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A Naturalistic Inquiry Into the Lived Experience of Nurse Practitioners Who Have Full Practice Authority

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A Naturalistic Inquiry Into the Lived Experience of Nurse Practitioners Who Have Full Practice Authority

by

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Dedication

To my husband and children, who have continued this lifelong learning journey with me without judgement or interference, but with love, commitment, and support.

To my mother, grandmother who has passed on, mother-in-law, sister, sister-in-laws, nieces, and nephews, as well as my dear brothers who have departed, who believed in me and claimed my doctoral degree before I could perceive it to be possible...because they did not forget where my strength lies (in God).

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Abstract

Full Practice Authority (FPA) is one of three types of practice authority that a nurse practitioner (NP) can obtain through state licensure, depending on the state where the NP plans to practice. The American Academy of Nurse Practitioners (AANP) explains that FPA entails "…the authorization of nurse practitioners to evaluate patients, diagnose, order, and interpret diagnostic tests, initiate, and manage treatments - including prescribing medications – under the exclusive licensure authority of the state board of nursing" (AANP, 2022, Policy Briefs section). To date, there are 29 FPA states and territories, 16 reduced practice states, and 11 restricted practice states. The purpose of the study, "A Naturalistic Inquiry Into the Lived Experiences of Nurse Practitioners with Full Practice Authority," was to explore the everyday experience of the FPA NP using Naturalistic Inquiry (NI). NPs were recruited through electronic mail (e-mail) requests using e-mail addresses obtained from the state Board of Nursing in FPA states. Eleven NPs were interviewed, and data collection followed a semi-structured interview format, with analysis resulting in the emergence of the following themes: (a) autonomy, (b) confidence, (c) collaboration/support system (d) standard credentialing/licensure process, (e) legislation, (f) accessibility and flexibility in patient care, (g) new FPA NP education and research, (h) limitations, (i) reimbursement. The participants indicated FPA is a positive experience in their practices, but limitations to practice and inconsistencies in regulation still exist as the United States, including the District of Columbia and U.S. territories. This study can offer information and insights about the experience of practicing with FPA to the NP who has yet to obtain FPA as all states progress towards FPA for NPs.

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LIST OF ABBREVIATIONS & DEFINITIONS

APRN	Advanced Practice Registered Nurse
NP	Certified Nurse Practitioner
CNS	Certified Nurse Specialist
CNM	Certified Nurse Midwife
CRNA	Certified Registered Nurse Anesthetist
FPA	Full Practice Authority
AANP	American Association of Nurse Practitioners
NCSBN	National Council of State Boards of Nursing
MD	Medical Doctor
VA	Veteran's Administration
NI	Naturalistic Inquiry

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Chapter 1: Introduction

The Nurse Practitioner is a type of professional healthcare provider, and one type of Advanced Practice Registered Nurse (APRN). APRNs are ". . . Registered Nurses (RNs) with advanced education, knowledge, skills and scopes of practice. Most possess a master's or doctoral degree in nursing and may also have passed additional certification examinations" (Kenward, 2007, p.4). There are four types of nationally recognized APRNs:

1. *Nurse Practitioner* (NP) – an NP is an APRN who ". . . deliver[s] front-line primary and acute care in community clinics, schools, hospitals and other settings" (Kenward, 2007, p.4). NPs provide services that may include but are not limited to ". . . diagnosing and treating common acute illnesses and injuries; providing immunizations; conducting physical examinations, as well as managing chronic conditions" (Kenward, 2007, p.4).
2. *Certified Nurse Specialist* (CNS) – CNS is a type of APRN who ". . . provides care in a range of specialty areas including cardiac, oncology, neonatal, pediatric, and obstetric/gynecological nursing" (Kenward, 2007, p.4).
3. *Certified Nurse Midwife* (CNM) – A CNM is an APRN who "...provides prenatal and gynecological care to normal healthy women; delivers babies in hospitals, private homes, and birthing centers. They also provide follow-up post-partum care" (Kenward, 2007, p.4).
4. *Certified Registered Nurse Anesthetist* (CRNA) – CRNA is an APRN who ". . . administers more than 65% of all anesthetics given to patients each year and are the sole providers of anesthesia in approximately one-third of all United States hospitals" (Kenward, 2007, p.4).

The proposed study will explore the lived experience of the NP with Full Practice Authority (FPA). FPA is one of three types of practice authority an APRN can have, depending on the state where the NP practices. The American Association of Nurse Practitioners (AANP) defines each state (or type) of practice authority as follows:

1. *FPA*– An NP is permitted to perform any task in their NP scope of practice without a physician's supervision or partnership. Examples: diagnosis, ordering tests, and prescribing treatments. The FPA NP is considered independent (Clarke, 2022).
2. *Reduced Practice Authority*– An NP can perform certain tasks without a physician's supervision or collaboration. Typically, the practitioner's authority to prescribe medication is limited (Clarke, 2022).
3. *Restricted Practice Authority*– An NP must perform all tasks with physician collaboration or supervision. They can have an elevated level of autonomy but cannot practice independently. They may diagnose and treat according to their scope of practice. They may prescribe according to their collaborative agreement with the physician (Clarke, 2022).

The AANP explains that FPA entails, "…[practicing] under state practice laws that regulate nurse practitioners to evaluate patients, diagnose, order, and interpret diagnostic tests, initiate, and manage treatments –including prescribing medications– under the exclusive licensure authority of the state board of nursing" (AANP, 2022). *Licensure/Credentialing*– For the purpose of this study, credentialing is the process of obtaining licensure in one or more of the FPA states of practice to practice as an NP under a specific population-based foci and/or specialty after obtaining certification through the AANP or the American Nurses Credentialing

Center or by obtaining authorization to practice by being "grandfathered in" by the state. As of 2022, there are 29 FPA states and territories, 16 reduced practice states, and 11 restricted practice states.

"A Naturalistic Inquiry into the Lived Experience of Nurse Practitioners who have Full Practice Authority" is a study that will reveal the experiences and perspectives of NPs who work under FPA. The reports should reveal information that allows novice and experienced NPs to learn about what it means to practice as an FPA NP. Several theories guide nursing practice, for instance, practice theory. Practice theory looks at the production of environments of care and how it promotes health and healing (Bender and Feldman, 2015). "The telling of stories about practice, helps uncover the hidden knowledge so that it can be shared with others and developed cumulatively, advancing the clinical discipline" (Wandel, 2003, p.1). However, J. C. Wandel (2003) summarized the 20th anniversary of Patricia Benner's book *From Novice to Expert* and recalled Benner's advice at the podium regarding the growth of the nursing profession: "...nurses must deepen their understanding of the important knowledge that develops during clinical work... avoiding the "practice *to* [emphasis added] theory gap" (p.1). In that regard, narratives from FPA NPs in the field may help us gain valuable insight into the experience of the FPA NP by providing information on education, skills, legislation, credentialing, and/or any other pertinent information that would prepare the potential FPA NP.

Several professional organizations, such as the AANP, approve of FPA NP as a concept. The AANP organization stands by FPA, acknowledging in *Issues at a Glance,* a publication on the AANP website, that FPA:

1. Improves access

2. Streamlines care and makes care delivery more efficient
3. Decreases costs
4. Protects patient choice (AANP, 2022).

AANP identifies the benefits gained when an FPA NP provides care as high in quality and safety, but also the lack of an FPA NP which could lead to disparities, increased disease burden, reduced available health care workers, and lowered quality of healthcare (AANP, 2022).

Therefore, the AANP supports both the National Council of State Boards of Nursing's (NCSBN) Model Nurse Practice Act and the APRN Consensus Model. The Model Nurse Practice Act forms the basis for legislation toward a regulated FPA NP practice. Together, the APRN Consensus Work Group and the NCSBN APRN Advisory Group became the APRN Joint Dialogue Group which developed the APRN Consensus Model. The APRN Consensus Model outlines the expectations for APRNs' licensure, accreditation, certification, and education. These proposed regulations aim to have all NPs under the same education, certification, and regulation no matter where they reside.

In the past, researchers investigated the cost-effectiveness of the NP as compared to the Medical Doctor (MD). Findings indicate that the NP spent 20% to 25% less than the MD on educational preparation and that NPs were getting paid less than half of the MD's salary (AANP, 2013, p.1). At the same time, researchers investigated productivity between the two disciplines, observing that both physician assistants and NPs saw more patients than MDs. Notedly, the addition of an NP to any practice was cost-effective. In AANP's Position Paper: "Nurse Practitioner Cost Effectiveness" (2013), "NP cost-effectiveness was not dependent on actual practice setting and is demonstrated in primary care, acute care, and long-term care settings"

(p.1). In addition, FPA would allow NPs to practice to their full scope of practice, further improving and enhancing NP cost-effectiveness.

FPA for NPs has increased amongst the states in the United States and has the potential to involve all states and surrounding territories. A recent change involving the Veteran's Administration (VA) has occurred, which complements the efforts of the APRN Consensus Model. In December 2016, the VA granted FPA to all APRNs except for CRNAs. The American Society of Anesthesiologists disagreed with the VA's ruling and thought it would be safer to maintain a collaborative agreement for CRNAs (Rappleye, 2016). Because the VA is a federal institution, its rules supersede state laws and render preemptive authority under the federal government for all APRN employees who are NPs, CNSs, or CNMs. Therefore, they are permitted to practice fully as per their credentials without direct physician supervision, regardless of state law in their VA facilities (Rappleye, 2016). The purpose of this study was to investigate the experiences of FPA NPs to understand better these APRNs' benefits, challenges, and practice. This Naturalistic Inquiry (NI) study involved individuals employed as FPA NPs. The NPs were asked to tell a story regarding their experience as an FPA NP.

Research Question

The specific question addressed in this study is: "What are the lived experiences of nurse practitioners who have full practice authority?"

Methodology

NI was used in this study to explore the lived experiences of NPs who have FPA. This method allowed for detailed descriptions from each participant. J. Armstrong (2010) describes

NI as "…an approach to understanding the social world in which the researcher observes, describes, and interprets the experiences and actions of specific people and groups in societal and cultural context. It encompasses qualitative research methods in which the naturalistic researcher draws on observations, interviews, and other sources of descriptive data, as well as their own subjective experiences, to create rich, evocative descriptions and interpretations of social phenomena" (p. 880).

Research Design

Participants were recruited using the State Board of Nursing databases of Nevada and Wyoming, which instated FPA for NPs. Initially, 10 States' (with FPA) Boards of Nursing received e-mails introducing the study as well as a request for their FPA NPs' e-mails for voluntary participation. Upon receiving an e-mail list from the State Boards of Nursing who agreed, e-mails were sent to each NP, 50-100 e-mails at a time. Once an NP responded asking for more information, the participant's consent was implied, and scheduling for interview dates and times began according to their convenience via Cisco Webex. *Snowball Sampling* encouraged respondents to tell other NPs-and FPA NPs about the study and subsequently request more information. Alongside the e-mail lists from Nevada and Wyoming, as well as those accumulated from snowballing, the final recruitment totaled 11 FPA NPs who met inclusion criteria. Each 60-75-minute virtual interview began with verbal consent and used a semi-structured questionnaire. Once achieving saturation, recruitment ceased. Data was analyzed and compared to developing themes throughout each NP interview as generalized conclusions concerning the FPA experience from the interviewed NPs evolved.

In Chapter 2, a review of the literature analyzed past and present information regarding the FPA experience for NPs and other disciplines that experienced a change in scope of practice. Chapter 3 will entail the methods used in the study to discover individual perspectives regarding FPA. Chapter 4 will detail the findings from the study. Lastly, a discussion regarding the findings will occur in Chapter 5.

CHAPTER 2: REVIEW OF LITERATURE

A literature review explored available information about the lived experience of NPs with FPA, including extant literature regarding FPA among other disciplines or professions. Databases used in the search included: EBSCO, CINAHL, OVID, and Nursing Reference Center Plus. Search Strings used in the databases included: "full practice authority," "the lived experiences of nurse practitioners," "full practice authority and nurse practitioners," "full practice authority experience of nurse practitioner," "nurse practitioner perspective of full practice authority," "full practice authority nurse practitioner," and "full practice authority nurse practitioners". The query limits refining the search included: "Peer Reviewed," "Available Online," and accessible in "Full Text." The article's subject had to include "Nurse Practitioner," except for extant literature regarding FPA or scope of practice advancement. Over 16,000 articles contained the requested string of characters. One hundred sixty-three articles specifically contained "the lived experience…" but not all of the articles reflected "the lived experience(s) of the nurse practitioner". Of the FPA articles identified, legislation, roles, and scope of practice were the focus. FPA was not explicitly required or implied in the articles on lived experiences.

