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In the United States, many states have revised their nurse practice acts to include provisions that promote full practice authority for nurse practitioners. Such revisions reflect the expanded qualifications and abilities of nurse practitioners and provide a mechanism by which to better utilize the full scope of nurse practitioner services that are available to address growing demands for access to health care. Although the research literature is beginning to describe strategies that states have used to successfully achieve regulatory changes to full practice authority for nurse practitioners, no published study identified in the literature has explored how stakeholders within a state decide on the appropriate time to pursue such legislation.

This is the first known study to use an embedded single case study design, guided by the Kingdon (2011) policy stream model, to provide a detailed account of how stakeholders for nurse practitioner full practice authority in one stated determined the appropriate time to pursue legislative changes to nurse practitioner scope of practice regulations. Qualitative data analysis was guided by Yin (2014), and used theoretical propositions, the development of a case description, pattern matching, and explanation building. Findings from the study addressed the research question by revealing four themes which included the components considered by the study state's stakeholders as they determined the appropriate time to pursue legislation to change nurse practitioner scope of practice regulations. Study findings can be used as a reference to increase the competency with which the nursing profession pursues the policy process for full practice

authority legislation, and can be used by stakeholders in other states as a guide for the assessment components to consider when making decisions to pursue related legislation.

WHEN IS THE APPROPRIATE TIME TO PURSUE NURSE PRACTITIONER PRACTICE LEGISLATION? A CASE STUDY

by

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Approved by

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To my husband, Christopher, and my sons, Logan and Mason. Thank you for believing in me, and for your love, sacrifice, and support.

APPROVAL PAGE

This dissertation written by CATHERINE MOORE has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

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CHAPTER I

INTRODUCTION

To maximize the contributions of nurse practitioners (NPs) in a transformed United States (US) health care system, legislative changes at the state and federal level are required to update and standardize scope of practice (SOP) regulations to promote patient choice in health care providers (Institute of Medicine [IOM], 2010). Nurse practitioners are governed by their state laws, and the extent to which they are used is partially influenced by state NP SOP regulations and policies (Federal Trade Commission [FTC], 2014; Xue, Ye, Brewer, & Spetz, 2016). Many states have revised their nurse practice acts (NPAs) to reflect the expanded qualifications and abilities of NPs in order to better utilize the full scope of NP services that are available to meet population needs (Cross & Kelly, 2015; Gadbois, Miller, Tyler, & Intrator, 2015; Iglehart, 2014). However, regulation remains inconsistent across the US (Gadbois et al., 2015; Lugo, O'Grady, Hodnicki, & Hanson, 2010; Schiff, 2012). Outdated, restrictive SOP regulations for NPs that remain in many states inhibit competition among health care providers and can lead to decreased access to health care services, decreased patient choice in health care providers, increased health care costs, decreased quality of care, and decreased innovation in health care delivery (Center to Champion Nursing in America, 2010; FTC, 2014; IOM, 2010; Lowery, Scott, & Swanson, 2015).

In the study state for this dissertation research, the first degree-granting NP program was established in 1970; seven graduates completed the program in 1971 (Lowery & Varnam, 2011). The study state pioneered the regulation of NPs in 1973 when it became the first in the US to establish statutes, rules, and regulations to define NP practice (Appalachian State University, 2016; Lowery & Varnam, 2011). In 1975, NPs gained the legal right to prescribe, compound, and dispense medications (Appalachian State University, 2016). However, early advances in the creation and regulation of the NP role in the study state required compromises, including the model of joint regulation (JR) of NPs by both the Board of Nursing and Board of Medicine, and requirements for physician supervision of NP practice that still remain in the state (Kugler, Burhans, & George, 2011; Lowery & Varnam, 2011).

Rigolosi and Salmond (2014) suggest that now is the time for states to pursue policy change for NP full practice authority (FPA) legislation. However, Kingdon (2011) asserts that policy change is more likely to occur when identified problems, policy proposals, and the politics surrounding an identified problem converge at the same critical point in time, creating an open window of opportunity to push a policy proposal forward. According to Kingdon's (2011) model, each state must assess its political environment, and competing policy problems and proposals to determine if the time is appropriate for introducing NP FPA legislation. Studies are needed to provide guidance on how stakeholders for NP FPA legislation determine whether or not the time for state-specific legislation is appropriate based on each state's assessment. This study is the first

known study to provide a detailed account of how stakeholders for NP FPA in one state determine the appropriate time to pursue legislative changes to NP SOP regulations.

Statement of the Problem

Although the research literature is beginning to describe strategies that states have used to successfully achieve regulatory changes to FPA for NPs (Duncan & Sheppard, 2015; Pruitt, Wetsel, Smith, & Spitler, 2002; Rigolosi & Salmond, 2014), no published study identified in the literature has explored how stakeholders within a state decide on the appropriate time to pursue NP FPA legislation. Studies are needed to provide guidance on how stakeholders for NP FPA legislation determine whether or not the current time in their specific state is appropriate.

Purpose

The purpose of this study was to achieve a comprehensive understanding of how stakeholders for NP FPA in one state determine the appropriate time to pursue legislative changes to NP SOP regulations.

Research Question

How do one state's stakeholders for NP FPA determine the appropriate time for pursing legislation to change NP SOP regulations?

Significance of Study

This study is important for nursing in that it is the first known study to provide a detailed account of how stakeholders for NP FPA in one state determine the appropriate time to pursue legislative changes to NP SOP regulations. Findings from the study are useful to the study state in that they may serve as a self-assessment of the state's current

political environment and readiness for legislative pursuits according to the Kingdon (2011) model. Additionally, the study's findings are useful as a guide for stakeholders in other states that are considering the pursuit of legislation to change NP SOP regulations. Finally, findings from this study add to the body of research literature that describes the policy process that NPs encounter when pursuing FPA legislation.

Theoretical Framework

The study was guided by Kingdon's (2011) policy stream model. According to Kingdon (2011), the policymaking process is dynamic and fluid, occurring in an unpredictable and chaotic environment. Within the model there are three separate streams: the problem stream, the policy stream, and the politics stream. The streams usually move through time separately but in parallel. However, at certain critical points in time, they converge to form an open window of opportunity in which an issue can be moved onto the governmental agenda with the potential for action. Based on the Kingdon (2011) model, the study explored the following theoretical propositions:

1. The current problems, available policy alternatives, and political environment in the study state will influence NP FPA stakeholders to decide that the 2017 legislative session is the appropriate time to introduce legislation to pursue changes to NP SOP regulations.
2. The 2017 legislative session will present an open window of opportunity for introducing legislation for NP FPA in the study state.

Methodology

A qualitative methodology, with an embedded single case study design was used to conduct the proposed study. Five rationales exist for using a single case design: the identification of a critical, unusual, common, revelatory, or longitudinal case (Yin, 2014). A *critical* case is beneficial for situations in which the researcher tests a previously developed theory. The single case can support a theory's propositions or offer an alternative set of explanations which can contribute to knowledge and theory building (Yin, 2014). An *unusual* case in one that deviates from theoretical norms or everyday occurrences and can reveal insights about normal processes that can be connected to a larger situation beyond that of the single, identified case (Yin, 2014). The purpose of a *common* case is to capture and describe the circumstances and conditions of an everyday situation and provide insight about the social processes related to a prior theoretical area of interest (Yin, 2014). A *revelatory* case is one in which the researcher has an opportunity to observe and analyze a phenomenon previously inaccessible to social science inquiry. In such situations, the opportunity for uncovering a previously inaccessible phenomenon and revealing the nature of its processes is rationale for the single-case study (Yin, 2014). A final rationale for the use of a single case study is the *longitudinal* case. This occurs when the researcher studies the same single case at two or more points in time to test theoretical propositions about how certain conditions and processes change over time (Yin, 2014). The study state is an unusual case in that it is the first state in the US to establish statutes, rules, and regulations for NP practice (Lowery &

Varnam, 2011) and it is one of the few remaining states in the US that use the JR model for regulation of NPs (Kugler et al., 2011; Lowery & Varnam, 2011).

Assumptions

The researcher for the study assumed that the stakeholders for NP FPA in the study state would willingly discuss their thoughts about how to determine the appropriate time to pursue NP FPA through legislative changes to NP SOP regulations. Additionally, the researcher held to the assumption presented by Kingdon (2011) that the policymaking process in the study state would be dynamic and fluid, and that it would occur in an unpredictable and chaotic environment.

Delimitations

Key informants for this study's interviews were limited to those who speak English and had knowledge of the legislative efforts regarding NP FPA in the study state. Documents and archival data included in the study were limited to those created within the past 25 years. The 25-year limitation allowed for sufficient review of documents and bills from the past 13 legislative sessions to reflect a timeline on advanced practice registered nurse (APRN) and NP-specific initiatives to effect change in the study state.

Definition of Terms

For the purposes of this study, the following definitions were used:

1. Access to health care: the use of personal health services in a timely fashion to achieve the best health outcomes, and everything that facilitates or impedes their use (Andersen, Davidson, & Baumeister, 2014; Healthypeople.gov, 2016).

2. Advanced Practice Registered Nurse: a registered nurse with a graduate-level degree in nursing who is prepared in one of four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP) (APRN Consensus Workgroup and National Council of State Boards of Nursing, [NCSBN], 2008).
3. Agenda: "the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time" (Kingdon, 2011, p. 3).
4. Decision Agenda: "the list of subjects within the governmental agenda that are up for active decision" (Kingdon, 2011, p. 4).
5. Governmental Agenda: "the list of subjects that are getting attention" (Kingdon, 2011, p. 4).
6. Nurse Practitioner: an advanced practice registered nurse who provides care, including the diagnosis and management of acute and chronic illnesses, health promotion, disease prevention, health education, and counseling to a variety of patient populations across the wellness-illness continuum (APRN Consensus Workgroup and NCSBN, 2008).
7. Nurse Practitioner Full Practice Authority: state practice and licensure laws that authorize nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments (including prescribing medications) under the exclusive authority of the state board of nursing (American Association of Nurse Practitioners [AANP], 2016c).

