels in navigating less common roles, such as payor industry roles, to maintain the profession's values.

Conclusion

Nurses have significant value in the payor industry advocating for health care accessibility and high-quality health care (AHIP, 2020a). Even so, nurses perceived some PVs as more important than others. In consideration of emerging ethical challenges in healthcare (Poorchangizi et al., 2017), assessing current nursing curricula and continuing education resources for supporting nurses navigating less common roles and practice environments is indispensable. Payor industry nurses have not previously been acknowledged with a targeted research study, which provides opportunity for discussions regarding professional nurse value in payor industry practice settings. This study found that nurses perceive their profession's values as important despite their years of experience, years of experience in the payor industry, and despite their having differing levels and types of patient contact, or not contact at all. Thus, the value of professional nurses in guiding health care toward high quality, lower cost, and patient-centeredness is exceedingly high. Efforts should be taken in all practice environments to ensure that

nurses are viewed less as functional doers and more as thoughtful strategists (Weston, 2018). Furthermore, organizations that employ nurses should be familiar with the profession's values to fully utilize the professional nurses' contribution. The experience of corporate nurses in holding steadfast to their profession's values could be elaborated in a qualitative study. Further research on corporate-based nursing populations may result in promoting increased value of nurses in indirect care-based organizations as well as identifying ways to support nurses in their maintenance of professional nursing values.

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Appendix A: Permission to use NPVS-3

Dear Kasey,

Thank you for your interest in our work on professional values. Our article, as well as The Nurses Professional Values Scale (NPVS-3) are enclosed. You have our permission to use the NPVS-3 in your proposed research. We are requesting persons who use the NPVS-3 to provide the following at the completion of the research:

An abstract of your research findings using the NPVS-3 which includes a description of the sample.

Our most recent publication regarding the NPVS-3 can be found in the Journal of Nursing Measurement:

Weis, D., & Schank, M.J. (2017). Development and Psychometric Evaluation of the Nurses Professional Values Scale-3. *Journal of Nursing Measurement*, 25(3), 400-410.

Best wishes for success with your research.

Sincerely,

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