The research on the lived experience of NPs was arranged into external and internal NP experiences. External experiences include transition into NP practice, educational models for transition or practice, and NPs' specific lived experiences in varying situations. Internal experiences include spiritual, moral, and interpersonal interactions with patients. The query, "the lived experience of nurse practitioners" (with or without FPA), yielded valuable information on the general aspects of the proposed study, but there were no explicit details of the lived experience of NPs who have FPA.

Legislation for Full Practice Authority

VanBeuge and Walker (2014) explored Nevada's journey from collaborative practice to FPA. The study entailed a literature review and the chronology of events that led to the successful implementation of FPA in Nevada in 2013. The study identified, step-by-step, the process of FPA attainment (which were):

1. Set Priorities
2. Secure a legislative champion
3. Acquire a representative on the ground
4. Seek external support and guidance with national organizations
5. Form a working group of NP leadership (Vanbeuge & Walker, 2014).

The authors focused their efforts on autonomy and the benefits to the Nevada community. The research concluded that autonomous practice would increase access to care, reduce emergency room visits, and improve access to early intervention and prevention services, with an overall reduction in the shortage of primary care providers. Nevada implemented FPA after passing the Affordable Care Act in 2014 (Vanbeuge & Walker, 2014). Barriers to practice for NPs prior to the inception of FPA were:

1. Required statement of competency from a physician
2. An ongoing collaborative agreement
3. A list of medications, treatments, protocols, diagnostics, and services that an NP could provide
4. Detailed protocols for NP practice (Vanbeuge & Walker, 2014).

In the research article, the authors provided the actual process experienced in their state to obtain FPA in Nevada but did not discuss the experiences of FPA NPs.

Nurse Practitioner Roles and Practice Experiences

Chulach and Gagnon (2015) analyzed the literature on integrating NPs into the Canadian healthcare system using Bhabha's post-colonial theory. Post-colonial theory applies to the NP role, challenges of traditional ideas of NPs in the health care system, and how these concepts may help integrate the NP role. Within the context of post-colonial theory, the authors see nursing and medicine as two diverse cultures, with NPs occupying a third space between nursing and medicine. As explained by Milostivaya, Nazarenko, & Makhova (2017), Bahba's post-colonialism theory examines old and new ways and allows an alternative or hybrid alternative to emerge. Bahba's theory explains the multiple cultures that create certain concepts or ideas to be a situation in which one could relate with resistance or transferability.

In transferability, the culture continues to emerge, and a sort of survival occurs (pp.181-186). *Third spacing* is a concept that is hybrid from the original concept of the nurse or doctor. The evolution of the NP and their advancement in the scope of practice occupies such a hybrid space. It is not a concept that should merge into the doctor or nurse role, but one that occupies its own scope of practice advancing access to healthcare. Chulach and Gagnon's research revealed difficulty integrating and implementing the NP role due to backlash from physicians, lack of legislative support, and community support (Chulach & Gagnon, 2015). The authors blame the inability of governmental systems to adapt to NPs. They encourage the current structures to remodel and adapt to the NP rather than maintaining old and accepted structures of the status quo.

Carryer and Adams (2016) explored the roles of New Zealand NPs and found that NPs were underutilized. The ethnographic study consisted of 13 New Zealand nurses from various community occupational backgrounds. NPs shared that they utilized their nursing expertise or

backgrounds to provide comprehensive care to the patients. However, the study concluded that NPs work in structures that have not recognized their value or potential.

Park et al. (2016) examined the relationship between the scope of practice and NP autonomy in a cross-sectional study. They used a large representative sample from a 2012 NP database from the U.S. Health Resources and Services Administration National Sample Survey of Nurse Practitioners linked to the NP state scope of practice laws. The survey collected licensure, education, clinical practice characteristics, and demographics. The study utilized a classification system that included the following:

1. Independent practice and prescriptive authority (FPA)
2. Independent practice and restricted prescriptive authority (reduced practice)
3. Restricted practice and prescriptive authority (restricted practice) (Park et al., 2016, p. 69).

Likert-scale, bi-variate analysis, regression analysis, and multivariate analysis evaluated five questions. The questions focused on autonomy measures:

1. NP skills being fully utilized
2. Billing independence
3. Relationship with physicians
4. Managing a panel of patients
5. Hospital admitting privileges (Park et al., 2016).

Park et al. (2016) concluded that the highest level of autonomy responses achieved four out of five autonomy measures, with 57% of NPs reporting skill utilization. Most of the NPs in this study were FPA NPs.

Lived Experiences – External

Daley and Polifroni (2018) interviewed 12 NPs using descriptive phenomenological analysis to gather information about their lived experiences in School-Based Health Centers (SHBC). Findings indicate NPs experienced a challenging time providing care for adolescents in the SHBC. Three themes emerged from the study:

1. Contraception is an essential part of care for teens using an SBHC - all NPs stressed abstinence and STI prevention to teens at SBHC.
2. Frustration! There are many hurdles to negotiate – NPs expressed that they had trouble providing care because of the parental signature requirement or lack of treatment available during the visit.
3. Walking a fine line – NPs were conflicted about giving care and breaking state laws and regulations (Daley & Polifroni, 2018).

The study concluded that NPs faced challenges recognizing what services adolescents needed versus what could be provided (Daley & Polifroni, 2018). Although the study poorly discusses the lived experiences of FPA NPs, notedly, the conflict between giving care to patients versus state law and regulations was a theme in this study. Although these studies did not relate to FPA, they point out the complexity and highly individual experiences of NPs in specific settings. These studies offer guidance for exploring the lived experiences of NPs in any setting.

Transition to Nurse Practitioner Role

Transition into practice is a prevalent issue in the discussion of FPA. A transition may be from a different type of practice authority state, practice hour requirements before obtaining FPA, or the transition from RN to NP. Each mentioned type of transition has been examined and determined to be important when establishing FPA for the NP.

In a study by Hendrickson (2018), 33 APRNs completed three different stress surveys that revealed varied stress levels during the transition process. Hendrickson (2018) revealed that average job satisfaction scores were highest among NPs with increased experience, working in an FPA state, and completing post-graduate training. However, the study was not explicitly in regard to the lived experience of FPA NPs.

Annmarie Waite (2019) investigated the NP's lived experience in independent practice. Seventeen NPs from multiple states (including the District of Columbia) were interviewed using hermeneutic phenomenology. These NPs were asked to describe their experiences and specific barriers faced during their transition to independent practice (Waite, 2019). Waite interviewed only NPs with FPA because "...they were considered to be practicing with actual independent status; thus, they could best speak to the process of transitioning to independent practice" (Waite, 2019, p. 788). Four emerging themes were:

1. Questioning – feeling limited, leading to frustration and discomfort (i.e., a corporate focus on productivity which could compromise patient care), leading to the desire for independent practice
2. Self-directing – feeling helpless about their lack of control in their workplace leading to a desire for independent practice

3. Transforming – having a niche in the market and utilizing experience as guidance to get started with independent practice
4. Achieving fulfillment – having a sense of achievement and satisfaction once establishing an independent practice.

The author reported job dissatisfaction and the desire to seek more meaning in the NP career as the primary reason for the NP to start independent practice (Waite, 2019). The author also reported that NPs experienced satisfaction with patient care and vice versa the patients with their NPs, since being in independent practice. Based on the findings, the author recommended removing state-restrictive practice acts to increase NP-owned practices and expand patient care access (Waite, 2019). In this research, the NPs were FPA NPs. Waite (2019), however, failed to report explicitly on details of NPs' FPA experience but instead related it to independent practice.

Rashotte and Jensen (2010) explored the lived experience of being and becoming NPs in acute care settings using the hermeneutic phenomenology method. Twenty-six NPs participated from several provinces in Canada. Five themes emerged:

1. Being called to more – the NPs' perception of nursing is no longer what they want, so they look for a role that fits that perception
2. Being adrift – NPs spend two years transitioning from nursing into the NP role of medical management of patients
3. Being acute-care NP – NPs emerge into acute care after gaining experience with time and reflective engagement within a team that acknowledges and values them
4. Being pulled to more – NPs felt compelled to do more and were confused about what to do without the resources to develop

5. Being more – NPs became the combination of direct practice, education, research, and leadership (Rashotte and Jensen, 2010).

Although the study revealed the NPs' experience during the transition to the acute care NP role and their contributions to advancements in patient care, the study does not explicitly discuss the lived experience of FPA NPs.

The literature review also revealed some information referencing educational models that could assist with NP transition to practice. The use of such models may enhance critical thinking skills, decision-making skills, as well as leadership skills necessary for FPA NPs. The NPs at Texas Children's Hospital in Houston, Texas, participated in a study using the Transformational Advanced Professional Practice (TAPP) model for practice and research. Using Husserl's method of descriptive phenomenology, Elliot et al. (2017) conducted interviews with 11 NPs to discuss their experience using the TAPP model. The interviews revealed significant themes:

1. Transforming professional practice
2. Cultivating inner self
3. Mentoring professional transitions (Elliot et al., 2017).

NPs felt that the TAPP model was relevant to practice and provided options based on their current and future development needs (Elliot et al., 2017). The TAPP model appears to provide training for those skills necessary for NPs transitioning into practice, although FPA NP was not mentioned.

Captain Julie M. Bosch (2000) of the U.S. Air force authored an article regarding military NPs during their first year of clinical experience. In a descriptive exploratory qualitative analysis, six NPs were interviewed, and seven themes emerged:

1. Nurse practitioner role issues

2. It is more than they bargained for
3. Control issues
4. Stress and challenges
5. Preceptor stories
6. Patients and practice
7. Looking toward the future (Bosch, 2000).

Transition to practice was an underlying central concept in the research. The study revealed specific aspects of their experiences, such as: "...understanding the NP role and scope of practice, dual-hatted challenges, rank issues, and autonomy adjustments [which] clarify the experience and provide opportunities to prepare military NPs for their initial year of practice" (Bosch, 2000, p. 60). The study did not explicitly report the experiences of FPA NPs but offered valuable information for NP transition into practice.

Experiences with Independence

NP Sophia L. Thomas (2018) reported her experiences during Hurricane Katrina in Louisiana, a reduced practice state. She recalls fleeing to Baton Rouge from New Orleans a few days before the hurricane with her children and father and returning to help with recovery efforts. She provided home healthcare to elderly, homebound individuals prior to the storm. After the storm, she began volunteering at Louisiana State University, collaborating with a cardiologist. She provided care, along with other volunteer medical professionals, to Katrina evacuees – no matter the background or ability to pay. She provided medical care as well as instructed medical residents in Baton Rouge. Upon returning to New Orleans, she worked for a waste management company providing occupational health services. She treated injuries, provided acute and chronic medical care, performed commercial driver's physicals, and worked on health promotion

programs for the workforce. As she reflected upon her experience, she took away the following themes:

1. Healthcare delivery and workforce – when the workforce is also victimized by disaster
2. The original state of healthcare in a particular area prior to the disaster
3. Disaster preparedness (Thomas, 2018).

She hoped to offer disaster preparedness resources for NPs faced with disaster. She did not work in an area of FPA; however, she was a part of a significant volunteer effort to assist in meeting healthcare demands despite the state practice type.

Ms. Elaine Johnson, RN, MS, ANP from Naknek, Alaska, describes her experiences as an NP living in a "true bush community." Johnson recalls when she was flown to a crash site where there were four victims and only one survivor out of the four. They used debris around them to stabilize the survivor and send her by plane (Johnson, 1996). Alaska is an FPA state; as such, Johnson acted independently and made patient care decisions to keep the patient safe.

The research on the "lived experience of nursing practitioners" also revealed a study that investigated the medical errors experienced by NPs. The research aimed to "discern NP's behaviors, perceptions, and coping mechanisms in response to having made a medical error" (Delacroix, 2017, p. 403). The qualitative analysis revealed:

1. The paradox of error victimization
2. The primacy of responsibility and mindfulness
3. Yearning for forgiveness and a supportive other
4. Coping with a new reality (Delacroix, 2017).