8. Physician Oversight: statutory requirements for mandated physician involvement in NP practice for activities including supervision, collaboration, protocol approval, prescriptive authority approval or signing practice-related forms requiring clinician record of signature (Lowery, 2012, p. 32).
9. Policies: proposed solutions to a problem. Policy proposals are floated in a *policy primeval soup* where they are considered, revised, combined with each other, and refloated before serious consideration is given to one particular policy. Policies that are seriously considered meet several criteria: their technical feasibility and value acceptability, the current national mood, budgetary workability, and the political support or opposition that they might experience (Kingdon, 2011).
10. Politics: electoral, partisan, or pressure group factors used to obtain the support of important interest group leaders (Kingdon, 2011).
11. Problems: subjects that gain the attention of governmental decision makers because they represent issues that are judged to require attention. Mechanisms that bring problems to the attention of governmental officials include systemic indicators, focusing events (such as a crises), or feedback from existing programs (Kingdon, 2011).
12. Regulation: "governing or directing according to a rule or bringing under the control of a constituted authority such as a state or federal government" (Lowery, 2012, p. 33).
13. Scope of Practice: The rules, regulations, and boundaries, as defined by state legislatures and governing boards, that direct the activities that a fully qualified

health care practitioner with substantial and appropriate education, training, knowledge, and experience may perform within a specifically defined field (Federation of State Medical Boards, 2005; NCSBN, 2006).

14. Softening-up: a process whereby policy advocates begin discussions of their proposals and "push their ideas in many different forums" with the goal creating a climate that will allow for the introduction of a proposed change (Kingdon, 2011, p. 228).
15. Stakeholder: a person or organization with a concern or interest in a particular course of action and the evidence that supports the course of action (Agency for Healthcare Research and Quality [AHRQ], 2014a; Oxford English Dictionary, 2016).

Summary

This study was an embedded single case study designed to achieve a comprehensive understanding of how stakeholders for NP FPA in one state determine the appropriate time to pursue legislative changes to NP SOP regulations. The study used the policy stream model by Kingdon (2011) to explore the constructs involved as stakeholders in the study state went through their decision-making processes to determine whether the 2017 legislative long session was appropriate time to introduce a bill with provisions for NP FPA. The proposed study adds to the body of research literature that describes the policy process that NPs encounter when pursuing FPA legislation. Findings from the study are useful for stakeholders in other states that are considering the pursuit of legislation to change NP SOP regulations.

CHAPTER II

LITERATURE REVIEW

Introduction

An understanding of the inception and evolution of the nurse practitioner (NP) role is essential before exploring how stakeholders for NP full practice authority (FPA) decide to pursue legislative changes that impact NP scope of practice (SOP) regulations. Therefore, the following literature review will begin with a discussion of the history of the NP role, followed by an overview of access to care in the United States (US) and the contributions that NPs make towards addressing needs for access to care. Next, trends in the policies that govern NP practice in the US will be explored, followed by a summary of the gaps in the current literature related to this policy issue. Finally, the status of access to care and governing policies for NP SOP in the study state will be discussed before concluding the chapter with a description of the theoretical model that was used to guide the study.

Nurse Practitioners and Access to Health Care

History of Nurse Practitioner Practice in the United States

Nurse practitioners are APRNs who are trained to provide a broad range of services to various patient populations across the life span (American Association of Nurse Practitioners [AANP], 2016, 2017c; Chattopadhyay, Zangaro, & White, 2015; Gadbois et al., 2015; National Institute for Health Care Reform, 2013). Nurse

practitioners hold either a master's degree in nursing or a doctor of nursing practice (DNP) degree, unless they began practicing before requirements for graduate work were required (AANP, 2017c; Gadbois et al., 2015). In 2012, 86% of the NP workforce held a master's degree in nursing as their highest degree, 5% held a doctoral degree in nursing, and 3% had a non-nursing graduate degree (United States Department of Health and Human Services [USDHHS], HRSA National Center for Health Workforce Analysis, 2014). Among the 6% of the NP workforce that did not hold a graduate degree in 2012, 69% were trained before 1992 and were *grandfathered in* because they began practicing before requirements were mandated for graduate work (USDHHS, HRSA National Center for Health Workforce Analysis, 2014).

The NP role in the US was developed in response to both a national shortage of physicians and the increased demand for access to care spurred by the Social Security Amendments of 1965 that created the Medicare and Medicaid programs (AANP, 2017a). The first NP program in the US was developed collaboratively by Dr. Loretta Ford and Dr. Henry Silver at the University of Colorado in 1965. The program's original focus was wellness-oriented health promotion and disease prevention services to meet the health care needs of the pediatric population, but quickly changed to address the health care needs of additional patient populations (Lugo et al., 2010; Wing, O'Grady, & Langelier, 2005). This change occurred due to patient demands for family health, disease prevention, and health promotion during a time in the US when specialization in medicine expanded, resulting in a shortage of primary care physicians (AANP, 2017a) and the Medicare and Medicaid programs increased the demand for primary care services

for low-income children, women, the elderly, and people with disabilities (AANP, 2017a).

Access to Health Care in the United States

Healthy People 2020 defines access to health care services as "the timely use of personal health services to achieve the best health outcomes" (HealthyPeople.gov, 2017, para. 3). To accomplish access to health care, the following three steps are required: gaining entry into the health care system, accessing a health care location that provides the services that are needed, and the ability to find a health care provider with whom the patient can communicate and trust (HealthyPeople.gov, 2017). Four components of access include health insurance coverage, availability of health care services, timeliness in the provision of needed services, and the availability of a sufficient workforce to provide health care services (HealthyPeople.gov, 2017). A usual source of care, and having a primary care provider as the usual source of care, is an important component of access to health care in that it facilitates the provision of more effective, timely health care services (HealthyPeople.gov, 2017).

Due to implementation of the Affordable Care Act (ACA), there has been an increase in the number of Americans that have access to health insurance, an important step towards their gaining access to care (HealthyPeople.gov, 2017). Nationally, about 20 million uninsured people have gained health insurance coverage through implementation of the ACA. As of 2016, 17.7 million nonelderly adults ages 18-64 gained health insurance (Uberoi, Finegold, & Gee, 2016). An additional 2.3 million young adults gained health insurance due to a provision allowing young adults to remain on a parent's

plan until the age of 26 (Uberoi et al., 2016). Although the ACA has made great strides with regard to the number of US citizens who have health insurance, the future of the ACA is uncertain under the new Trump administration (Pear, 2017). Additionally, health insurance coverage does not necessarily lead to having access to primary care services. One example of this is the Massachusetts' 2007 legislation that resulted in the provision of health insurance to over 300,000 Americans. Increased access to health insurance for citizens of Massachusetts contributed to challenges with regard to emergency department (ED) flooding and physicians having to stop accepting additional patients due to increased demand for services (Gadbois et al., 2015; IOM, 2010; Long & Masi, 2009).

A 2014 Commonwealth Fund report ranked the US last among 11 industrialized countries on measures of health system quality, efficiency, access to care, equity, and healthy lives (Mahon & Fox, 2014). The low rank that the US received was greatly influenced by deficiencies in access to primary care and health care system inequities and inefficiencies (Mahon & Fox, 2014). Schoen, Osborn, Squires, and Doty (2013) compared health care expenditures and experiences of US citizens with those of citizens in eleven other countries that implemented universal or near-universal coverage decades ago. The researchers found US adults to be significantly more likely than adults in other countries to go without care because of cost, to have difficulty paying for care (even with insurance), and to encounter insurance complexities that were time-consuming (Schoen et al., 2013). Additionally, adults in the US and Canada reported long wait times in primary care offices and high use of hospital EDs, indicating a lack of timely access to primary care services in both countries (Schoen et al., 2013). These findings, along with

information from the 2007 Massachusetts experience support the importance of having an adequate supply of primary care providers to meet the needs of the newly insured, as well as current patients to promote access to primary health care services in the US.

Primary Care

Primary care is an overarching term used to describe the integrated health care services provided by clinicians who practice in the context of family and community with sustained provider-patient partnerships; provided services may include health promotion, disease prevention, health maintenance, counseling, patient education, the initial evaluation and treatment of new symptoms, and ongoing care for chronic diseases (American Academy of Family Physicians [AAFP], 2016; Bodenheimer & Pham, 2010; IOM, 1996). Primary care services are provided in a variety of settings by primary care providers who collaboratively work with other health care professionals for consultation and referral services when appropriate to accomplish cost-effective, patient-centered care (AAFP, 2016; IOM, 1996). Ideally, a patient's primary care environment is the first point-of-contact for care. Continuity of care is provided over time with health system coordination and a focus on the needs of the patient (Bodenheimer & Pham, 2010). The quality of care is to be measured regularly to ensure maintenance of high standards, practice systems must focus attention on preventive and chronic care and a patient centered culture needs to be maintained (Bodenheimer & Pham, 2010).

Although ideally the primary care location is a patient's first access point for care, it is not always the reality in the US health care system. In a 2016 report by the National Center for Health Statistics, 12% of adults who visited the ED in the past year did so

because their doctor's office was not open and 7% visited the ED because they had no other place to go for care (USDHHS Centers for Disease Control and Prevention [CDC] National Center for Health Statistics, 2016). Given this information and the fact that over 58 million US citizens resided in an estimated 6,100 primary care health professional shortage areas (HPSAs) in 2014, it is clear that there is insufficient access to primary care in the US (Health Resources and Services Administration [HRSA], n.d.).

Access to Primary Care

As of June, 2014, the US had approximately 6,100 primary care HPSAs, defined by the Health Resources and Services Administration (HRSA) as an area with a physician-to-population ratio of 1: 3,500 (HRSA, n.d.). In 2010, there was an estimated shortage of 9,000 primary care physicians and there is a projected shortage of 45,000 primary care physicians by 2020 (Agency for Healthcare Research and Quality [AHRQ], 2012; Association of American Medical Colleges Center for Workforce Studies, 2010). With a national estimate of 20 million health care consumers gaining access to health insurance through the ACA, the increased demand for primary care services will strain practicing providers in a health care system that is already overburdened (Cross & Kelly, 2015; Xue et al., 2016), which could negatively impact the ability of health care consumers to access appropriate health care services in a timely manner (Hoffer, Abraham, & Moscovice, 2011).

America's senior population will more than double by the year 2060 to 98 million people. The population of seniors aged 85 years and older will triple from 6.2 million in 2014 to 14.6 million by 2040 (USDHHS Administration for Community Living, 2014).