NPs were found to lack the appropriate resources in place to help them cope with medical errors. Therefore, a model for NP practice that could provide resources and support to prevent

errors and promote education and training for common errors would benefit NP practice. However, it would mainly be assistive to FPA NP practice as they practice independently, although Delacroix (2017) did not mention FPA NPs.

Lived Experiences - Internal

The query for "Lived experiences of nurse practitioners with full practice authority" also revealed research about internal experiences. Those experiences were spirituality, moral dilemma, and interpersonal interaction. David (2014) authored research on an individual NP's lived experience with spirituality in the article "Living out Christian Spirituality in Patient Care: One Nurse Practitioner's Experience". In her research, she found that spirituality led to better patient outcomes. "Healthcare providers may attempt to help patients restore spiritual balance to promote healing" (David, 2014, p. E3). FPA was not mentioned.

Ten NPs were interviewed in Viens' (1995) study using the phenomenological approach. The study aimed to explain the moral dilemma as an emerging concern since the AIDs epidemic, abortion issue, and increased technological advancement in healthcare with the resultant dwindling of healthcare resources. Certain themes emerged:

1. The contextual framework for moral reasoning
2. Values
3. Influencing factors
4. Recognizing the dilemma
5. Outcomes (Viens, 1995).

NP interviews revealed that moral issues result from a lack of access to quality healthcare and problems within everyday clinical practice. NPs sought to manage moral dilemmas by

practicing caring and having continued value to the nurse-client relationship (Viens, 1995). The study did not explicitly mention that the participants were FPA NPs.

The qualitative research article "What is the Nature of Nurse Practitioners' Lived Experiences Interacting with Patients?" by Susan Kleinman, PhD (2004), explores the concept of interpersonal interaction. Six NPs were interviewed in this descriptive phenomenological study. The interviews revealed the following themes:

1. Openness
2. Connection
3. Concern
4. Respect
5. Reciprocity
6. Competence
7. Time
8. Professional identity (Kleinman, 2004).

Kleinman (2004) concludes that NPs were overall certain about their professional identity and provided care they valued. The study, however, did not explicitly imply that the NPs were FPA NPs.

Change in Scope of Practice for Non-Nursing Professions

Literature regarding the scope of practice was reviewed to identify the presence of different professions or disciplines that experienced scope of practice expansions or changes in practice authority, like that of the NP, such as pharmacy, optometry, and dentistry. Expansion in the scope of practice often precedes or coincides with granting of FPA. These professions all require specific education and training, leading to changes in their scope of practice by their state

boards. In this review, advancing the scope of practice is the central concept, emphasizing improved access to patient care.

Pharmacy

Over the last 20 years, pharmacists have been granted prescriptive authority depending on the state where they practice as an example of scope expansion (Thidrickson & Goodyer, 2019). This expansion in practice has allowed consumers to benefit from an additional provider of medication, which initially required a medical practitioner prescription for a patient to receive it. Now, pharmacists can prescribe medications under specific protocols, collaborations, and/or certifications as identified by the state in which they practice. As a result, pharmacists are more accessible to the patient, given the increased scope of practice.

Majercak (2019) describes in the article "Advancing Pharmacist Prescribing Privileges: Is it time?" the finding that both prescribers and pharmacists in Washington State were favorable to collaborative agreements for pharmacist prescriptive authority. The author also described the necessary training and other requirements for different states. For example, Ohio State University Medical Center's collaborative agreement allows pharmacists to order labs, analyze the labs, and adjust medications. Additionally, Kaiser Permanente of Colorado's Clinical Pharmacy Cardiac Risk Service authorizes clinical pharmacy specialists to prescribe for persons with elevated lipids, blood pressure, and diabetes with a proven reduction in cardiovascular-related mortality (Majercak, 2019).

In the qualitative study, "Pharmacy Travel Health Services in Canada: Experience of Early Adopters," 21 pharmacists were interviewed. Pharmacists experienced challenges with limitations in prescriptive authority and access to public health vaccinations. However, the

respondents expressed that consumers were impressed with the convenient appointment times, ease of billing, and the idea of having all services at one place (Thidrickson & Goodyer, 2019).

According to an article found on the *GoodRx Health* website – "Prescribing Authority for Pharmacists: Rules and Regulations by State," standard state prescriptive authority agreements for pharmacists include: immunizations, hormonal contraception, smoking cessation, naloxone therapy, travel medications, as well as Human Immunodeficiency Virus (HIV) pre- and post-exposure medications, (Evans, 2022). Currently, pharmacists are authorized to prescribe naloxone in 50 states, birth control in 20 jurisdictions, and smoking cessation products in 17 states. Several states even allow pharmacists to dispense pre-exposure prophylaxis and post-exposure prophylaxis for HIV prevention without a doctor's prescription (Evans, 2022). Limitations or resistance to the expansion of pharmacy practices are due to concerns that pharmacists lack education and training in the areas of diagnosis and treatment (Austin et al., 2014).

In the qualitative study, "Stories from the Trenches: Experiences of Alberta Pharmacists in Obtaining Additional Prescribing Authority" (Charrois et al., 2012), 14 pharmacists discussed their experience obtaining Additional Prescribing Authorization (APA). In Alberta, "pharmacists can adapt prescriptions and prescribe in an emergency…[which] includes altering a dose, formulation or regimen; therapeutic substitution; or renewal of a prescription…this designation APA uniquely allows them to initiate therapy for any condition, as long as it is within their area of expertise and act as an independent prescriber" (Charrois et al., p. 30). Three themes about obtaining APA surfaced from the Charrois et al. study:

1. Motivation – "Desire to improve overall patient health; being at the leading edge of pharmacy practice and change; improving collaborative relationships with other health

care professionals; increasing continuity of care; validating some of the responsibilities they were already undertaki ıg; and ensuring timely care is provided to patients through a collaborative process…" (pp. 31-32)

2. Hurdles – lack of time, confidence to start the application, application expectations, and content.
3. Outcomes – change in practice and improvement of health.

Respondents reported improvements in patient access to care and the ability to become more functional collaborators in the healthcare team upon obtaining their APA (Charrois et al., 2012).

Pharmacists have experienced a change in practice authority and similar barriers that NPs encounter since obtaining FPA. Su›port from healthcare professionals, education, and training are vital factors in the continued development of the profession's functionality. Another study, "Evaluation of a Pharmacist-Performed Tuberculosis Testing Initiative in New Mexico," examined the expansion of pharmacists by granting them permission to prescribe, administer, and read Tuberculosis (TB) skin tests after completing training (Jakeman et al., 2015). The study revealed that expanding scope by providing impactful TB care leads to increase in follow-up readings, convenience, accessibility, and increased patient satisfaction due to their ability to walk in without an appointment at any time (Jakeman et al., 2015).

Optometry

Optometry was a drugless discipline when it initially started over one hundred years ago. It originally sold eyewear and other appliances for vision, not disease management. "Optometry is a profession dedicated to improving the function of a particular sensory modality, whereas ophthalmology is a surgical profession" (Wallis and Wedding, 2004, p. 326). According to

Wallis and Wedding (2004), optometrists want to be primary eye care practitioners, using their full scope of education and training. The authors explain phase by phase the journey it took to create and then advance optometry. They report the absence of support for their growth in an autonomous profession and the inevitable increase in scope due to their responsibility to patient care and advocacy. Initially blocked by legislation, the inability to prescribe treatments and diagnose certain eye conditions led to changes that increased the scope of optometry. In this study, four lessons emerged from the expansion of the scope of practice for optometry:

1. Education must precede legislation
2. The impetus for change in the scope of practice legislation is more likely to come from state associations than from national organizations
3. Improved access is the strongest argument in support of prescriptive authority
4. Support from professional groups with no pecuniary interest significantly bolsters the public interest argument (Wallis & Wedding, 2004).

Dentistry

Dentistry and dental hygiene professions (established in 1913) have experienced changes in the scope of practice, which caused a shift in tasks and the establishment of independent practices by both professions. In a study of dentists and hygienists, Renders et al. (2017) compared attitudes toward the extended scope of practice and independent dental hygiene practice. A systematic exploratory review of quantitative literature was conducted, researching attitudes regarding changes in the scope of practice for dental hygiene among 26 studies. The authors found that most dental hygienists had positive attitudes about the scope of practice changes and independent practice. Findings indicated that a cheerful outlook existed amongst most dentists regarding dental hygienists' expanded scope of practice. However, most dentists

had negative attitudes associated with the independent practice of hygienists. The authors conclude that the following may have contributed to the findings in the research: "People in high status occupations, like dentists, advance by delegating lower-status skills and roles to subordinate groups, such as dental hygienists...[hence] 54% of dentists had a positive attitude towards extended scope of dental hygiene practice but only 14% had a positive attitude toward independent dental hygiene practice" (Reinders et al., 2017, p. 53). The hierarchy in healthcare is evident in these findings, which reflect the hierarchy in medical practice, partially preventing the full integration of FPA into all NPs.

Although most dentists may not favor dental hygienists' independent practice, dentists themselves experienced an expansion of practice during the coronavirus disease 2019 (COVID-19) pandemic and participated in the administration of vaccines. In the past, dentists in New York State administered tetanus vaccines through a mandate from Governor Cuomo in response to Hurricane Sandy. The Emergency Preparedness Act continued this precedent under President Joe Biden, encouraging the recruitment of other healthcare providers to administer the COVID-19 vaccine (Rojas-Ramirez et al., 2021).

In addition, the Kentucky Board of Dentistry developed a process for training and expanding the scope of practice. It involved the use of a specialized task force and a strategic plan. In combination with a successful bill for expanding the scope of practice in Oregon and during the spread of the COVID-19 virus, a temporary regulation from the Kentucky Board of Dentistry, filed on January 2021, allowed dentists and dental hygienists to administer any COVID-19 vaccination. This decision was based on their ability to provide proof of the following:

1. An active Kentucky dental or dental hygienist license
2. Registration to practice anesthesia
3. Submit documentation of training (Rojas-Ramirez et al., 2021).

At the end of the 6-hour vaccination event, trained dental immunizers interacted with community members who expressed satisfaction with the receipt of the vaccine and with the organization, easiness, and speed of the process (Rojas-Ramirez et al., 2021). Mimicking this process could be used for the FPA of NPs.

The professions of pharmacy, optometry, and dentistry have experienced changes in the scope of practice, causing improvements in access to care for the community in the same ways an NP can. The resistance to expansion has hindered other professions' ability to practice to their full scope of education and training in the disciplines as it has the NP. The professions of pharmacy, optometry, and dentistry overcame many obstacles and experienced an expanded scope of practice. By following some of the mechanisms these disciplines have employed to achieve expansion, NPs may achieve FPA throughout the United States of America and surrounding territories.

Gap in the Literature

The lived experience of NPs queries with or without FPA allowed for the retrieval of results that yielded essential information to the general aspects of the study. Some literature identified NPs as having FPA, but most did not explicitly state that the NPs involved in the study were FPA. In addition, some of the literature provided no details on the FPA scope of practice nor the process of becoming an FPA. No comparisons between "reduced practice" or "restricted practice" to FPA, nor transitions from those states of practice to FPA were found during the review. However, the transition from RN to the NP role was discussed in some of the studies.

Overall, the gap in the literature exists that the lived experiences of NPs with FPA remain unexplored as it exists in different states. As the United States and surrounding territories move closer to all states and territories having FPA, more research should be done to prepare NPs for the move to FPA.

Significance

As NPs advance towards FPA across the United States and its surrounding territories, knowing the FPA experience of those working within this type of authority is vital.

Chapter 2 discussed all relevant literature on the lived experience of NPs with FPA and extant literature amongst other professions who have experienced advances in their scopes of practice. The gap in the literature highlighted the lack of those narratives about the FPA experience and the attainment process as described by FPA NPs. The next chapter, Chapter 3, will discuss this study's methodology in detail. It will address the research question and discuss the detailed data collection gained from naturalistic inquiry and data management. NI helps discover the FPA NP's experience with the FPA phenomena as it allows for obtaining, exploring, and analyzing results in this study.