Older adults (those aged 65 and older) accounted for 14.5% of the US population in 2014, but will represent 21.7% of the population by 2040. The elderly population is known to use more and different health services than younger populations and the emerging older adult population will be increasingly ethnically and racially diverse (HRSA National Center for Health Workforce Studies, Bureau of Health Professions, 2006; USDHHS Administration for Community Living, 2014). Additionally, this population will be better educated with more socioeconomic resources, which may lead to possible changes in health care utilization patterns (HRSA National Center for Health Workforce Studies, Bureau of Health Professions, 2006; USDHHS Administration for Community Living, 2014). Given the increase in the proportion of the US population that is aging and the needs that the aging population will have for health care resources, it is important that the US consider ways to efficiently use its health care workforce to promote access to care for this rapidly growing sector of the US population.

Nurse practitioners and access to primary health care. The range of health care services provided by NPs includes activities such as holistic patient assessments and screenings; diagnosis and treatment of both acute and chronic conditions; activities involved in the provision and interpretation of diagnostic tests; prescribing treatments and medications; health counselling and education; and overall patient care management (AANP, 2017c; NCSBN, 2016b). Nurse practitioners are educated to practice independently, providing primary and acute care at an advanced level in a variety of settings with a focus on one of six populations: family/individual across the lifespan; adult-gerontology; neonatal; pediatrics; women's health/gender-related; and psychiatric

mental health (NCSBN, 2016b). In 2010, approximately 52% of NPs in the US practiced in primary care (AHRQ, 2014b). Almost half of the estimated 127,000 NPs providing patient care in 2012 worked in primary care practices or facilities (Chattopadhyay et al., 2015). This accounted for 20% of primary care providers nationally (Poghosyan et al., 2013). As of June 2016, over 222,000 NPs were licensed in the US, 83.4% of whom were certified in an area of primary care (AANP, 2016). The 2012 national sample survey of NPs revealed that NPs who graduated from programs more recently than 2008 had greater proportions of graduates choosing careers in primary care than NPs who graduated from earlier programs, illustrating that recent trends of NP graduates are contributing positively to the overall number of primary care providers nationally (Chattopadhay et al., 2015). According to a 2012 report by the Agency for Healthcare Research and Quality (AHRQ), primary care NPs are much more likely than physicians to work in rural settings (AHRQ, 2012). With this information in mind, and an understanding of the clinical expertise and broad range of services that NPs are educated and trained to offer, new models of health care delivery must consider the ways in which NPs are integral to providing essential access to primary care (American College of Physicians, 2009; National Conference of State Legislatures, 2016; Newhouse et al., 2011).

According to a report by Issacs and Jellinek (2012), only 15 to 20 percent of medical students end up practicing in primary care. While the number of medical students and residents entering primary care has been declining since the 1980s, the number of NPs choosing primary care careers has been steadily increasing (IOM, 2010). By 2011,

NPs accounted for 27% of primary care providers nationally (AHRQ, 2011; Stange & Sampson, 2010). In 2012, an estimated 154,000 NPs were licensed in the US; almost half (60,407) of which worked in primary care facilities or practices (USDHHS, HRSA National Center for Health Workforce Analysis, 2014). Nurse practitioners represent a greater share of the primary care workforce in less dense, less urban, lower income areas. Additionally, NPs are more likely than primary care physicians to practice in underserved areas, and to care for large numbers of minority patients, Medicaid beneficiaries, and other vulnerable populations (Buerhaus, DesRoches, Dittus, & Donelan, 2015; DesRoches et al., 2013; Stange and Sampson, 2010). If utilized to the full extent of their education and training, NPs have the potential to ease projected shortages of primary care services and increase access to health care, particularly in historically underserved areas and populations (Auberbach et al, 2013; IOM, 2010; Schiff, 2012).

Research on Nurse Practitioners and Access to Care

The roles in which NPs practice vary widely, as do the settings in which they provide health care services (Daele et al., 2010; Fletcher, Copeland, Lowery, & Reeves, 2011; Hannan, 2013; McNall, Lichty, & Mavis, 2010; Murihead, Roberson, & Secrest, 2011; Odell, Kippenbrock, Buron, & Narcisse, 2013; Oliver, Pennington, Revelle, & Rantz, 2014; Pollack & Armstrong, 2009; Wand, White, Patching, Dixon, & Green 2012), and the populations that receive services from NPs (Coddington, Sands, Edwards, Kirkpactrick, & Chen, 2011; Evangelista et al., 2012; Everett, Schumacher, Wright, & Smith, 2009; Hannan, 2013; Mesidor, Gidugu, Rogers, & Kash-MacDonald, 2011; Murihead et al., 2011; Pohl, Tanner, Pilon, & Benkert; 2011; Wand et al., 2012). Patients

who have received care by NPs have shown positive health outcomes (Coddington et al., 2011; Hannan, 2013; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Mundinger et al., 2000; Newhouse et al., 2011; Swan, Ferguson, Chang, Larson, & Smaldone, 2015) and they are generally satisfied with the care that they receive (Dierick-van Daele et al., 2010; Ellington, 2013; Stanik-Hutt et al., 2013; Swan et al., 2015). Nurse practitioners have made positive contributions to patient access to primary care (Coddington et al., 2011; DesRoches et al., 2013; Ellington, 2013; Evangelista et al., 2012; Fletcher et al., 2011; Mesiodor et al., 2011; Xue et al., 2016) and have the potential to contribute positively to health-related cost savings (Chenoweth, Martin, Pankowski, & Raymond, 2008; Conover & Richards, 2015; Spetz, Parente, Town, & Bazarko, 2013).

Nurse Managed Health Centers are a cost-effective model of primary healthcare delivery. They are staffed and operated by NPs, other APRNs, and RNs (Auerbach et al., 2013; Coddington et al., 2011) in collaboration with the communities that they serve (Hansen-Turton, Ritter, & Torgan, 2008; Resick et al., 2011). Nurse Managed Health Centers offer health services to vulnerable populations in both rural and urban communities with limited access to health care and emphasize health promotion, disease prevention, and education for patients in the management of chronic-illnesses (Coddington et al., 2011; Resick et al., 2011).

Retail clinics are health care clinics located within retail outlets, usually staffed by NPs, and offer routine preventive and urgent care services including care for upper respiratory infections, urinary tract infections (UTIs), sinusitis, bronchitis, pharyngitis, otitis media, otitis externa, conjunctivitis, immunizations, screening laboratory tests, and

blood pressure checks (Kaissi & Charland, 2013). Retail clinics complement primary care offices in that they also include evenings and weekends within their hours of operation, appointments are not required for care, wait times are short, prices for their menu of services are posted, and major insurance plans are accepted but not necessary for care (Kaissi & Charland, 2013; Pollack & Armstrong, 2009; Shrank et al., 2014). As of February 2012, 1,360 retail clinics were open in the US with the majority of clinics being located in Illinois (119 clinics), Florida (108 clinics), and Texas (89 clinics). Seventy percent of clinics in 2012 were owned by retail pharmacies; hospital systems owned 18%, and private companies owned 12% of open clinics (Kaissi & Charland, 2013).

A 2014 study compared the quality of care for treatment of otitis media, pharyngitis, and UTIs among patients treated in retail clinics, ambulatory care facilities (ACFs), and EDs and found that patients treated in retail clinics received better quality care than those in ACFs or EDs across all quality measures constructed from RAND Corporation's Quality Assurance Tools, guidelines from the American Academy of Pediatrics, the American Academy of Family Physicians, and the Infectious Diseases Society of America (Shrank et al., 2014). Retail clinics appear to be gaining momentum in acceptance as a source of convenient, affordable care that compliments care provided by private providers. However, Pollack & Armstrong (2009) found that retail clinics tend to be located in areas characterized by higher resident income and lower levels of poverty, limiting the ability of this model of care for improving access to care for disadvantaged and uninsured populations (Pollack & Armstrong, 2009).

Comparison of Nurse Practitioners with Physicians. Nurse practitioner-provided primary health care services, including prescriptive practices, are similar to those of physicians (DesRoches et al., 2013; Fletcher et al., 2011; Gielen, Dekker, Francke, Mistiaen, & Kroezen, 2014; Kurtzman & Barnow, 2017; Lenz et al., 2004; Naylor & Kurtzman, 2010; Newhouse et al., 2011; Stanik-Hutt et al., 2013). Additionally, NPs have similar, if not better health care outcomes (Fletcher et al., 2011; Lenz et al., 2004; Mundiger et al., 2000; Newhouse et al., 2011; Shrank et al., 2014; Stanik-Hutt et al., 2013; Swan et al., 2015). Such outcomes include cost-effectiveness of care, patient satisfaction (Chapman, Wildes, & Spetz, 2010; Naylor & Kurtzman, 2010; Poghosyan et al., 2013; Swan et al., 2015) and a reduction in overutilization of health care services and ED visits (Murphy, Siebert, Owens, & Doorenbos, 2013; Robles et al., 2011). Although the available body of evidence comparing primary care services provided by NPs versus physicians shows few differences, additional research is warranted given that rigorous research of this area is dated; randomized controlled trials in the US are over ten years old (Lenz et al., 2004; Mundinger et al., 2000). Additionally, Gielen and colleagues (2014) recommend that more randomized controlled trials in the area of nurse prescribing be conducted given the methodological weaknesses in the body of available research comparing prescriptive practices of nurses with that of physicians (Gielen et al., 2014).

Policies that Govern Nurse Practitioner Practice

The purpose of regulating health professions is to protect the public and promote its safety (Lugo et al., 2010). By the early 1900s all states in the US enacted Medical

Practice Acts (MPAs) in order to consistently regulate the practice of medicine. Established MPAs included a wide scope of activities for its medical professionals (Lowery et al., 2015; Lugo et al., 2010). Nurse practice acts were developed between the 1930s and 1950s identifying and regulating the SOP for registered nurses (including NPs) and licensed practice nurses. Nurse practitioners in the US are authorized to perform services according to the SOP provisions outlined in each state's NPA. When the NP role was developed in the 1960s, NP activities were delegated by a supervising physician (Lugo et al., 2010).

> Statutory requirements for mandated physician involvement in NP practice for activities including supervision, collaboration, protocol approval, prescriptive authority approval or signing practice-related forms requiring clinician record of signature (Lowery, 2012, p. 32),

or *physician oversight*, remains an active part of many NP SOP regulations in US states.