CHAPTER 3: METHODS

This study used the qualitative method of NI to explore the lived experience of NPs who have FPA. Armstrong (2010) states that this research method encourages participant observation, description, and interpretation in their natural environment. The evolution of the method can be traced as far back as Charles Darwin, who developed the method of natural history, which appears to be like ethnography with details derived from direct observation and interaction with the subject and the environment. Utilizing the NI method allows rich, evocative descriptions and interpretations of phenomena to emerge as per the individuals rather than by assumptions of the investigator (Armstrong, 2010). NI's focus is to stimulate the revelation of the phenomena through its process. Therefore, NI is an appropriate approach to attain knowledge regarding the lived experience of NPs with FPA. Although there is quantitative evidence about the outcomes of NPs with FPA, there is no literature examining the experience of NPs working in FPA environments.

Research Question

The specific question addressed in the study is: "What are the lived experiences of nurse practitioners who have full practice authority?"

Sample and Recruitment

Lincoln and Guba (1985) describe a four-part phase to obtaining participants through purposive sampling for NI. The phases are:

1. Making Initial contact and gaining entry
2. Negotiating consent
3. Building and maintaining trust
4. Identifying and using informants (Lincoln & Guba, 1985).

First, the University of Texas Medical Branch Institutional Review Board must approve the research protocol (See Appendix A) before sampling can begin. Purposive sampling was initially solicited via e-mail, requesting a list of NPs' e-mail addresses from a State Board of Nursing with FPA. "Purposive sampling supports the development of theories grounded in empirical data tied to specific local settings" (Armstrong, 2010, p.3). Snowball sampling gathered additional contacts, allowing both those ineligible and eligible to solicit other NPs who may have been eligible. Potential participants were encouraged to tell their peers about the study.

Upon receiving the list from a state board of nursing, e-mails were sent to the first 50 contacts (with an intended goal of at least 20 responses). After that, recruitment continued by sending 50-100 e-mails at a time to receive at least 10-20 study participants.

After receiving a potential interviewee's e-mail response, a follow-up e-mail was sent with the assumption that acceptance to the study had taken place upon its receipt. The follow-up e-mail included the demographic questionnaire, IRB fast facts, and the study flyer. In addition, with implied consent, participants were given a confidential identification number and encouraged to "refer others to the full practice authority nurse practitioner study." The study inclusion and exclusion criteria (demographic questionnaire) screened potential respondents prior to explicit consent for the FPA NP study. The criteria were as follows:

The eligible nurse practitioner shall be:

1. A certified nurse practitioner (NP) with full practice authority (FPA) currently practicing in one of the full practice authority states
2. In practice for 12 months or greater
3. Identifies as a male or female 21 years of age or greater
4. Reads, writes, and speaks American English

An ineligible nurse practitioner may be:

1. A certified registered nurse anesthetist (CRNA); certified nurse specialist (CNS); certified nurse midwife (CNM)
2. A nurse practitioner working in a reduced or restricted practice state
3. In practice for less than 12 months in a full practice authority state, which does not include those who have spent 3 months of those 12 months in credentialing for their position
4. Does not read, write, or speak American English

Upon completion of the demographic questionnaire, a scheduled interview occurred at the participant's convenience, alongside a description of voluntary consent. The consent included all aspects of the study, including incentives and assured confidentiality of information.

The goal was to have a representative sample with a minimum number of participants at 10. A few (3) potential participants responded by e-mail but failed to complete all steps required for entry (particularly their demographic questionnaire), which determined eligibility. The number of respondents increased until saturation was achieved. An expected 10% of interviewees may not adhere to scheduled meeting dates and times.

As mentioned in the consent, the recorded interviews took place via audio/visual link, Cisco WebEx. The audio/visual service was ensured to be free and clear of noise to reduce transcription errors, creating an environment for in-depth interviews.

Data Collection

Semi-structured interviews took place, one-on-one, between the investigator and the participant using online video conferencing (Cisco Webex). Each eligible participant was asked to answer the open-ended question: "What is it like for you to practice as a full practice authority

nurse practitioner? Tell me about your experiences." Each participant was encouraged to respond and expound in narrative form. Additional probing questions followed the initial opening question (see Appendix J). Each interview took 60-75 minutes. Breaks were allowed upon request, as explained in the consent. The semi-structured interview and the time allotment encouraged an open-ended format of in-depth explanations and exploration of the FPA NP experience.

Lincoln and Guba (1985) describe fidelity as the ability to reproduce data perfectly as originally presented and can be obtained by audio or video recordings. The data collection method, NI, secured fidelity and structure in the study using Cisco Webex virtual interviews. An audio recording took place during each interview via electronic audio/visual media to ensure fidelity. A transcription of each interview followed, and, when necessary, member checks were done.

Member checks occurred during the interview and post-interview, during the review of transcript recordings. These member checks called on information within responses to be clarified or explained versus relying on the interviewer's understanding of the response. For example, suppose in the interview, the participant gives a lengthy narrative in which journaling would occur simultaneously. In that case, a member check could clarify those responses instead of misinterpreting information. Member checking is also known as informant feedback or respondent validation, whereas the clarification of concerns, comments, quotations, and questions takes place using the journal.

A journal for self-observation and self-reflection was kept throughout the process to manage inadvertent subjectivity and ensure both accuracy and confirmability. Constant and consistent descriptions and quotations were derived from the study to avoid researcher bias.

Upon reaching a confusing comment during the interview, journaling and member checking lead to reminders for the researcher of the comment's intention. I took field notes, recording both the verbal and nonverbal behavior of the participants, along with any ideas beyond the participant's response (Lincoln and Guba, 1985). The combination of field notes and journaling allows for thick descriptions, generalizations, and pattern findings. All data referenced each participant's unique number.

Data Management

Data was stored in a password-protected computer to maintain the confidentiality of participants. In addition, copies of the data were kept in an internet "cloud" and a USB drive. All consents and data will remain under lock and key for five years to protect participant information and confirmability.

Data Analysis

Analysis of the interview data began with the first interview and continued throughout the study. Armstrong (2010) explains, "The first step in qualitative data analysis involves transforming experiences, conversations, and observations into text [data]" (p.881). The review combined journaling, field notes, recordings, and other information as I collected data. Next, the data were grouped demographically and then non-demographically. Analytic induction was used throughout the process to look for patterns in the data constantly where the frequency of data and repeated patterns were logged. The grouping of themes continued until established generalizations on the FPA NP experience emerged. With a combination of exemplars, narration, and themes, I gathered findings about the interviewees' FPA NP lived experience.

Trustworthiness

According to "Naturalistic Inquiry" (Lincoln & Guba, 1985), qualitative methodologies, such as NI, require establishing trustworthiness between the investigator and the participant. Four criteria to meet the standard of trustworthiness established in this study were: credibility, confirmability, transferability, and dependability.

Credibility was established by utilizing a field journal. Throughout the process, this field journal created moments of self-reflection and self-observation, helping to differentiate my perceptions (as an investigator) from those reported in the research by participants. Credibility also came through the triangulation of descriptive experiences from several interviewees. Participants were from different states with FPA and varying ages, years of practice, experiences, and some with experience in other types of practice authority. Some practice in one or more states at the time of the study. Prolonged engagement, member checking, and peer debriefing took place throughout each interview. As such, constant and consistent recording, journaling, and documentation solidify this research study's confirmability.

The study established transferability through thick description. Thick description contextualizes the socio-cultural-political phenomena relative to the FPA of the NPs in each state.

Dependability is suggested when the process is approached in a stepwise manner and can be repeated in the same manner as explained by the investigator, confirming that the data is consistent with the research. Dependability was established when the process for verbal communication, verbal consent attainment, and a semi-structured interview took place alongside journaling –the journaling process created space for notes and clarification throughout interviews.

NI phenomenological perspective relies on empirical data to be expressed by participants and followed by bracketing the data, which then identifies common themes. Bracketing is when the researcher analyzes the data to understand the data better. Bracketing was used in the study during the ongoing analysis process. I set aside my assumptions and preconceptions to better understand the participant's experiences. This analysis was done by evaluating each response and finding key terms repeated between interviews. Journaling ensured that the concepts later leading to bracketed themes conveyed only the participant's intended explanations. Each participant's responses, questions, and themes resulted in the final nine themes found in this study. In doing so, every participant's experiences, without variation from their personal experience in FPA, warrant consideration.

The study's research design was discussed in Chapter 3, including the sample and recruitment, inclusion and exclusion criteria, data management, data collection methods, and limitations. Chapter 4 will include a review of the questions from the semi-structured interview and the themes derived from the 11 respondents of the study.

CHAPTER 4: FINDINGS

Eleven NPs with FPA voluntarily agreed to participate in the study. After obtaining verbal consent, they were asked questions using a semi-structured interview during a 60–75-minute virtual meeting. Eligible respondents met the criteria as described in the study: being male or female, over 21 years of age, speak English, practicing for 12 months or more as an NP, and received licensure to practice in an FPA state under their respective State Board of Nursing.

Table 1: Demographics

Gender	Ethnicity	Age Range	Practice Years	Practice States
Female	Caucasian	39-62	10	22 (includes 1 non-FPA)
Female	Caucasian	39-62	9	1
Female	Hispanic	39-62	12	1
Female	Hispanic	39-62	1+	1
Female	African American	39-62	7	4 (includes non-FPA)
Female	African American	39-62	5	3 (includes non-FPA)
Female	Caucasian	39-62	25	1
Female	Caucasian	39-62	10	2
Female	Caucasian	39-62	12	5
Female	Caucasian	39-62	12	4
Female	Caucasian	39-62	10	5

All participants were of the female gender between the ages of 39 and 65 years of age. Most of the NPs had never worked in any other type of practice other than FPA. Their FPA NP experiences ranged from one year to 25 years (see Table 1).

Many FPA states were represented in this research because at least one participant had licensure within 22 FPA states, although not all states were represented in this study. States and surrounding territories that are FPA (currently 29) include Alaska, Arizona, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New

York, North Dakota, Oregon, Rhode Island, South Dakota, Vermont, Washington State, Wyoming, Guam, and the Northern Mariana Islands (AANP, 2022). VA NPs were not included in the recruitment due to the complexity of the system making it difficult to access NPs.

Upon obtaining verbal consent from each participant, semi-structured interviews were conducted. Analysis began with the initial interview and continued throughout the study until saturation was met. Each recorded interview was transcribed to find developing themes and ceased at saturation.

The semi-structured interview contained the following six questions:

Question#1: What is it like for you to practice as a nurse practitioner with full practice authority (FPA)?

Question #2: What does full practice authority mean to you?

Question #3: What was the credentialing process for nurse practitioners with full practice authority?

Question #4: What has been a challenge in your career as it relates to full practice authority?

Question #5: Have you ever worked as an NP in any other state of practice other than a full practice authority state?

Question #6: What are some recommendations for the new nurse practitioner who will have full practice authority?

Further explanation was encouraged during the interviews. The questions encouraged full descriptions of the FPA experience as it related to each participant. Clarification was requested to capture the perspective of the participant precisely. There was constant journaling to avoid bias. Interviews took place through Cisco Webex.

Question#1: What is it like for you to practice as a nurse practitioner with full practice authority?"

The themes derived from this question were: (a) accessibility, (b) autonomy, (c) collaboration, (d) flexibility, (e) limitations, (f) reimbursement, and (g) legislation.

Accessibility was expressed as the NP's ability to see more and do more for their patients. The NPs believed patients experienced improved access to care under FPA. NPs also expressed that they experienced autonomy in providing care without mandatory physician collaboration or supervision. The need for collaborative agreements between NPs and MDs were seen as not necessary. However, collaboration between the interdisciplinary teams was seen as necessary for holistic patient care. Flexibility was described as the ability to provide patient care to several types of patients throughout their lifespan and encompassed the ability to set schedules for patient care.

According to the NPs, limitations exist due to legislation and insurance companies hindering reimbursement. Current legislation does not explicitly outline the full practice role in a way that makes the FPA NP have unrestricted FPA. Insurance companies (Medicaid and Medicare included) also fail to adjust the payor/payment responsibility comparable to other healthcare providers for the same service necessary for fair compensation to the FPA NP. The process for insurance registration for NP reimbursement is cumbersome, and the agencies even require a collaborative physician in an FPA state to reimburse for services.

Participant Response (s):

A. "Awesome sauce…I feel like I make a difference. I'm doing my life's work. I'm not tied to any clinic. I can reach many people who would not get psych care. I can bring on colleagues." *Autonomy, Confidence, Accessibility, Collaboration*

B. "Overwhelming...worked hard for...strived for...[I] want to be the person that helps and makes decisions. NPs gained the respect that they didn't have many years ago. MDs are welcoming us into their practice and know that we have the knowledge base. It could be chaotic, but manageable on a daily basis." *Accessibility, Autonomy, Collaboration*

C. "Not tied to a clinic. No paying MDs. Able to reach many people who would not get psych care." *Accessibility (increase in), Autonomy*

D. "Feel like full practice has limits. Acute care practices does not provide credentialling unless you have a collaborative physician." *Accessibility (lack of), collaboration (lack of), Limitations, Insurance credentialing*

E. "There are many barriers that legislation does not outline. I am unable to order to home health, diabetic shoes, or sign death certificates." *Limitations, Insurance credentialing, Legislation*

F. "No one looking over your shoulder." *Autonomy*

Question #2: "What does Full Practice Authority mean to you?"

Developing themes that were prevalent within participants' responses to this question were: (a) Independent practice, (b) Autonomy, (c) Collaboration, and (d) Legislative limitations.

Independent practice was described as not having a supervising physician. It was associated with being able to see more patients and being able to give more to those patients as opposed to an environment in which a doctor must co-sign. Autonomy meant the NP held sole authority on decisions regarding the care, treatment, and type of patient seen, including the schedule and time chosen to offer patient care. Collaboration was considered something available but not mandatory. Participants agreed that an integrated approach to care involved several healthcare team members and that collaboration with all team members was key to

helping the patient to achieve better health outcomes. Legislative limitations were a barrier to providing care and explained as FPA not being completely unrestricted. Participants shared that certain legislation within their states' full practice agreement hindered some parts of patient care management. One participant spoke about being unable to delegate to medical assistants as an NP, and several spoke of an inability to write prescriptions for diabetic shoes.

Participant response (s):

A. "Full practice means that I could order home health, sign death certificates, and order oxygen for my patients…I cannot, so this is not truly full practice." *Independent practice (lack of), Autonomy (lack of), Legislative limitations, Restrictions, Barriers*
B. "Full practice means that the patient care is in your hands. You have to manage the patient from A to Z. My job is to follow-up and patient stays on top of things. Optimal care, holistic care…whatever happens is your responsibility." *Autonomy, Responsibility*
C. "I could order home health, sign death certificates, and also could order oxygen [sarcasm]. It's not truly full practice." *Legislative limitations, Barriers*
D. "I can work to the very best of my educational and clinical abilities to best serve my patients." *Independent practice, Autonomy, Accessibility (increased)*
E. "Full practice [is] independent practice. I am authorized to provide healthcare services to seekers that include assessment, diagnosis, and treatment. I adjust treatments accordingly. I make decisions, but that does not mean that I am not seeking help. I use peer support groups and referral networks. I have felt no restrictions. There is a balance between freedom and burden of responsibility." *Independent practice, Autonomy, Collaboration, Legislative limitations (reduced), Flexibility, Accessibility*

F. "Full practice means that I don't have to pay a physician to practice. I can continue to collaborate with doctors and other nurse practitioners, I just don't have to pay."

Independent practice, autonomy, collaboration

Question #3: "What was the credentialing process for Nurse Practitioners with Full Practice Authority?"

The following themes appeared in the narratives of all participants in no specific order:

- RN license must be in place or apply if changing states
- Meet requirements to apply for APRN license and complete application
- Pay fees for licensure
- Apply for prescriptive authority
- Apply for DEA or controlled substance permit
- Fingerprints
- Background check
- Continuing education unit requirement

Although the process appeared to be the same for all participants who desired to become an FPA NP, additional requirements were also mentioned. For example, some interviewees described a process called attestation, depending on which state they practice. An attestation is a document provided by a physician or other clinical provider about the APRN's ability to perform clinical duties and/or have completed or met clinical practice hour standards in that FPA state. According to the participant's responses, the hours vary by state; some states require an MD to provide an attestation.

Participant response (s):

A. "Every state you must apply for your RN, fingerprints, apply for the APRN, and the controlled substance. There are no compact states for the APRN. There are frequent audits. Attestation for some states – needing a physician to sign off. This is a barrier." *Pay fees, Apply for certifications, Additional requirements*

B. "After one year of physician collaboration, you become full practice authority." *Additional requirements*

C. "Complete application. Show completion through a program. Fingerprints. Background check. [American Nurses Credentialling Center] ANCC certification. Pay fees." *Certifications/credentialing*

D. "Supervision for a certain time period. Then, [you] are able to practice to full scope of practice." Additional requirements, *Certifications/credentialing*

Question #4: "What has been a challenge in your career as it relates to full practice authority?"

Three themes emerged as most prominent in the interviews: (a) standardization of the credentialing/licensure process, (b) letting go of arbitrary practices, and (c) social awareness. Under these themes, standard licensure meant a desire to establish required licensure to practice as an FPA NP under one national nursing board. The licensure process would include the number of practice hours, continuing education units, years of practice requirement, and prescriptive authority requirements. The process would be the same no matter the state or individual to become a licensed NP.

Participants believed that fully licensed, unencumbered NPs should be able to practice to the full extent of their license no matter what state they are in without restriction or need for a collaborative physician, agreeing that arbitrary or unnecessary practices needed to stop. Mentioned examples of such practices, including the physician's co-signature as a requirement

for documentation, insurance practices that result in incomplete payment of services, legislation that blocks NPs from practicing to the fullest extent of their ability, and the need for more education about the FPA NP role to the public.

Participant response (s):

A. "Patient perception of what you can and cannot do. They think that you are not a full provider. Patient wants to see an MD. There are problems with delegating [to] Medical Assistants due to laws and pushback." *Public perception, Legislative restrictions, Barriers*

B. "Does not recognize full practice at the medical center. You would have to have a collaborating doctor." *Public perception, Barriers to practice, Arbitrary practices*

C. "Working in a hospital. No one knows how to use NPs. Implementation is slower." *Barriers to practice, Lack of knowledge about the FPA NP, Credentialing, Arbitrary practices*

D. "Physician groups giving NPs bad reputations. NPs spend a lot of time with patients. Physicians have different requirements for NPs. The credentialling process with insurance companies – they don't understand the FPA. NPs get 85-95% reimbursement." *Public perception, Barriers to practice, Insurance barriers, Legislative restrictions*

Question #5: "Have you ever worked in any other state(s) of practice?"

The question evoked two responses: One way of responding described the practice type – FPA, reduced practice authority, and restricted practice authority, while the second way of responding to the question referred to the states or places of practice. Some participants had only practiced in their current state, while others held several state licensures. Some states were not initially FPA states when the interviewees began to practice. Some NPs admitted that they had to

complete hours of practice and submit an attestation signed by a physician or current FPA NP to the State Board of Nursing to obtain FPA recognition.

Participant Response (s):

A. "Yes. I am credentialed in three states…Nevada, Florida, and California." *Credentialed in more than one state*

B. "Yes. I have worked in telemetry in other states which include Louisiana, Florida, Nevada, and New York." *Credentialed in more than one state*

C. "Yes. I have only worked for Colorado and New Mexico. Colorado requires 3 years of hours under a physician to receive full practice." *Credentialed in more than one state, Additional requirements, Arbitrary practices*

Question #6: What are some recommendations for the new NP who will have full practice authority?

This question resulted in the following themes: (a) Education/research, (b) Collaboration/support system, (c) Confidence, and (d) Do not feel limited.

Participants expressed that new NPs should continue to educate themselves and stay abreast of current research to provide patient care and seek a mentor to collaborate with for discussion because it takes a team to care for the patient. They also agreed that the new NP should be confident but never afraid to keep learning. In addition, the new NP should feel okay without knowing everything, not feel limited, and discover ways to do the most for their patients. Lastly, participants were prompted to mention anything else regarding their FPA experience. No other themes were identified.

Participant Response (s):

A. "Stay current with the literature. Know what you are talking about. Earn your credentialing. Know what you don't know. Earn and deserve your full practice authority." *NP Education/research, Confidence*

B. "Get a residency program. If you don't feel prepared, get some help. Mentorship…send suggestions. Get resources and research. Get someone to bounce things off of. Go on a Facebook group. Being new in an MD led practice is not good. It is better being new in an NP led practice." *NP education/research, Collaboration/support group*

C. "New NPs need some type of shadowing before putting them (into) full practice states. One thousand hour minimum with an NP or collaborating MD for a minimum of six months in place. [It is] different from RN to NP. A lot more responsibility. Across the board NPs should have a residency to transition into practice, full practice or not. Afterwards, someone can sign off after showing competency." *New NP education/training/research, Support/collaboration, Confidence/competency*

D. "The new NP [should have] thick skin, not take offense to bumps in the road. [Have] a strong collaborative circle to discuss…support [which leads to being] safe in full practice "doing no harm" protecting [your] license and the patient." *Support/collaboration*

E. "Never stop learning. [New NPs should be] mentored in the first year. [It would include] watching and making suggestions [from the mentor]; time management; and, applying for Medicare and Medicaid. There should be a path to learning [RN to NP]." *New NP education/training/research, support/collaboration, transition*

This research study began during the COVID-19 pandemic. Participants in the study were not explicitly requested to comment regarding the pandemic; however, at the height of the pandemic, many states waived collaborative agreements and expanded the scope of practice for

many NPs. It did not matter if they were in a state which practiced FPA, reduced practice authority, or restricted practice authority. Depending on the state where the NP practiced, they may have experienced a brief period where a requirement for physician collaboration or oversight was lifted.

A few comments regarding COVID-19 emerged from the interviews. Out of 11 participants, four individuals had comments that were COVID-19 related after a thorough review of transcripts.

Participant Response (s):

A. One participant recalled being licensed in several states, and each state had different rules for obtaining licensure to practice in that state. During the pandemic, the APRN could go to the state site, follow the rules, and receive licensure. The participant provided an example relating to geographic residency, in which one no longer had to live in the area or pay taxes in the area of licensure to receive approval. The participant's colleagues were concerned about the Drug Enforcement Agency (DEA) certificate once the pandemic ended. Due to progressive changes in FPA agreements at the time, the participant decided to move forward to obtain as many licenses as possible. The participant concluded that the COVID-19 pandemic provided "...a place in telemedicine where an NP can practice without paying off a doctor."
B. A second individual's COVID-19 remarks were not so much in reference to the advancements in NP autonomy but were about the survival of the NP workforce due to the COVID-19 illness. The participant was also concerned about NPs returning to the bedside and the escalated pay at the bedside for RNs who were not NPs. The participants felt that NPs were more likely to not return to NP practice due to the pay.

C. A third participant's remarks on COVID-19 described the scope of practice, licensure, and telemedicine issues. The participant remarked, "...[the] pandemic has brought forward the limitations of the healthcare delivery system. There has been a temporary allowance for NPs to practice outside of their specialty without certification. The pandemic loosened regulations for that. The delivery of telehealth, being a vital part of the pandemic...[we will] never go back from telehealth...being able to provide care to those who wouldn't seek care..."

D. The fourth participant to mention the COVID-19 pandemic reported, "COVID opened the general public's view about the need for full practice authority like California, Kentucky, Florida...we will see a lot more, and I believe restricted practice will become the exception. Advocates for Interprofessional Education believe we will see more collaboration."

Participants' remarks referencing the pandemic and its effects on NP practice support the idea of loosening practice barriers and permitting FPA to help provide care during the pandemic. Additionally, passing FPA in telemedicine/telehealth showed patients an alternative to receiving care rather than in-person, which was difficult during the pandemic, prompting those who would not regularly seek care to do so.

NPs used their RN capacity at the bedside and outside of their usual NP practice areas, showing the versatility of the NP workforce. Currently, NPs are licensed according to their population-based focus, such as family or adult health, and even this is a limitation on an NP who has different experiences in medical care. Although there were health concerns, pay, and post-pandemic regulations without FPA, FPA encouraged many NPs to practice to the full extent of their license and training. The pandemic demonstrated that FPA is a good fit for the world

during desperate times and measures, so it should be deemed the gold standard for practice moving forward, alleviating the reduced and restricted practice scopes of practice.

Chapter 4 revealed responses from FPA NPs to each semi-structured interview question, as well as additional comments regarding the COVID-19 pandemic. Themes were revealed per question and eventually bracketed toward the study's conclusion according to all responses. In Chapter 5, the study's findings will be discussed and compared to extant literature regarding FPA experiences among NPs. In addition, there will be a comparison to other types of methodology possibly used in other studies. Lastly, implications will be discussed, including a synopsis regarding the impact of the COVID-19 pandemic as it relates to APRNs and FPA.