Nurse Practitioners are governed by their state laws and the extent of their impact on patient care and population health is partially influenced by state NP SOP regulations and policies (Cassidy, 2013; Gadbois et al., 2015; Vleet & Paradise, 2015). Many states have revised their NPAs to reflect the qualifications and abilities of NPs in order to better apply NP services to meet population needs (Alexander, 2015; Gadbois et al., 2015; Iglehart, 2014; NCSBN, 2016a; NCSBN, 2017b), although regulation remains inconsistent across the US (Lowery et al., 2015; Lugo et al., 2010; Poghosyan, Boyd, & Clarke, 2016; Schiff, 2012; Vleet & Paradise, 2015). Some states have implemented the regulatory model recommended by the Institute of Medicine (IOM) and the National

Council of State Boards of Nursing (NCSBN) which includes autonomous regulation (AR) of NPs (AANP, 2017b). In this model, the state Board of Nursing (BON) is the sole regulator of NP practice and there are no requirements for physician oversight (AANP, 2017b; Lowery, 2012). In these states, NPs have FPA. As of 2017, twenty-two states and the District of Columbia had regulations using this model (AANP, 2017b; Phillips, 2017). Nine AR states (Colorado, Connecticut, Maine, Maryland, Minnesota, Nebraska, Nevada, South Dakota, and Vermont) require NPs to have an initial period of supervision, collaboration, or mentorship immediately following post-licensure/certification before they have FPA (Phillips, 2017). Other states have partially autonomous regulation (PAR) where the BON is the regulatory body for NP practice but requirements for physician oversight exist for activities such as prescriptive privileges, or the use of collaborative practice agreements is required (AANP, 2017b; Kuo, Loresto, Rounds, & Godwin, 2013; Lowery, 2012; Phillips, 2017). In 2017, 24 states used the PAR model (AANP, 2017b; Phillips, 2017). The most restrictive states require joint regulation (JR) of NPs by both the state BON and Board of Medicine (BOM), and requirements for physician oversight are in place for the provision of NP care (Lowery, 2012, Lugo et al., 2010). In 2017, five states, including the study state, remained which used the JR model (AANP, 2017b; Phillips, 2017). See Table 1 below for an itemized list of states according to their regulatory category as of January 2017.

Table 1. State Regulatory Categories

Autonomous Regulation	Partially Autonomous Regulation	Joint Regulation
Alaska	Arkansas	Alabama
Arizona	California	Florida
Colorado[a]	Delaware	North Carolina
Connecticut[a]	Georgia	Virginia
District of Columbia	Illinois	
Hawaii	Indiana	
Idaho	Kansas	
Iowa	Kentucky	
Maine[a]	Louisiana	
Maryland	Massachusetts	
Minnesota[a]	Michigan	
Montana	Mississippi	
Nebraska[a]	Missouri	
Nevada[a]	New Jersey	
New Hampshire	New York	
New Mexico	Ohio	
North Dakota	Oklahoma	
Oregon	Pennsylvania	
Rhode Island	South Carolina	
South Dakota[a]	Tennessee	
Vermont[a]	Texas	
Washington	Utah	
Wyoming	West Virginia	
	Wisconsin	

Note. This table reflects information as of January 2017

[a]These autonomous regulation states require NPs to have an initial period of supervision, collaboration, or mentorship immediately following post-licensure/certification before they have full practice authority (Phillips, 2017)

Trends in Nurse Practitioner Regulatory Changes

Some states have very specific, detailed laws and regulations for NPs while other states have laws and regulations that are vague and more open to interpretation (Gadbois et al., 2015). The recommendation by the IOM (2010) that called for regulatory standardization of APRNs reflects the discrepancy in the ways in which states update

their SOP regulations – with some regularly updating laws in consideration of broader health care system changes and current trends in the education and qualifications of NP providers; however, most do not (Gadbois et al., 2015). Gadbois and colleagues (2015) conducted a study that included an assessment of the trends in state regulation of NPs from the years of 2001 through 2010 with regard to changes in entry-to-practice qualifications, physician involvement in treatment/diagnosis, and prescriptive authority during the decade. Findings from the study indicated that states progressively relaxed regulations for NPs, granting them greater authority, while at the same time many states increased entry-to-practice requirements. Specifically, there was a decrease in the number of states that required physician involvement in treatment and diagnosis (a drop to 27 from 32); a decrease in the number of states that required physician involvement for NP prescription writing (a drop to 37 from 43); an increase in the number of states that allowed prescription of controlled substances (an increase to 49 from 43); and an increase in the number of states that required an MSN for entry-to-practice as an NP (from 32 to 43) (Gadbois et al., 2015).

Advanced practice registered nurse [APRN] consensus model. The variability in NP authority and requirements for entry-to-practice that remain across US states contributes to the difficulty in understanding the potential role that NPs have in reducing the primary care shortage in the US (Gadbois et al., 2015). Clarity of the NP role is required for regulation that provides consistency and promotes a benchmarking process whereby practice standards can be met and maintained (Lowe, Plummer, O'Brien, & Boyd, 2011). Variations in the NP role definition, function and preparation, in addition to

differences in physician and NP perceptions of the NP role, create barriers that prevent reform of existing primary health care models and hamper full use of NPs in new models of care (Lowe et al., 2011). In 2008, the APRN Consensus Work Group and the NCSBN APRN Advisory Committee released a document titled, *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education*. The purpose of the document is to provide guidance for states to adopt uniformity in the regulation of *all* APRN roles, including that of NPs (APRN Consensus Work Group NCSBN, 2008; NCSBN, 2015). The Consensus Model document provides a comprehensive definition of APRN practice, describes a uniform regulatory model for APRNs, identifies specific titles to be used by APRNs, defines specialty, describes the emergence of new roles and population foci, and presents strategies for states to use to implement the model (APRN Consensus Work Group & NCSBN, 2008). The following four areas of variability in APRN regulatory standards are identified and addressed within the APRN Consensus Model document: licensure, program accreditation, national certification, and education. Licensure refers to the granting of authority to practice. Accreditation is "the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs" (APRN Consensus Work Group & NCSBN, 2008, p. 7). Certification is granted to formally recognize the knowledge, skills, and experience demonstrated by an APRN through achievement of standards identified by the profession. Education is the formal graduate degree-granting or post-graduate certificate program of preparation for APRNs (APRN Consensus Work Group & NCSBN, 2008). The Consensus Model has been recognized by policy makers and other

leaders as foundational to the future of APRN practice regulations (Stanley, 2012) and has been used by states to support persistent legislative efforts to change state-level NP SOP regulations (NCSBN, 2015).

Research on Factors Associated with Nurse Practitioner Practice

Regulation of Nurse Practitioners and Nurse Practitioner Supply and Practice

States with positive practice environments, including less restrictive SOP regulations, supportive institutional policies within organizations employing NPs, and positive reimbursement policies for NPs, have greater numbers of NPs (Conover & Richards, 2015; Poghosyan et al., 2016; Reagan & Salsberry, 2013; Xue et al., 2016) and have greater numbers of NPs credentialed by Managed Care Organizations (MCOs) as primary care providers (Hansen-Turton et al., 2006; Hansen-Turton, Ritter, & Torgan, 2008; Hansen-Turton, Ware, Bond, & Cunningham, 2013). Kuo and colleagues (2013) found a 2.5-fold greater likelihood of Medicare patients' receiving primary care services by NPs in states with the least restrictive regulations of NPs compared to states with the greatest regulatory restrictions of NPs. In their study, the greatest increase in the number of NPs per 100,000 residents between 2006 through 2010 occurred in states with the least restrictive regulations (Kuo et al., 2013). Regulatory requirements for NPs are associated with the number of NPs employed by community health centers, which can impact the ability of community health centers to employ non-physician primary care providers to fulfill their mission of serving members of poor and underserved populations (Ku, Frogner, Steinmetz, & Pittman, 2015; Xue et al., 2016). Regulations that require physician supervision and limit the independent functioning of NPs can affect the

productivity and range of health services that NPs provide to their patients (Kleiner, Marrier, Park, & Wing, 2014). For example, in their investigation on the impact of occupational licensing laws on wages, employment, costs, and quality of medical services, Kleiner and colleagues (2014) found that requiring physician supervision for prescribing controlled substances lead to a 6% -14% reduction in hours worked by NPs each year and was associated with a 3% - 6% increase in the cost of a well-child visit (Kleiner et al., 2014). However, such regulations did not appear to influence changes in infant mortality rates or malpractice premiums as indirect measures of the quality of services provided by NPs (Kleiner et al., 2014).

Conover and Richards (2015) conducted a simulation study to estimate the economic impact of removing unnecessary regulations on all APRNs (including NPs) in North Carolina. Findings from the study estimated that modernizing regulations for APRNs in the state would increase the full-time-equivalent (FTE) count of APRNs by 24.4% (a net increase of 1,744 FTE APRNs). The researchers suggested that the increase in APRNs in NC would reduce the estimated shortage of primary care physicians by 843, equivalent to reducing the predicted 2020 shortage of primary care physicians by 92% (Conover & Richards, 2015). Additional findings from the report suggested a potential annual health cost savings ranging from $422 million to $4.3 billion ($44 - $437 per North Carolina resident) in the state from expanded use of APRNs with less restrictive regulation (Conover & Richards, 2015).

Barriers to Nurse Practitioner Practice

Nurse practitioner SOP regulations can pose barriers which keep NPs from providing the comprehensive primary care services permitted by their licenses and educational preparation (Chapman et al., 2010; Kleiner et al., 2014; Naylor & Kurtzman, 2010; Poghosyan et al., 2013; Xue et al., 2016). Lowery and colleagues (2015) conducted a study to assess NP perceptions of the impact of physician oversight on the safety and quality of NP practice. Among the 1,093 participants in the study, the majority of participants indicated that physician oversight did not improve patient safety or quality; only 37.9% of participants felt that it promoted safe NP practice, 28.6% perceived that it improved patient safety, and 25.4% suggested that it enhanced the safety of the public (Lowery et al., 2015). Additionally, only 27.8% of participants agreed that physician oversight promoted safe medication management and 18.7% reported that it improved provider-patient communication (Lowery et al., 2015). The view of the majority of study participants was that physician oversight created provider-patient confusion (74.4%), hindered provider-patient trust (52.8%), and impeded transitions to other levels of care (70.4%) (Lowery et al., 2015).