CHAPTER 5: DISCUSSION AND CONCLUSIONS

The lived experiences of 11 NPs who have FPA were explored in this study. The recorded findings are stated in Chapter 4. The qualitative process of NI was used to stimulate each perspective to emerge as participants recalled their experience as an FPA NP.

Statement of the Problem

This study aimed to explore the everyday experience of the FPA NP through NI. The initial research documented only 23 FPA states, including the District of Columbia (DC) and some U.S. territories (Guam and the Northern Mariana Islands) (AANP, 2022). To date, legislation in the United States and surrounding territories has increased the number of states with FPA for NPs (AANP, 2022). Before this, the VA Hospital System in December 2016 declared FPA for all APRNs, except for CRNAs in all VA facilities. Although the shift to FPA is not without challenges, research can help inform and prepare NPs who may soon obtain FPA. During the last two years, the COVID-19 pandemic issued state executive orders, which temporarily released restrictions for restricted and reduced practice states. This change occurred to better serve the community during a time of emergency. The country is approaching a time when FPA has become the dominant practice for APRNs, and APRNs need to know the FPA experience.

Review of Methodology

Even though NI is a method of qualitative inquiry that captures statistical and demographic information, it also provides space for in-depth explanations of lived experiences, personal perception, and emotion in the process, alongside interpretations that evolve through interviews (Armstrong, 2010). According to Armstrong (2010), NI involves using a particular group, in this case, NPs, to develop interpretations and local theories that afford deep insights

into the human experience. Armstrong (2010) continues to describe the following steps as the process of performing NI:

1. Gaining access to and entering the field site
2. Gathering data
3. Ensuring accuracy and trustworthiness.
4. Analyzing data (begins almost immediately and continues throughout the study)
5. Formulating interpretations on an ongoing basis
6. Writing up the findings
7. Member checking (involves sharing conclusions and conferring with participants)
8. Leaving the field site (p. 881).

For this study, the field site is a virtual interview platform. Virtual interviews were used due to the potential geographic variation and distance of participants. Upon consent to the research, virtual interviews were scheduled according to the participant's availability. Journaling reduced researcher bias and assisted with obtaining clarity during the interview process. Processes of triangulation, member checking, and auditing took place to validate the accuracy of findings. The process ensured that the findings represented the FPA NP's experiences rather than mine.

Study Findings

Several themes were found in the study revealing inconsistencies in FPA laws and requirements. The FPA NPs participating in this study agreed that FPA had been a positive experience. However, limitations still exist that prevent them from practicing to the full extent of their licensure and training. The themes were:

a) Autonomy: the FPA NP should be able to practice to the full extent of their training and education without physician oversight
b) Confidence: NPs need to be empowered that they are skilled and trained, but they also need to know when to collaborate and ask questions
c) Collaboration/Support System: Collaboration should not be mandatory. However, it is essential in providing holistic care
d) Standard Credentialing/Licensure: All states should have the same process and requirements for licensure
e) Legislation: Restrictive barriers should be lifted to allow NPs to practice to the full scope of their practice. NPs in FPA felt restricted
f) Accessibility and Flexibility in patient care: NPs felt that they were able to meet better patient needs as well as have a sense of life-work balance when practicing in FPA
g) New FPA NP education and research: Education and research need to be rigorous so that new NPs can meet the demands of FPA
h) Limitations: barriers and legal restrictions (which vary by state) should be removed which require unnecessary hindrances in patient care that can lead to delays in care or lead to a decline in quality of life for the patient; education and training should be extensive to support work under FPA; and the FPA NP should not have to rely on a costly collaborative physician to provide care, but should work collaboratively to provide holistic care to the patient, recognizing self-limitations and/or barriers
i) Reimbursement: NPs provide holistic care that is not being compensated similarly to other medical professions, although it is well-researched that the quality of care is comparable.

FPA NPs were favorable towards FPA. Some NPs favored FPA more in some states than others due to the varied restrictions in each FPA state. These variations may include practice hour requirements, attestation forms, or restrictions like the inability to work in a hospital setting without a collaborative physician, regardless of whether the state was FPA for NPs. However, findings indicate that FPA NPs felt they could do more for their patients and with more flexibility over their time. Most credentialing requirements were the same across FPA states, except for a few additional requirements, like specific educational requirements per state. Interviewees recalled hindrances from recertification practices, multiple licensure practices, legislative restrictions, and problems with receiving fair compensation from insurers, including Medicare and Medicaid.

Participants also mentioned the COVID-19 pandemic. Some NPs found the pandemic a time of opportunity because practice restrictions were suspended at this time. As a result, a few became credentialed or received a license to practice in several states. One participant had the opportunity to gain FPA in her state, originally a reduced practice. According to the interviews, this temporary suspension expanded services in psychiatric care due to the increase in telemedicine practices.

NPs with FPA in this study discussed the problems with several licensing fees for an NP license in each state. In an article on the impact of COVID-19 on APRNs, practice researchers surveyed 7,467 APRNs, including 6,478 NPs across all 50 states. Their findings indicated that despite suspended practice restrictions during the pandemic, barriers to practice continued even in FPA states (Kleinpell et al., 2021). Restrictions existed in the hospital setting and the outpatient setting. The restrictions included admitting privileges, restricted home health approval, orders for durable medical supplies, co-signature requirements from physicians, and

restricted health insurance credentialing. The findings in the Kleinpell et al. (2021) study are consistent with the findings of the FPA NP study because participants indicated that barriers to practice persisted despite having FPA.

During the COVID-19 pandemic, Tennessee experienced a suspension of some practice restrictions by executive order, which expired two months after they were issued. In the research, "COVID-19 Effects on Practice: Perspectives of Tennessee APRNs," 15 APRNs were interviewed using descriptive qualitative analysis to explore their perceptions of pre-pandemic practice regulations, barriers, executive orders, and the pandemic and the effects of these on APRN practice in Tennessee (Myers et al., 2022). The themes found in this study were: practice changes, the impact of executive orders, and ongoing care barriers.

Myers et al. (2022) described the impact of COVID-19 as a time of improved accessibility to care due to telemedicine. The practice barrier themes revealed were restrictive practice regulations, increased time and money expenditures, and decreased care access. Myers et al. concluded that the executive order was short-lived in Tennessee and was insufficient to implement or evaluate meaningful changes or impacts on practice in the two months it was in effect. Similar to this, the interviewed NPs of the current study expressed that they had both barriers and limitations to practice within FPA but were supported or in collaboration with other healthcare team members.

Limitations

In the study, there are several limitations. The limitations exist in time, participant numbers, recruitment setting, bias against or for FPA, and variations in FPA by state. Time is a limitation because the study was based on the availability of potential participants and some interviews required more than the 60-75 minutes allotted for the interview. Some interviews

were rescheduled 2-3 times before an interview took place. Participant numbers were limited due to the number of potential eligible respondents who answered e-mails for interest in the study. Recruitment was completely contingent on e-mails, and there were no additional ways to contact potential subjects if e-mails were unread or were no longer in service. The goal was 20 FPA NPs, but only 11 participated. The setting of the interviews was virtual – Cisco Webex. Due to some states having FPA and others having reduced or restricted practice authority, there may have been bias during the interview. This bias may be due to APRNs who practice in both capacities or have associates who are not in FPA. The study encouraged a dialogue about the experience of the NP, not limited to the political or legislative sides of FPA. Furthermore, FPA varies by state, but this study incorporates NPs from several FPA states offering a broader perspective of the experience of FPA NPs.

Implications

The study revealed several themes based on 11 NP interviews utilizing NI. Themes were categorized as the following: (a) Autonomy, (b) Confidence, (c) Collaboration/Support System, (d) Standard credentialing/Licensure process, (e) Legislation, (f) Accessibility and flexibility in patient care, (g) New FPA NP education and research, (h) Limitations, and (i) Reimbursement.

The participants believed that improved healthcare access and improved patient health outcomes could result from FPA. NP education and training should be extensive to support work under FPA. The FPA NP should not need to rely on a costly collaborative physician to provide care but should work collaboratively to provide holistic care to the patient, recognizing self-limitations and/or barriers. Insurance companies and legislative restrictions continue practices that do not fully accept FPA. Advocacy for FPA must engage all stakeholders, including the medical boards and insurance companies, by establishing a patient-centered multi-disciplinary

approach. Acknowledging the FPA NP's benefits and expertise will improve patient health outcomes. NPs must lobby for the APRN Consensus Model so that all NPs can participate in the same licensure process, no matter the practice area or state. A national model will mitigate issues with barriers to practice as well as eradicate restricted practice authority and reduced practice authority. However, there is a need for this effort to be nationally supported to attain complete unrestricted FPA recognition and legislation in the United States and surrounding U.S. territories. The study has shown that FPA still needs work due to varying restrictions in practice. However, it stands to be beneficial to the patients in providing the most care.

Further implications for research should be done to compare the three types of practice authority and compare restrictions by state. The restrictions should be evaluated based on necessity while doing the research. Research should also be done to explore internal and external factors that promote the transition to FPA practice. This research can help further eradicate restricted or reduced practices and allow for FPA without restrictions.

Conclusion

This qualitative study used virtual interviews to derive in-depth, thick descriptions of the FPA experience of selected NPs. All NPs in the study agreed that having FPA is a positive experience. However, legal restrictions, insurance policies, and mandatory physician supervision or collaboration limit NP's ability to provide care comparable to their education and training. These were issues for some FPA NPs and were common barriers in more restrictive states. As the Institute of Medicine (2011) has stated before, APRNs should be able to practice to the full extent of their education and training. Collaboration with team members is a practice that NPs accept as a benefit to the patient's holistic care. However, mandatory for-fee supervision is a costly practice. As the profession aims for FPA for all states, DC, and U.S. territories, there is

much work to do to eliminate state-by-state regulation of NPs. To do so, some participants recommended that the new NP with FPA be active in their local and state nursing chapters to impact change and remain current with laws that affect NPs.

The study's results further acknowledged the necessity of FPA for all NPs proposed by the APRN Consensus Model. The organizations responsible for regulating and implementing standards of education, certification, clinical practice, and community public safety worked together to reach a consensus in support of FPA (APRN Joint Dialogue Group Report, 2008). A combination of past research and this study's findings can contribute to policy agendas and remove practice barriers for NPs to obtain FPA in every state and U.S. territory. This shift will allow NPs to practice to the full extent of their education and training, increasing community-accessible care. "The Naturalistic Inquiry into the Lived Experience of Nurse Practitioners Who Have Full Practice Authority" study offers insight into the FPA experience, as the profession aims for an FPA for all.

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Appendix A

IRB Approval Letter

utmb Health

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Institutional Review Board
301 University Blvd.
Galveston, TX 77555-0158
Submission Page

27-Apr-2021

MEMORANDUM

TO: Kimberly Jenkins
Grad School Biomedical Science GSBS9999

FROM: Jacqueline S. Meyer PhD
Vice-Chairman, IRB #1

RE: Initial Study Approval

IRB #: IRB # 20-0229

Submission Number:20-0229.003

TITLE: A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners who have Full

Practice Authority

DOCUMENTS: Research Protocol

APRN FP Flyer

Demographic Form

Fast Fact Sheet

NP Email 1

NP Email 2

Semi-Structured Interview

State Board Request Email

Verbal Consent Script

Verbal Consent Log

The UTMB Institutional Review Board (IRB) reviewed the above-referenced research protocol via an expedited review procedure on **27-Apr-2021** in accordance with 45 CFR 46.110(a)-(b)(1). Having met all applicable requirements, the research protocol is approved. The approval for this research protocol begins on **27-Apr-2021.**

Continuing Review for this protocol is not required, as outlined in 45 CFR 46.109. The Principal Investigator is still responsible for:

1. Submitting amendments for protocol changes.
2. Reporting Adverse Events, Protocol Violations, and Unanticipated Problems, as outlined in IRB policies and procedures.

3. Closing the project once it ends, or when personal identifiers are removed from the data/biospecimens and all codes and keys are destroyed.

Written documentation of consent is waived in accordance with 45 CFR 46.117(c).

The approved number of subjects to be enrolled is **50.00**. If the approved number needs to be increased, you first must obtain permission from the IRB to increase the approved sample size.

If you have any questions, please do not hesitate to contact the IRB office via email at IRB@utmb.edu.