Rudner and Kung (2017) conducted a study to determine the patterns of physician supervision of NPs in Florida and the relationships between physician supervision, practice setting and NP characteristics. Results from their study showed that NPs with more experience and with doctorate degrees worked without a physician on site more often, they had fewer patient records reviewed, and they were required to consult with physicians on fewer patients than NPs with less experience or without a doctorate.

However, the study did find that some NPs in the state with no experience had no physician oversight, and some NPs with over 20 years of experience had extensive oversight. Additionally, male NPs were more likely to practice without a physician on site and had fewer records reviewed than female NPs (Rudner & Kung, 2017). The authors concluded supervision in the state of Florida to be a formality and financial agreement without consistent application. They further stated that supervision of NPs is not supported by research literature and that it can add to the cost of patient care through payment to the supervising physician for the supervisory relationship or through the requirement of physician time (Rudner & Kung, 2017).

Often, Medicaid and many MCOs, do not credential NPs as primary care providers, or they pay NPs at lower rates than physicians for the provision of the same services, limiting the reimbursement of NPs (Chapman et al., 2010; Coddington et al., 2011; Hansen-Turton et al., 2006, 2008, 2013). Lack of third party reimbursement for NP-provided primary care services leaves NMHCs unable to cover costs associated with providing primary care (Hansen-Turton et al., 2006) and is attributed to the financial failure of NMHCs (Coddington et al., 2011; Hansen-Turton et al., 2006, 2013; Pohl et al., 2011). Professional medical organizations, health care systems, and MCOs have resisted changes to NP SOP regulations (Hain & Fleck, 2014; IOM, 2010; Naylor & Kurtzman, 2010; NCSBN, 2016) although evidence does not show SOP regulations which require physician oversight of NPs to promote safe NP practice, improve patient safety, enhance public safety, or promote safe medication management (FTC, 2014; IOM, 2010; Lowery et al., 2015; Villegas & Allen, 2012). Instead, such regulations patient choice in health

care providers, increases health care costs for consumers, and constrain reimbursement for NP providers (FTC, 2014; Hain & Fleck, 2014; Lowery, 2012; Xue et al., 2016).

Policy Changes for Nurse Practitioner Practice

A recently published conceptual model for optimizing full SOP for NPs in primary care emphasized that NP SOP regulations are one of the key factors in determining NP care and patient outcomes (Poghosyan et al., 2016). The full model illustrated the interrelationship between NP SOP regulations, institutional policies, NP practice environment, and NP workforce outcomes as determinants of NP care and patient outcomes (Poghosyan et al., 2016). Restrictive SOP regulations which require NPs to work in close geographic proximity to physicians limit NPs' ability to practice fully in geographic areas and organizations with the greatest need, and further limit policy makers', insurers', and administrators' abilities to propose policies to fully utilize NPs in efforts to eliminate disparities (Poghosyan et al., 2016). Authors of the model recommended that NP SOP regulations mirror NPs' advanced education and training and eliminate unnecessary restrictions that hinder NPs from delivering the high quality care with which they are trained and capable of providing (Poghosyan et al., 2016).

Three qualitative studies have described the strategies and/or barriers involved when states pursue changes to NP SOP regulations (Duncan & Sheppard, 2015; Pruitt et al., 2002; Rigolosi & Salmond, 2014). Pruitt and colleagues (2002) conducted a qualitative study which involved 21 APRNS in 11 states who were instrumental in passing NP practice autonomy legislation. The study was conducted to determine the strategies involved when pursuing autonomy legislation. Themes that emerged from the

study's qualitative analysis included APRN involvement in legislative initiative, plan of action, communication among stakeholders, successful strategies, financing, negotiation points, personal outcomes, and strategies respondents would change (Pruitt et al., 2002). The following sub-themes were discussed within the theme of successful strategies: coalition building, publications, lobbyists, ***timing,*** legislators, research, and political savvy (Pruitt et al., 2002). Within the discussion of timing, the following quote was highlighted:

> You cannot just dive in and say, 'We need to change the law…this year.' You need a couple of years of planning…then you may decide the year to do it, the political climate is not where it ought to be… (Pruitt et al., 2002, p. 63).

which can impact the progress of a proposed piece of legislation.

Rigolosi and Salmond (2014) conducted a qualitative descriptive study, guided by the Kingdon (2011) policy stream model, to assess the journey of states that achieved independent NP practice from 2007 to 2011. Twelve individuals who served as leaders in their respective state's efforts towards NP autonomy were interviewed. The following states were represented: Colorado, Hawaii, Maryland, North Dakota, and Vermont. Thematic analysis of the interviews revealed two major themes, driving factors and process approaches, as being integral to passing legislation for autonomous NP practice. Driving factors included: problems with finding collaborators, exorbitant fees and payment for physician signature rather than a service, a shortage of physicians, limited access to care, sunset laws, and the perfect storm (the combination of health care reform, physician shortage, the IOM report validating effectiveness of NP practice in primary

care, and grassroots efforts already in progress within the state) (Rigolosi & Salmond, 2014). Process strategies included coalition support; coalition opposition; grass roots; face-to-face contact with legislators; the use of patient stories; focusing the conversation on patients; education, communication, and relationship building; speaking with solidarity; knowing the evidence; use of appropriate language; use of a lobbying firm; revising and negotiating a final bill; and the open window (the period of time for achieving policy change) (Rigolosi & Salmond, 2014).

Duncan and Sheppard (2015) conducted a case study of Nevada's experience pursuing NP FPA legislation to identify legislative barriers to FPA legislation and propose ways in which those barriers were overcome during Nevada's 2013 legislative session. Eight barriers identified by the researchers' qualitative analysis included a lack of clear vision, lack of physician support, inability to address all stakeholders, lack of a strong coalition, lack of vital resources, nurse practitioner role recognition, community and regulatory organizations, and social media (Duncan & Sheppard, 2015). Barriers were overcome in Nevada's 2013 legislative session in the following ways: supporters of FPA legislation had a clear vision that was supported by a coalition, shared with all stakeholders, and related to community needs (Duncan & Sheppard, 2015). The researchers noted the importance of the BON in having a strong reputation for upholding regulations and ensuring the safety of the public in order to gain support from stakeholder organizations. Additionally, good rapport between professional organizations that supported FPA legislation and the community, legislators, and other stakeholders was helpful for mitigating barriers (Duncan & Sheppard, 2015).

Gaps in the Literature

Further research on strategies used in the process of pursuing legislation for regulatory changes is needed to guide states that wish to successfully implement changes to NP SOP regulations (Duncan & Sheppard, 2015). Pruitt and colleagues (2002) specifically noted the importance of *timing* as a strategy in the pursuit of legislation, but did not elaborate on how timing is assessed. Rigolosi and Salmond (2014) referred to Kingdon's (2011) window of opportunity and suggested that the findings from their study could be used by future states to create their windows of opportunity. Yet, the actual decision-making processes that stakeholders encounter when determining whether or not the time in their specific state is appropriate for pursuing NP FPA legislation were not enumerated. Although the previously described studies have been conducted on issues related to the pursuit of NP FPA legislation, those studies have not explored how stakeholders within a state decide on the appropriate time to pursue legislation for NP FPA. This study attempted to address this gap in the literature.

The Study State

The study state for this research presented a unique case in that it is one of the five remaining states that use the restrictive, JR model for NP regulation. The state is located in the southeastern US. According to a 2010 report titled, *Access to Care and Advanced Practice Nurses: A Review of Southern US Practice Laws*, southern states in the US "restrict APRN practice through their state's nurse practice act and through interpretation and rule-making" (Center to Champion Nursing in America, 2010, p. 3). Supporters of NP FPA within the study state have made recent attempts to legislatively

change SOP regulations for NPs. However, those efforts have been unsuccessful thus far. Data collection for this study began October 18, 2016 (prior to initiation of the 2017 legislative long session) and concluded February 13, 2017, when companion bills with provisions for NP FPA were introduced in both of the state's legislative houses. This time frame was opportune for the study because the data collection period occurred as stakeholders for NP FPA actively went through their decision processes to determine if the 2017 legislative session would be appropriate for introducing legislation with provisions for NP FPA.

Access to Health Care in the Study State

With a population of almost ten million people, the study state for this research ranked ninth in the US for population after an increase of more than 95,000 people between July 2013 and July 2014 ([Identifying information removed] Office of State Budget and Management, n.d.) The United Health Foundation [UHF], which evaluates the health of states according to behaviors, community and environment, policy, and clinical care ranked the study state 31 out of 50 for overall state health in 2015; the state was ranked 30 out of 50 for senior health in 2016 (Kippenbrock, Lo, Odell, & Buron, 2015; United Health Foundation [UHF], 2015, UHF, 2016). Additionally, the study state ranked 27 out of 50 in 2015 for the number of primary care physicians per 100,000 population, having 119.7 primary care physicians per 100,000 residents (UHF, 2016). Specific challenges with regard to the overall health of the study state included a large disparity in health status by educational level, low per capita public health funding, and a high infant mortality rate (UHF, 2016). As of 2016, the study state had 111 designated

medically underserved areas/populations, defined as areas/populations that HRSA has designated as facing barriers to accessing health care. Furthermore, the study state has 89 designated rural health clinics (federally designated health clinics certified to receive special Medicare and Medicaid reimbursements) and 140 designated primary care HPSAs (American Association of Colleges of Nursing [AACN], 2016; HRSA Data Warehouse, 2016a; HRSA Data Warehouse, 2016b). All of the previously mentioned indicators highlight that the study state requires additional health care resources to address its needs for access to health care; NPs are one valuable, yet underutilized, asset for addressing the state's needs for additional health care providers (AACN, 2016; Center to Champion Nursing in America, 2010).

Nurse Practitioners in the Study State

The first degree-granting NP program in the study state was established in 1970; seven graduates completed the program in 1971 (Lowery & Varnam, 2011). Additionally, the study state pioneered the regulation of NPs in 1973 when it became the first in the US to establish statutes, rules, and regulations for NP practice (Appalachian State University, 2016; Lowery & Varnam, 2011). In 1975, NPs gained the legal right to prescribe, compound, and dispense medications (Appalachian State University, 2016). However, early advances in the creation and regulation of the NP role in the study state required compromises, including the model of JR of NPs by the Board of Nursing and Board of Medicine, and requirements for physician supervision of NP practice that still remain in the state (Kugler, Burhans, & George, 2011; Lowery & Varnam, 2011).

The study state has several universities that offer nationally accredited graduate NP programs; the programs offered within the state include master's and DNP nursing programs that are among the top nationally ranked programs by the *US News and World Report* (US News and World Report, 2016). In 2015, 1,336 of the 3,794 graduate students enrolled in the state's nursing schools were studying to become NPs (AACN, 2016). In 2016, 57.69% of the state's practicing NPs were noted to have graduated from in-state programs while 42.10% were noted to have graduated from out-of-state programs ([Identifying information removed] Board of Nursing, personal communication, October 18, 2016). Recently published information on the number of licensed/certified APRNs indicated that there were approximately 6,491 licensed/certified NPs in the study state at the close of 2016 (Phillips, 2017). Published information on the distribution of NPs according to specialty and practice location within the study state was not identified in the literature. However, according to the state Board of Nursing, as of October, 2016, 38.65% of practicing NPs in the state worked in a group medical practice/physician office; 30.77% worked in a hospital setting (to include in-patient, out-patient, and emergency departments); 2.74% worked in long term care settings; 0.33% worked in group nursing practices; 3.96% worked in retail clinics; 2.92% worked in mental health settings; and 20.63% worked in other areas, such as HMO/insurance, home health care, industry/occupational settings, medical schools, nursing schools, public/community health settings, school health, or were self-employed ([Identifying information removed] Board of Nursing, personal communication, October 18, 2016).

Research that examines the impact of the NP workforce in the South is limited (Kippenbrock et al., 2015), and studies on the overall impact of the NP workforce in the study state have not been identified in the literature. However, Kippenbrock and colleagues (2015) investigated the distribution of NPs in the southern region of the US and described the characteristics and workforce distribution of NPs with regard to rural areas and HPSAs. Descriptive analyses from their study indicated that the majority of NPs were females with a mean age of 45.5 years, and two-thirds of respondents worked more than 40 hours per week (Kippenbrock et al., 2015). Seventy-two percent of 1,583 NPs surveyed worked in HPSAs and less than half (47%) worked in rural areas. The employer type and work location in a HPSA were statistically significantly related, with the percentage of NPs who worked in primary care settings being significantly greater when they practiced in a non-HPSA (54%) rather than HPSAs (48.4%) (Kippenbrock et al., 2015). Similarly, the percentage of NPs who worked in the primary care setting was significantly greater when they practiced in a rural area (59.7%) versus an urban area (41.8%) (Kippenbrock et al., 2015). Although the study provides information that will be useful for comparison with future research on NPs in the southern region of the US, its results should be interpreted with caution given the use of nonprobability convenience sampling and the low response rate (4.8%) (Kippenbrock et al., 2015). Even with the limitations of this study in mind, it illustrates that NPs play a role in addressing the needs for access to health care in the South's rural and medically underserved areas.

Theoretical Framework

Kingdon Policy Stream Model

The Kingdon policy stream model served as the guiding framework for the study. Kingdon's model describes how the constructs of three separate streams (problems, policy solutions, and politics) converge in a chaotic and unpredictable environment to form an open window of opportunity in which an issue can be moved onto the governmental agenda with the potential for action (Kingdon, 2011). The *problem stream* encompasses the issues presented by different constituencies or events that have risen to the level where policy makers pay attention. Focus is given to problems that are presented via systemic indicators, focusing events (ex: crises or disasters), or by feedback from the operation of current programs (Kingdon, 2011). The *policy stream* includes the various possible solutions proposed by different stakeholders and specialists to address identified problems. Proposals are revised and sometimes combined with one another, and refloated for additional consideration through a process called *softening-up*. Proposals that are seriously considered meet several criteria: "their technical feasibility, their fit with dominant values and the current national mood, their budgetary workability, and the political support or opposition they might experience" (Kingdon, 2011, p. 19). The *political stream* includes factors such as swings in the national mood, turnover of administrative or legislative officials, and pressure campaigns of interest groups (Kingdon, 2011).

Theoretical assumptions and propositions. Kingdon's policy stream model assumes that the policymaking process is dynamic and fluid, and that it occurs in an

unpredictable and chaotic environment (Kingdon, 2011). The model proposes that the three streams of problems, policies, and politics occur separately and simultaneously; when the streams converge at a critical point in time, an *open window* of opportunity is formed through which policy advocates can move their interests forward on the governmental agenda, with the goal of placing a particular solution on the decision-making agenda where it can potentially result in an ultimate change in policy (Kingdon, 2011). The historical development of a problem occurs in "jumps and step-level changes, not a gradual and incremental fashion" (Kindgon, 2011, p. 226). Policy proposals are created over a long period of time; their development is evolutionary as ideas are floated, discussed, revised, and refloated before a final proposal emerges from the policy stream (Kingdon, 2011). The coupling, or joining, of the streams is facilitated by the presence of an open window of opportunity and advocating policy entrepreneurs. Policy entrepreneurs promote their position on a particular issue on several occasions in different forums over time to increase the chances of a specific solution being placed on the decision-making agenda (Kingdon, 2011). The period in which a policy window is open is very limited. The opportunity for action by policy entrepreneurs is constrained to this short time before the policy window closes, creating, the need to have a proposal ready before a policy window opens to avoid missing a potential opportunity (Kingdon, 2011).

Summary

Full utilization of NPs in the US will continue to be a challenge due to NP SOP regulations in many states which restrict the services that NPs can provide autonomously;

this hinders contributions of NPs in primary care and overall access to care (Conover & Richards, 2015; FTC, 2014; Newhouse et al., 2011; Newhouse et al., 2012). The first key message in the 2010 IOM report, *The Future of Nursing: Leading Change, Advancing Health*, is that nurses should be permitted to practice to the full extent of their education and training (IOM, 2010). This recommendation includes the removal of barriers to NP practice that result from restrictive SOP regulations, such as those in place in the study state (IOM, 2010).

Published research and systematic reviews of research have supported the positive impact of NP-provided services on patient outcomes, including health-related cost savings (Conover & Richards, 2015; Oliver et al., 2014; Newhouse et al., 2011; Swan et al., 2015). However, the continued existence of regulations and policies that hinder full use of NPs during a time when implementation of the ACA has increased the provision of health insurance to Americans (HealthyPeople.gov, 2017) and fewer physicians are available to provide primary care services to those Americans (Issacs & Jellinek, 2012) is evidence that policies that govern NP SOP regulations are lingering behind the recommendations from current research. Research on strategies used in the process of pursuing legislation for regulatory changes is needed to guide states that wish to successfully implement changes to NP SOP regulations. Although a few qualitative studies have been conducted on issues related to the pursuit of NP FPA legislation, studies have not explored how stakeholders within a state decide on the appropriate time to pursue legislation for NP FPA. Research on this critical strategy must be conducted to fill the gap in the literature related to stakeholder decision-making processes when

pursuing regulatory changes through the legislation. The study state is an ideal state for such studies given the fact that it is one of the few remaining states with a JR model and that it has made recent attempts to legislatively change NP SOP regulations.

To better understand the complicated background surrounding the issue of NP FPA, this chapter reviewed the history of the NP role, issues surrounding access to care in the US, and the contributions of NPs towards addressing the needs for access to care. Additionally, policies that govern the practice of NPs in the US were discussed and gaps in the current literature were presented. The chapter concluded with a brief presentation of access to care in the proposed study state along with a review of the theoretical framework that guided the dissertation study.

This study attempted to answer the following research question: *How do one state's stakeholders for NP FPA determine the appropriate time for pursuing legislation to change NP SOP regulations?* The research question for this study asked a *how* question about a contemporary set of events in the study state, over which the researcher had no control (Yin, 2014). Therefore, a case study methodology was ideal to guide the steps used in an attempt to find answers to the research question. The following chapter will discuss case study methodology in detail.

CHAPTER III

METHODOLOGY

Introduction

A qualitative methodology, with an embedded single case study design was used to conduct this research study. Qualitative methodology is a systematic, subjective approach used to explore phenomena where little is known or where previously offered interpretations of the phenomena seem inadequate (Richards & Morse, 2013). Qualitative methodology allowed the researcher to simplify and manage multi-context data, complex situations, and changing and shifting circumstances without destroying the complexity and context of the situation under investigation (Richards & Morse, 2013). The following chapter will begin with a review of the appropriate situations for applying case study methodology in research, and will then discuss the selection of the case and the theoretical propositions that were investigated through the case study method. Procedures used to collect and analyze relevant data are specified, and strategies used to increase the scientific rigor of the study are be presented.

Case Study Design

The case study design is appropriate for research situations in which "a how or why question is being asked about a contemporary set of events, over which the investigator has little or no control" (Yin, 2009, p. 13). Within a case study design, the investigator explores a contemporary phenomenon in depth and within its real-life

context, especially in situations when the boundaries between the phenomenon and context are not clearly defined (Yin, 2009). In case study inquiry, a technically distinctive situation is explored in which there are many more variables of interest than data points. Therefore, multiple sources of evidence are used to inform the case; data converge in a triangulating fashion, and data collection and analysis are guided by the development of prior theoretical prepositions (Yin, 2014, p. 17).

The following are four different applications for case study research: to *explain* causal links in real-world interventions that are too complex for survey or experimental methods; to *describe* an intervention in its real-world context; to *illustrate* specific topics within an evaluation; and to clarify, or *enlighten*, situations in which an intervention being evaluated does not have a single, well-defined set of outcomes (Yin, 2014). Single case studies may use a holistic design in which the case itself is the unit of analysis or an embedded design in which there are multiple units of analysis within a single case (Yin, 2014). Yin (2014, p. 50) provides an illustration of the four basic types of case study designs, including the embedded single case study previously described.