Appendix B

E-mail to Full Practice Authority State Boards of Nursing

Dear State Board of Nursing,

My name is Kimberly Jenkins-Morris, FNP-BC, PhD in nursing candidate at University of Texas Medical Branch (UTMB), Galveston. I am writing to request the participation of your full practice authority nurse practitioners (FPANPs) in my study, "A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners with Full Practice Authority". I would like to obtain an email list of your nurse practitioners to request voluntary participation into the study. The purpose of the study is to increase knowledge about the experience of the full practice authority nurse practitioner. If the nurse practitioners agree to participation, each participant will engage in a sixty (60) to seventy-five (75) minute interview about their full practice authority nurse practitioner experience. I look forward to your response. If there are any questions or concerns regarding recruitment, please feel free to reach out by email to knjenkin@utmb.edu or by cellular phone at 832-368-4788.

Sincerely,

Kimberly Jenkins-Morris, RN, FNP-BC

GSBS School of Nursing, PhD Candidate

UTMB Galveston

Appendix C

Initial E-mail to Potential Study Participants

Dear Advanced Practice Registered Nurse (APRN),

My name is Kimberly Jenkins-Morris. I am a PhD graduate student from the University of Texas Medical Branch in Galveston, Texas. I am seeking to interview nurse practitioners in your area. You are being contacted to request your participation in a research study called, "A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners who have Full Practice Authority". The purpose of the research study is to increase knowledge about the APRN full practice authority experience. The research study is voluntary. If you are interested in participating in the study, please reply to this e-mail with a simple comment of "APRN FULL PRACTICE AUTHORITY" so that the follow-up e-mail can be sent. Upon receiving your email indicating your willingness to participate in the research study, an e-mail with further instructions was sent to you with a link for further instructions including completion of demographic survey. By completing the demographic survey and sending it back to the principal investigator (PI), consent is implied that you have agreed to participate in the study. Participation can be withdrawn at any time. A schedule of potential interview times and dates was sent to you once the survey is completed for you to choose a convenient interview appointment. The interview was virtual and take about sixty (60) to seventy-five (75) minutes, including breaks as requested per participant. If you agree with finding out more about the study and are thinking about participation, please send an e-mail to knjenkin@utmb.edu. If there are any questions or concerns, please contact Kimberly Jenkins at bushknj@gmail.com or at 832-368-4788. The University of Texas Medical Branch (UTMB) committee that reviews research on human subjects, the Institutional Review

Board (IRB), will answer any questions about your rights as a research participant. They will also take any comments or complaints that you may wish to offer. You can contact the UTMB IRB by calling +1-409-266-9400.

Sincerely,

Kimberly Jenkins-Morris, RN, FNP-BC

GSBS School of Nursing, PhD Candidate

University of Texas Medical Branch Galveston

knjenkin@utmb.edu

Appendix D

Follow-Up E-mail

Dear Potential Research Participant,

My name is Kimberly Jenkins- Morris. I am a PhD graduate student from the University of Texas Medical Branch (UTMB) in Galveston seeking to interview nurse practitioners in your area. Thank you for seeking out more information about, "A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners who have Full Practice Authority" research study. The purpose of the research study is to increase knowledge about the APRN full practice authority experience. The research study is voluntary. By completing the demographic survey, consent is implied that you have agreed to participate in the study. You will find a demographic questionnaire and information to give to your peers if you feel they may be interested in participation. Upon completing the survey, you will need to send the e-mail to knjenkin@utmb.edu e-mail. Participation can be withdrawn at any time. The interview was scheduled and take place online for about sixty (60) to seventy-five (75) minutes, including breaks as requested per participant. If you have questions about participation, please send an e-mail to knjenkin@utmb.edu. If there are any questions or concerns, please contact Kimberly Jenkins at bushknj@gmail.com or at 832-368-4788. The University of Texas Medical Branch (UTMB) committee that reviews research on human subjects, the Institutional Review Board (IRB), will answer any questions about your rights as a research participant. They will also take any comments or complaints that you may wish to offer. You can contact the UTMB IRB by calling +1-409-266-9400. Upon acceptance into the study, you was contacted by the principal investigator by email to determine a time and date for your interview. If you are not accepted

into the study, you was sent an e-mail stating that you have not been accepted into the study.

Again, thank you for your interest and I look forward to your participation in the research study.

Sincerely,

Kimberly Jenkins-Morris, RN, FNP-BC

UTMB School of Nursing, PhD Candidate

University of Texas Medical Branch Galveston

knjenkin@utmb.edu

Appendix E

IRB Fast Facts

utmb Health

FAST FACT SHEET **IRB#: 20-0229**

Study Name: A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners who have Full Practice Authority

Contact Information:

Principal Investigator/Study Coordinator:

Kimberly Jenkins, RN, MSN, FNP-BC Office: 832-368-4788 Email: knjenkin@utmb.edu

What is the purpose of this research study? The purpose of this research study is to explore the lived experiences of nurse practitioners who have full practice authority.

What are the Research Procedures? A list was requested from a state board of nursing that has full practice nurse practitioners. Potential participants were solicited via electronic mail once the list is obtained. Participants will reply to the email if they are interested in participation. Upon receiving the second email from the principal investigator, the participant was able to voluntarily choose to consent electronically to the study. Upon receiving your consent, the participant was contacted to establish a date and time for their 60–75-minute interview. The interview will take place via electronic audio/visual media. The interview was recorded. The principal investigator will also use journaling during each interview. Once the data has been collected from a minimum of ten participants, and no more than 20 participants. The data was transcribed by a professional transcription service, accepting the audio/video media used for the interviews.

What are the Risks and Benefits? There are no direct benefits that result from participation in the study. Every effort was made to keep your information confidential; however, this cannot be guaranteed. You may not receive any personal benefits from being in this study. We hope the information learned from this study benefits other people with similar conditions in the future.

Costs and Compensation: Two participants will be randomly selected to receive a fifty (50) dollar Amazon gift card. The selected participants will be contacted via telephone/email and their cards to be sent via email.

How will my information be protected? The information we learn about you in this study will be handled in a confidential manner. If we publish the results of the study in a scientific journal or book, we will not identify you. In order to maintain confidentiality, study participants are given participant numbers. Information will be stored according to those numbers. Data will be stored in a password protected computer to maintain confidentiality of participants. The only person having access to the password protected computer is the principal investigator. Copies of the data are kept in an internet "cloud" by way of photo, per transcription. Copies of the recording will also be kept on a password protected USB drive. All consents and data will remain under lock and key for a duration of five (5) years to protect participant information and for confirmability.

Who can I contact with questions about this research study? This study has been approved by the UTMB Institutional Review Board (IRB). If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information about the protection of human subjects in research, you may contact the IRB Office, at (409) 266-9400 or irb@utmb.edu..

For questions about the study, contact Kimberly Jenkins, RN, MSN, FNP-BC at the numbers listed above. Before you agree to participate, make sure you have read (or been read) the information provided above; your questions have been answered to your satisfaction; you have been informed that your participation is voluntary, and you have freely decided to participate in this research.

Appendix F

Demographic Questionnaire

Demographic/Eligibility Questionnaire

1. How old are you?

2. What do you identify as your gender?

3. What do you identify as your ethnicity?

4. Are you a certified nurse practitioner (NP)?

5. What is your certified specialty area?

6. What state or state(s) do you currently practice as a nurse practitioner?

Alabama	Georgia	Maine	Nevada	Oregon	Virginia
Alaska	Hawaii	Maryland	New Hampshire	Pennsylvania	Washington
Arizona	Idaho	Massachusetts	New Jersey	Rhode Island	Washington, D.C.
Arkansas	Illinois	Michigan	New Mexico	South Carolina	West Virginia
California	Indiana	Minnesota	New York	South Dakota	Wisconsin
Colorado	Iowa	Mississippi	North Carolina	Tennessee	Wyoming
Connecticut	Kansas	Missouri	North Dakota	Texas	
Delaware	Kentucky	Montana	Ohio	Utah	
Florida	Louisiana	Nebraska	Oklahoma	Vermont	

7. What state or state(s) have you previously practiced in as a nurse practitioner?

Alabama	Georgia	Maine	Nevada	Oregon	Virginia
Alaska	Hawaii	Maryland	New Hampshire	Pennsylvania	Washington

Arizona	Idaho	Massachusetts	New Jersey	Rhode Island	Washington, D.C.
Arkansas	Illinois	Michigan	New Mexico	South Carolina	West Virginia
California	Indiana	Minnesota	New York	South Dakota	Wisconsin
Colorado	Iowa	Mississippi	North Carolina	Tennessee	Wyoming
Connecticut	Kansas	Missouri	North Dakota	Texas	
Delaware	Kentucky	Montana	Ohio	Utah	
Florida	Louisiana	Nebraska	Oklahoma	Vermont	

8. Do you have full practice authority in the state where you practice?

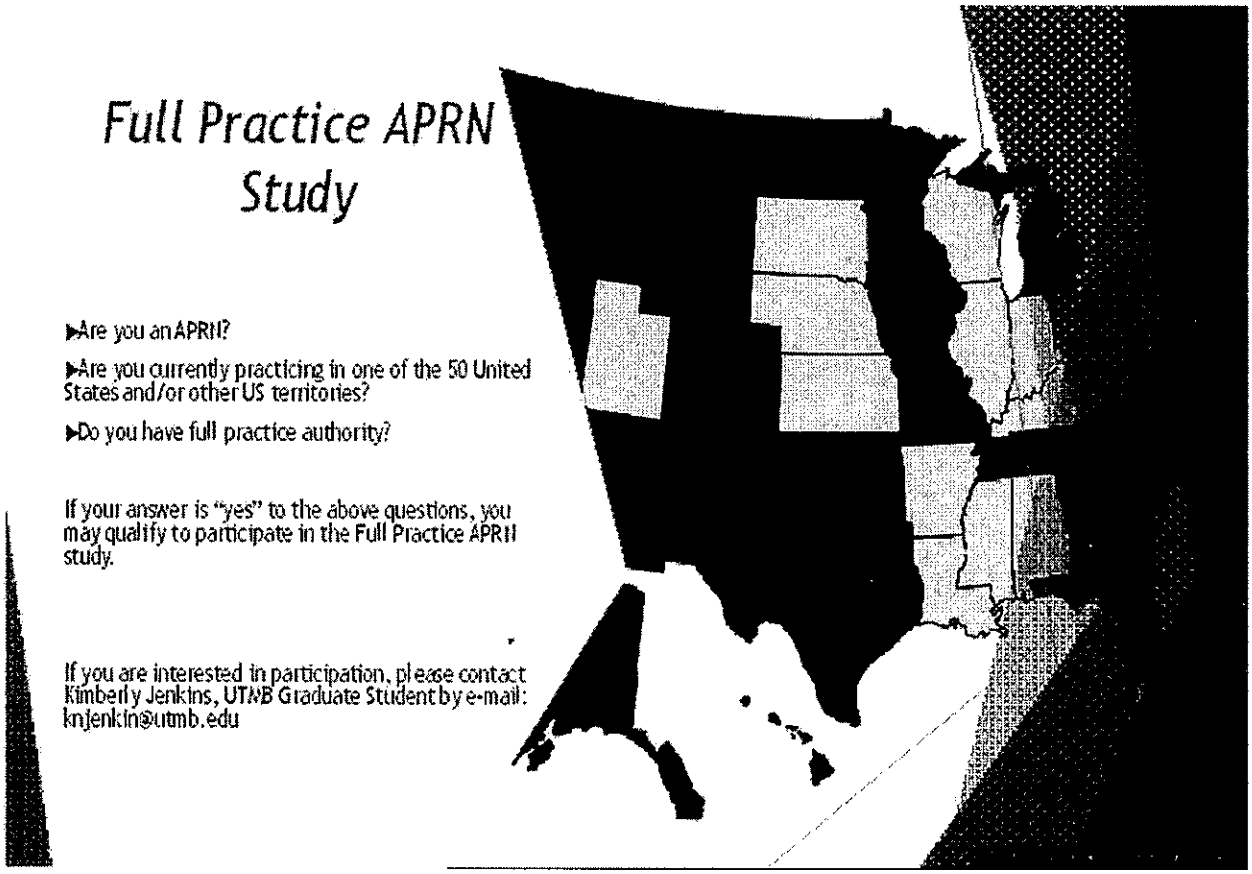
9. Have you been employed at least 12 months in your full practice authority nurse practitioner role?