There is a lack of documentation in the published nursing literature about how stakeholders for nurse practitioner (NP) full practice authority (FPA) determine the appropriate time to pursue legislation to change NP scope of practice (SOP) regulations. Additionally, no identified study in the research literature has discussed the decision-making processes that occur when stakeholders for NP FPA determine whether the time is appropriate within a state to pursue such legislation. With these two points in mind, an embedded single-case study design was appropriate to address the study's research

question: *How do one state's stakeholders for NP FPA determine the appropriate time for pursing legislation to change NP SOP regulations?*

Selection of the Case

The study state was an unusual case in that it was the first state in the US to establish statutes, rules, and regulations for NP practice (Lowery & Varnam, 2011) and it is one of the few remaining states in the US that use the JR model (Harkey et al., 2017; Kugler et al., 2011; Lowery & Varnam, 2011). Although the state has made recent attempts to legislatively change SOP regulations for NPs, those attempts have not been successful. This study's data collection began began October 18, 2017 (prior to initiation of the 2017 legislative long session) and concluded February 13, 2017. The data collection period occurred as stakeholders planned their strategies for the 2017 legislative long session and decided whether the time was appropriate for introducing proposed legislation containing provisions for NP regulations that support NP FPA. The units of analyses in this single case study were the processes that influenced the decisions made by stakeholders as they determined the appropriate time to pursue legislation to change NP SOP regulations; they included the problems, policies, and politics that comprised the policymaking environment during the time in which the stakeholders' decisions were made (Kingdon, 2011).

Theoretical Propositions Within the Methodology

According to Yin (2014), theoretical propositions about the case should be stated during the design phase of a case study to provide a blueprint for the study and to provide guidance in determining the data to collect and the strategies for analyzing the data. Such

statements should explain a complex pattern of expected results that will facilitate a strengthened ability to interpret the data collected (Yin, 2014). The following propositions, guided by Kingdon's (2011) policy stream model, were explored through the case:

1. The case will show how the current problems, available policy alternatives, and political environment in the study state influenced NP FPA stakeholders to decide that the 2017 legislative session was the appropriate time to introduce legislation to pursue changes to NP SOP regulations.
2. The case will also show that the 2017 legislative session presented an open window of opportunity for introducing legislation for NP FPA.

Procedure

Yin (2014) states that good preparation for conducting case study research includes development of the desired skills and values on the part of the case study researcher, proper training for a specific case study, and development of the research protocol for the case study. Preparation for this case study has included these elements. The following paragraphs discuss in detail how each element was addressed.

Yin (2014) states that the following attributes are desirable in the case study researcher: the ability to ask good questions, to be a good listener, and to fairly interpret the answers; the skill of remaining adaptable through newly encountered situations; the attribute of having a firm grasp of the issues being studied; and the ability to avoid biases and conduct research ethically (Yin, 2014). The researcher's professional nursing and academic background provided a foundation for the development of suitable interview

and listening skills, and the ability to adapt to new situations. The researcher worked to increase her understanding of the issues studied through the literature review for this study and by conducting telephone interviews during the spring of 2016 with nursing regulatory and advocacy experts in states that successfully passed recent legislation related to NP FPA. To guard against personal biases that may have led to inaccurate conclusions during the conduct of this research, the researcher maintained a reflective journal and had regular meetings with dissertation committee members to seek feedback on potential biases during the conduct this research (Jessup, 2013; Yin, 2014).

Training for this case study began with defining the research question to guide the case study and development of the case study design. Additional training for the case study included the plan for protecting human subjects who participated in the study. The informed consent form was developed and an application was made to the University of North Carolina at Greensboro Institutional Review Board (IRB) after receiving approval for the study from the dissertation committee (Yin, 2014). The university IRB determined that the research did not constitute *human subjects* research as defined under federal regulations [45 CFR 46.102 (d or f)] and did not require IRB approval. The informed consent form described the purpose of the study and outlined participant rights for participating in the proposed research. Participants were given the opportunity to read the information on the informed consent form and ask questions. A copy of the informed consent form was given to each participant who chose to participate in the study. Participants could choose to decline participation in the study at any time for any reason, without penalty.

The third step of preparing for case study research is development of the case study protocol (Yin, 2014). The case study protocol contains the procedures and general rules to be followed, is used to guide the data collection for a single case, and is one way of increasing the reliability of the case study research (Yin, 2014). A case study protocol should have four sections: an overview of the case study, data collection procedures, data collection questions, and a guide for the study report (Yin, 2014). The case study protocol developed for this research study is presented in Appendix A.

The overview for this study's case study protocol included the purpose of the study, the research question guiding the study, the theoretical framework that was used, the role of the protocol, and reasons for the creation of a research log. Data collection procedures discussed in the protocol include the identification of the field contacts and how those contacts were accessed, procedures for protection of human subjects, and the likely sources for data collection. The case study protocol includes a list of the study's data collection questions, guided by the Kingdon (2011) policy stream model. The following are examples of questions included in the case study protocol:

- Tell me your thoughts about whether now is the time for this state to grant nurse practitioners full practice authority through legislative changes to nurse practitioner scope of practice regulations.
- How have circumstances surrounding nurse practitioner full practice authority presented themselves as being important issues for the state?

The final section of the case study protocol contains the guide for the case study report. A case study guide may include preliminary thoughts about the intended audience

for the study report, such as potential journals for publication, and initial thoughts about the presentation of the findings from the analysis of data (Yin, 2014). The last section of Appendix A outlines the guide for the case study report for this study. It includes a list of potential journals for publishing the findings from the study in addition to a brief outline of the components included in the discussion of the study's findings.

Data

Case study data collection provides the opportunity to use multiple sources of evidence to address a broad range of historical and behavioral issues related to the case (Yin, 2014). A goal of using multiple sources of evidence in the case study is the development of converging lines of inquiry where information from the different sources of evidence all point to a similar conclusion, thus strengthening the argument for the conclusion (Yin, 2014). For this reason, the data collected for this case included several sources: interviews with NP FPA stakeholders in the study state, observation of meetings relevant to the case, document review, and archival data.

Document review included the following: thirty-one NP-focused publications from the state nurses association, which were available online for the years 2003-2013 before the publication was discontinued. The 2017-2018 legislative, regulatory, and political platform, and twenty-three legislative updates from the nurses association (available online for the months of March 2015 through January 2017) were also included. Additionally, ten state legislative bills related to NP practice ranging between the years of 1993-2017 were obtained from the state's legislative website. Other document data included one research report, an online news article and interview

associated with the research report; one Board of Nursing (BON) report; the final rule on APRNs from the Department of Veterans Affairs (VA) and the American Medical Association (AMA) statement responding to the VA final rule; three state medical society briefings related to activities associated with NP FPA efforts in the state; one legislative summary from the state medical society; one state medical journal issue focused on nursing in the state; one medical practice webpage; and three emails (Yin, 2014). Archival data included the 2014 health professions data book for the state, released April 2016, and reports generated from NP survey data collected by the state BON through October 2016. Observation data included researcher observation of an NP activist meeting with 233 participants and a nurses association legislative update meeting with 133 participants, both of which took place via conference call.

Sample. Purposive convenience and snowball sampling was used to recruit a sample of 11 participants for interviews, who represented the following NP regulation stakeholder groups in the study state: state legislators, NP activists, nursing regulatory experts, nursing advocacy experts, NPs who work in the community, nursing educators, physicians, and large employers of NPs within the state. The researcher conducted participant interviews until saturation of data was reached (Richards & Morse, 2013). The sample size was also determined by the previous literature related to the subject of the proposed study. Duncan and Sheppard's (2015) case study of legislative barriers to FPA legislation included a sample of four participants. Jessup's (2013) comparative case study dissertation of NP and certified nurse midwife (CNM) Medicare reimbursement legislation used a sample of 24 (14 participants for the CNM case and 10 participants for

the NP case) (Jessup, 2013). Rigolosi and Salmond's (2014) qualitative descriptive study of strategies used during the pursuit of FPA included a sample of 12. To be included in this study, key informants had to speak English and have knowledge of the legislative efforts regarding NP FPA in the study state.

Recruitment. Prior to the implementation of this proposed study, the researcher had discussions during the spring of 2016 with leaders from NP advocacy organizations (nurses associations and NP associations) and regulatory organizations (BONs) in other states that recently passed legislation to modernize NPAs with regard to the regulation of advanced practice registered nurses (APRNs). Within the conversations, leaders highlighted the importance of the roles that each state's nursing regulatory organization and NP advocacy organization played in state-level efforts to pursue legislation for regulatory changes. The leadership roles that nursing advocacy organizations and regulatory organizations play in the pursuit of legislative efforts to change SOP regulations for NPs are also supported in the literature (Duncan & Sheppard, 2015; Rigolosi & Salmond, 2014).

The study state's BON and nurses association were the first organizations contacted to recruit for the proposed study. The state nurses association, rather than a nursing union or NP association, is the advocacy association for NPs in the study state and was therefore the first point of contact to recruit NP advocacy experts. After making contact with the initial individuals at each organization, the purpose of the study was explained and individuals at both organizations were asked to identify other people from within the state that could serve as key informants for the remaining stakeholder

categories. The initial contact persons from both organizations were asked to reach out to the individuals that they identified as stakeholders for the remaining categories, to inform them of the study, and to forward a recruitment email to the individuals with the researcher's contact information. Additionally, study participants were asked to identify pertinent sources of archival data, documents of relevance for the study, and any observable meetings that the researcher might attend for data collection purposes during the study's data collection period.

Data collection. To gather information to present a comprehensive description of the study state's story, data collected for this study came from several sources including participant interviews, documentation data, archival data, and direct observation. All participant interviews were semi-structured face-to-face, or telephone, audio-taped, transcribed interviews of key informants using an interview guide that was sent to participants in advance of the scheduled interview time. Documentation data included NP-focused publications from the state nurses association, the 2017-2018 legislative, regulatory, and political platform, and legislative updates from the nurses association were included. State legislative bills related to NP practice ranging between the years of 1993-2017 were obtained from the state's legislative website. The legislative bills included in the study were obtained by conducting a search on the study state's legislative website for bills between the years of 1992 – 2017 using the words "nurse practitioner". Bills identified by the legislative website's search tool were then reviewed by the researcher for content relevant to the study before including them as document data. Documents, including the legislative bills, were limited to those created within the last 25

years. The 25-year limitation allowed for sufficient review of documents and bills from the past 13 legislative sessions to reflect a timeline on APRN and NP-specific initiatives to effect change in the study state. Evidence that supports the existence of ongoing efforts to pursue NP FPA within the state is relevant within the Kingdon (2011) model to show that stakeholders in support of NP FPA have engaged in the softening-up process. According to Kingdon (2011), softening-up is a process whereby policy advocates begin discussions of their proposals and "push their ideas in many different forums" over time with the goal creating a climate that will allow for the introduction of a proposed change (Kingdon, 2011, p. 228).