10. How many years of practice have you had in a full practice authority state?

11. Are you able to speak, read, and write American Standard English?

Appendix G

Study Recruitment Flyer



Appendix H

Verbal Consent Documentation for Study 20-0229

Language verbal consent interview completed in: ENGLISH

Subject Number:	Subject Name and Birth month/year (XX/XX):	Date/Time of Verbal Consent	Principal Investigator (PI) Signature
1			
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Appendix I

The University of Texas Medical Branch at Galveston

Verbal Consent Script

Protocol Title: A Naturalistic Inquiry into the Lived Experience of Nurse Practitioners Who Have Full Practice Authority

IRB Number: **20-0229**

Principal Investigator: Kimberly Jenkins, MSN, APRN, FNP-BC, PhD-candidate

knjenkin@utmb.edu

(832) 368-4788

You are being asked to participate in the study, "A Naturalistic Inquiry into the Lived Experience of Nurse Practitioners who have Full Practice Authority". You are being asked to participate because you are a certified nurse practitioner (NP) practicing in a state of full practice authority (FPA). Participation in this study is completely voluntary. You may refuse to participate or withdraw from this research study at any time without penalty. The purpose of this study is to explore the lived experiences of nurse practitioners who have full practice authority. Upon receipt of your verbal consent, you will participate in a sixty (60) to seventy-five (75) minute virtual interview via Cisco Webex. The date and times will be chosen by you at your convenience. You are allowed to take breaks during the interview. There are no direct benefits to you by participating in this study. Risks or discomforts from this research include the loss of confidentiality. Steps was taken to minimize this risk. Your name will be entered into a random drawing to receive one of two fifty (50) dollar gift cards. By stating your name, you are giving

verbal consent to participate in this study. The interview will begin after you give verbal consent. If you have any questions, concerns, or complaints before, during or after the research study, or if you need to report a research related injury or bad side effect, you should immediately contact **Kimberly Jenkins** at **(832)368-4788** or by email at knjenkin@utmb.edu. This study has been approved by the UTMB Institutional Review Board (IRB). If you have any complaints, concerns, input, or questions regarding your rights as a subject participating in this research study or you would like more information about the protection of human subjects in research, you may contact the IRB Office, at (409) 266-9400 or irb@utmb.edu.

Appendix J

Semi-Structured Interview Questions

Semi-Structured Interview

I want to thank you for agreeing to participate in this research study which will explore the lived experiences of nurse practitioners who have full practice authority. You, the participant, will be asked questions during the interview to encourage detailed descriptions of your experience as a full practice authority nurse practitioner. The virtual interviews will take place by audio/visual media and recorded by Cisco Webex. The PI will also journal the information. You will be informed when the recording will begin. The interview will take about sixty (60) to seventy-five (75) minutes to complete. Please inform the PI if you are uncomfortable or are no longer interested in the study. Please request a break at any time. This study is a voluntary study and you can withdraw voluntary consent at any time.

My Main question is:

"What is it like for you to practice as a nurse practitioner with full practice authority?"

I would like you to contemplate the question and share what it is like for you to experience your practice on a daily basis?

Additional Probing questions:

1. What does full practice authority mean to you? Please explain.
2. What was/is the credentialing process for NPs with full practice authority?
3. What has been a challenge in your career as it relates to full practice authority? Positive (facilitators) or negative (barriers) experiences? Please Explain.

4. Have you ever worked as an NP in any other state of practice other than a full practice authority state? What state of practice was that? Please explain any comparisons according to your experience, between states of practice.

5. What are some recommendations for the new NP who will have full practice authority? Please provide in detail your recommendations.

6. Are there any other details that you would like to mention? Please explain.

Appendix K

Final Themes for: A Naturalistic Inquiry into the Lived Experiences of Nurse Practitioners Who Have Full Practice Authority

Interview Questions	Themes
Question#1: What is it like for you to practice as a nurse practitioner with full practice authority?	Preliminary Analysis: Legislative Limitations, Autonomy, Flexibility, Reimbursement, Accessibility, Legislation, Collaboration Final Analysis: unchanged
Question#2: What does Full Practice Authority mean to you?	Preliminary analysis: Independent practice/Autonomy, Collaboration, Limits due to legislation Final Analysis: Unchanged
Question#3: What was the credentialing process for NPs with full practice authority?	Preliminary Analysis: Pay fees, RN licensure application, APRN licensure application, fingerprints, background checks, controlled substances application, Continuing education units; there may be additional requirements Final Analysis: Unchanged
Question#4: What has been a challenge in your career as it relates to full practice authority?	Preliminary Analysis: Letting go of arbitrary practices - MD needing to sign documentation, Standard Credentialing Process for all states all under one system, Increase knowledge about the Full Practice Authority Nurse Practitioner and the benefits of having

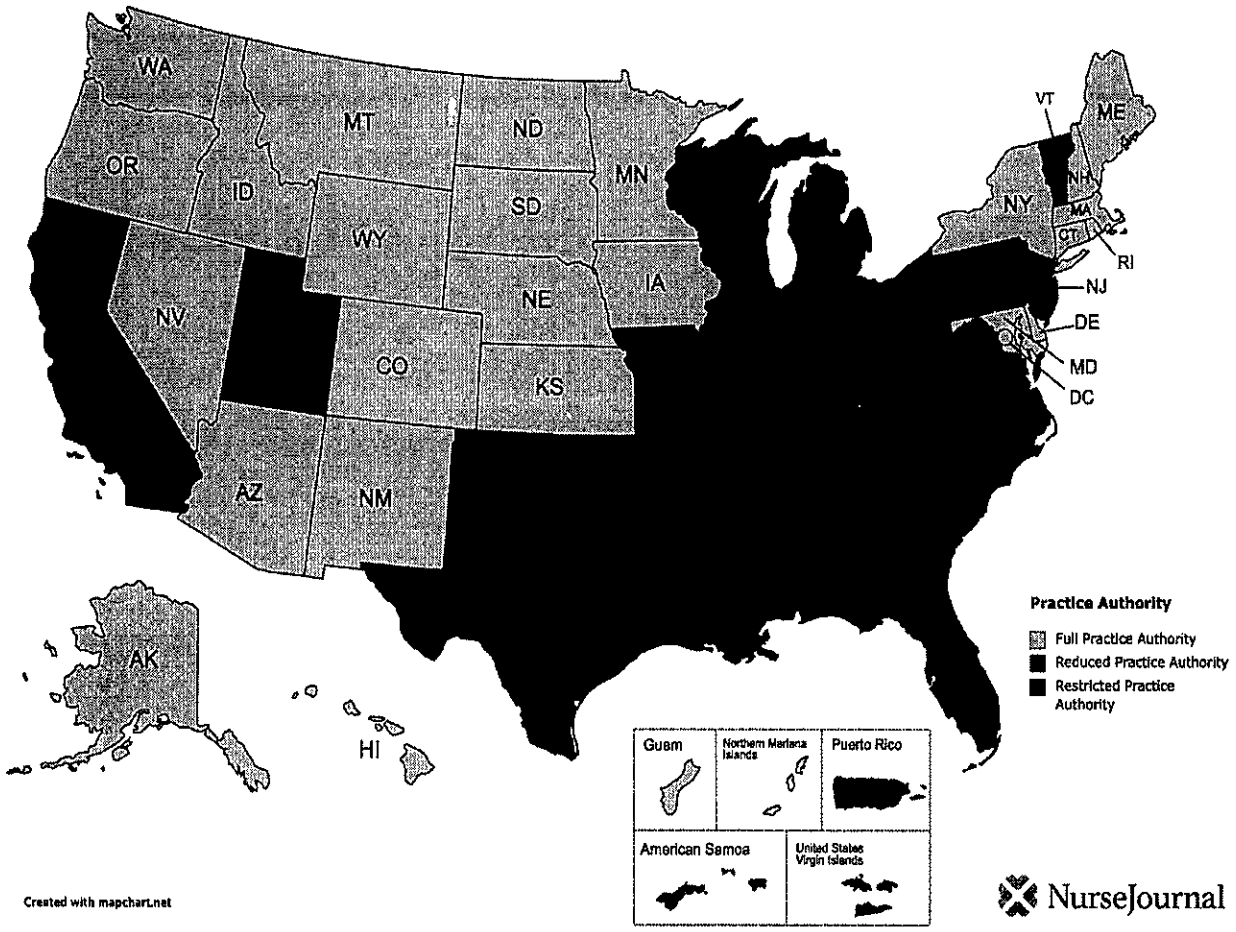
	this type of provider to the public, Change legislation and insurance policies regarding NP care Final Analysis: 1. Standardization of credentialing process 2. Letting go of arbitrary practices 3. Social awareness
Question#5: Have you ever worked as an NP in any other state of practice other than a full practice authority state?	Full Practice Authority NPs have worked in other types of practice before working as a FPA NP or only as a FPA NP.
Question#6: What are some recommendations for the new NP who will have full practice authority?	Preliminary Analysis: Confidence, Don't feel limited, Education/Research, NP Mentors, Self-Sufficient, Support System/Collaborative Network Final analysis: Unchanged
COVID-19 Comments:	Waiver of restrictions and license requirements by state Increased pay to the in-patient role of RN due to COVID-19 that could lead to loss of NPs NPs practiced outside of scope of practice Telemedicine is here to stay COVID-19 brought awareness to the public about the need for FPA in reduced and restricted states

	Expansion of Interprofessional collaboration due to COVID-19

Final Themes of the Study: 1) Autonomy; 2) Confidence; 3) Collaboration/Support System; 4) Standard Credentialing/Licensure process; 5) Legislation; 6) Accessibility and Flexibility in patient care; 7) New FPA NP education and research; 8) Limitations; and, 9) Reimbursement

Appendix L

State-by-State NP Practice Authority



Sourced from: Nurse Practitioner Practice Authority: A State-by-State Guide | NurseJournal.org

https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/

CURRICULUM VITAE

NAME: Kimberly Jenkins (Morris) DATE: 12/4/2022

PRESENT POSITION AND ADDRESS: Family Nurse Practitioner
4800 Fournace Place
Bellaire, Texas 77401

BIOGRAPHICAL: Date of Birth: 06/08/1979; Houston, Texas; United States of America
Address: 5422 Pecan Pass Court, Missouri City, Texas 77459

EDUCATION: B.S.P.H., May 2002, Dillard University, New Orleans, Louisiana
B.S.N., May 2005, Prairie View University, Prairie View, Texas
M.S.N., May 2009, Prairie View University, Prairie View, Texas

PROFESSIONAL AND TEACHING EXPERIENCE: February 2014-Present
Family Nurse Practitioner
Harris Health System
Houston, Texas 77030

January 2010-February 2014
Instructor/Nurse Practitioner
Baylor College of Medicine
Houston, Texas 77030

June 2005- January 2010
Registered Nurse
Harris Health System
Houston, Texas 77030

RESEARCH ACTIVITIES:

A. HIV Research – Family Nurse Practitioner – grant funded position on several HIV infected, exposed, and prevention protocols – through Maternal Fetal Medicine; assisted with Adolescent Trial Network at Baylor College of Medicine (2010-2014)
B. Homeless – Family Nurse Practitioner – grant funded position with several quality initiatives to include, but are not limited to, HIV PrEP initiation, BP Management, Statin Initiation; Early HIV diagnosis and prevention, Early detection of diabetes and management: Goal of Hemoglobin A1C <9 - under Health Resources and Services (HRSA) grant (2014-Present)

COMMITTEE RESPONSIBILITIES:

A. American Association of Nurse Practitioners (AANP), Member Since 2015

B. American Nurses Credentialing Center (ANCC), Member Since 2009
C. Harris Health System, Ambulatory Care Services, Community of Practice, Chair 2020

TEACHING RESPONSIBILITIES AT UTMB: N/A

MEMBERSHIP IN SCIENTIFIC SOCIETIES: National Science Honor Society, Inducted 2002 Dillard University

BOARD CERTIFICATION: ANCC #: 2009009201 Expiration: 10/2024

LICENSURE INFORMATION: Registered Nurse, Texas
License #: 716833 Expiration: 06/23

Advanced Practice Registered Nurse, Texas
License #: AP118526 Expiration: 06/23

HONORS: Good Samaritan Award, Patient-Centered Medical Home Designation (Homeless Department), Quality Improvement Project – HIV screening and early diagnosis – First place