Other document data included one research report, an online news article and interview associated with the research report; one BON report; the final rule on APRNs from VA and the AMA statement responding to the VA final rule; state medical society briefings related to activities associated with NP FPA efforts in the state; one legislative summary from the state medical society; one state medical journal issue focused on nursing in the state; one medical practice webpage; and three emails (Yin, 2014). Archival data included the 2014 health professions data book for the state (released April 2016) and reports generated from survey data collected by the state BON. Observation data included researcher observation of an NP activist meeting and a nurses association legislative update meeting (Yin, 2009).

Data analysis. Yin (2014) describes four general strategies with five different analytic techniques for guiding data analysis in case studies. Any number and combination of the proposed strategies and techniques may be used for case study

analysis; the purpose of the chosen strategies and techniques should help the researcher treat the evidence fairly, produce compelling analytic conclusions, and rule out alternative interpretations (Yin, 2009; Yin, 2014). General strategies used to begin preliminary organization and analysis of collected data may include relying on theoretical propositions, working with data from the *ground up*, developing a case description, and/or examining plausible rival explanations (Yin, 2009).

This research study used theoretical propositions and the development of a case description to begin preliminary analysis of the collected data. Given that theoretical propositions using Kingdon's (2011) policy stream model guided the data collection for this case study, a theoretical comparison, using those same propositions was used to begin preliminary analysis of the collected data. With the theoretical propositions in mind, thematic analysis of transcribed interviews was conducted according to the stages of coding and analysis described by Braun and Clark, (2014). This included transcription, reading and familiarization (taking note of items of potential interest), coding (complete across all transcripts), searching for themes, reviewing themes, defining and naming themes, and writing (finalizing analysis). Data from the additional sources of evidence (documentation data, archival data, and direct observation data) were then organized according to the themes that emerged from the thematic analysis of the interviews. Next, the development of a case description occurred by further collapsing the themes and codes within key concepts from the Kingdon (2011) model: how the problem became a priority, how communities supported or opposed the issue and the politics involved, the process of softening up, and how the three *streams* converged leading to the

open window of opportunity for introducing legislation for NP FPA (Kingdon, 2011; Rigolosi & Salmond, 2014).

The five analytic techniques detailed by Yin (2014) include pattern matching, explanation building, time-series analysis, logic models, and cross-case analysis (which only applies to the analysis of multiple cases). Final analysis for this study used the analytic techniques of pattern matching and explanation building. Pattern matching, according to Yin (2014), is "one of the most desirable techniques to use" in case study analysis (p. 143). If the observed and predicted patterns show some similarity, the results strengthen the validity of the case study (Yin, 2014). Pattern matching for the proposed study occurred by comparing the thematic analysis of the case (observed patterns) with the theoretical propositions (predicted patterns), guided by the Kingdon (2011) model. Next, the patterns were used to answer the proposed study's research question and analytically generalize the study's findings to the Kingdon (2011) model through the process of explanation building. Yin (2014) states that case study results are used in analytic generalization in order to shed empirical light on theoretical concepts. In this sense, findings from the case may advance the theoretical concepts from the theory through corroboration, modification, or rejection (Yin, 2014). The following processes, outlined by Yin (2014) were used in building an explanation about the case: make an initial theoretical statement, compare case study findings against the theoretical statement, revise the statement, compare other details of the case against the revision, repeat the process as many times as needed.

Reliability and validity. In qualitative research, the term trustworthiness, rather than the terms reliability and validity, is traditionally used for establishing a study's integrity (Braun & Clark, 2014; Lincoln & Guba, 1985). Trustworthiness should be demonstrated through the methods used to collect and analyze data (Braun & Clark, 2014) which involve establishing the credibility, transferability, dependability, and confirmability of a study. Trustworthiness for this study was addressed according to the processes described by Yin (2014). Yin believes that case study research, like any empirical social research, should hold to the tests that have been commonly used to establish the quality of empirical research. The four tests include establishing construct validity, internal validity, external validity, and reliability (Yin, 2014). Given that this case study was guided by Yin (2014), the researcher addressed each of the tests through techniques suggested by Yin (2014).

Construct validity. Yin (2014) defines construct validity as "identifying correct operational measures for the concepts being studied" (p. 46). He also describes construct validity as an especially challenging test of rigor in case study research because critics of the methodology often state that case study researchers fail to develop a sufficiently operational set of measures. Instead, they use subjective judgements to collect data (Yin, 2014). Tactics offered by Yin (2014) to increase the construct validity of case studies include the use of multiple sources of evidence, establishment of a chain of evidence, and having key informants review findings from the study.

To increase the construct validity of the proposed study, multiple sources of evidence were used (interviews, documentation data, archival data, and observation data).

The participant interview questions for the proposed study were modified, with permission, from questions used in a related study which used the Kingdon (2011) model (Rigolosi & Salmond, 2014). Additionally, the lead author of the related study (Rigolosi & Salmond, 2014) reviewed the modified questions and agreed that they were consistent with the constructs presented in the Kingdon (2011) model. To document the chain of evidence in the study, a journal was maintained and a data reference list was created. The data reference list included a catalogue of the document data, archival data, and observation data collected. The data reference list also included columns where the researcher entered codes during data analysis and wrote notes related to specific data sources. Participants from the study verified accuracy at two different points during analysis: validation of transcribed interviews and early summaries of the case description.

Internal validity. Internal validity, according to Yin (2014), does not apply to descriptive or exploratory case studies. Instead, it only applies to explanatory or causal studies that attempt to explain how and why one event leads to a subsequent event. In these types of case studies, if the researcher incorrectly assumes that there is a causal relationship between a first and second event, without knowing that another, third event may have actually caused the second event, the original research design will have failed in its attempt to deal with a threat to internal validity (Yin, 2014). In case study research, the concern over internal validity applies to the more general problem of making inferences – "an inference is made every time an event cannot be directly observed" (Yin, 2014, p. 47). Yin (2014) suggests that four analytical tactics can be used to address internal validity in case study research. The four tactics occur during data analysis phase

of research; they include pattern matching, explanation building, addressing rival explanations, and/or the use of logic models (Yin, 2014). In the proposed study, pattern matching and explanation building were to address internal validity.

External validity. External validity refers to "defining the domain to which a study's findings can be generalized" (Yin, 2014, p. 46). A comparable term used in qualitative research is the term, transferability. According to Lincoln and Guba (1985), transferability is the ability to show that the findings of a study are applicable in other contexts. In case study research, analytic generalization is used to apply the findings from a case study to other, broader contexts. It is incorrect to attempt statistical generalization of case study findings, as one would attempt in survey research, because the single case or multiple cases used in case study research are too small in number to serve as an adequate sample to represent a larger population (Yin, 2014). Analytic generalization is used to generalize case study findings to other concrete situations and to the broader theory that was used to guide the case study. As an example, findings from a single case could be used to form working hypotheses that can be applied to reinterpret results of existing studies of other concrete situations or to define new research that will focus on another concrete situation (Yin, 2014) Analytic generalization to a broader theoretical base " may be based on either (a) corroborating, modifying, rejecting, or otherwise advancing theoretical concepts that you referenced in designing your case study or (b) new concepts that arose upon the completion of your case study" (Yin, 2014, p. 41). In single case study research, external validity is addressed by using analytic generalization

to generalize to the broader theory (Yin, 2014). For this study, external validity was addressed by generalizing the findings from the case study to the Kingdon (2011) model.

Reliability. Reliability refers to the accuracy and consistency of information acquired in a study; it is often associated with the study's methods (Polit & Beck, 2012). Reliable methods in a study seek to minimize the errors and biases of a study. Subsequent researchers should be able to demonstrate that the methods of the first case study can be repeated in future attempts to do the same case study over again (Yin, 2014). In qualitative research, the term d*ependability,* is often used in lieu of reliability. In this study, dependability was established by discussion and approval of emergent codes and themes via frequent communication with the two qualitative research experts, including the chairperson on the dissertation committee.

Reliability can be addressed in case study research by using a case study protocol, maintaining a chain of evidence, and developing a case study database (Yin, 2014). This study used all three tactics to address reliability. The case study protocol (Appendix A) was used to clarify, guide, and standardize field procedures. To maintain a chain of evidence, a research log was kept in journal form to record thoughts and decisions about data sources and sampling choices used within the case, selection of analytic techniques, emerging themes and conclusions from data analysis, and reflective thoughts about changes in researcher thinking that occurred throughout the case. The case study database was kept electronically by using Word, portable document format (pdf), and Excel files on a password protected computer in the researcher's home office and in an online folder on the researcher's UNCG Box account. The dissertation committee provided continuous

review and feedback of the research log and case study database via access to the researcher's online UNCG Box account folder. The following components were among the electronic files contained within the case study database: field notes, case study documents, and narratives. *Field notes* consisted of the researcher's thoughts in relation to the interviews conducted, observations, or document analysis that occurred throughout the case (Yin, 2014). *Case study documents* included the documents previously described as document data (Yin, 2014). *Narratives* included the data reference list of case study data (Yin, 2014).

Credibility. Credibility is confidence in the truth, or believability of a study's findings (Lincoln & Buba, 1985; McGinn, 2010). There is no parallel test in quantitative tests for rigor given the difference in the nature of the data collected in quantitative versus qualitative research (Jessup, 2013). McGinn (2010) asserts that there should be a level of agreement between participants and the researcher with regard to the findings of case study research. In this study, credibility was established through member checking by sending participants copies of their transcribed interviews with an interviewee transcript validation form (Appendix B). All participants reviewed their narratives and provided verification of accuracy. Participants were given a transcript validation form to provide comments and/or clarify any part of the interview with which they did not agree (Lincoln & Guba, 1985; McGinn, 2010). All participants validated the accuracy of their transcripts. Most participant comments focused on discomfort with the use of filler words such as *um* and *you know*; few participant comments focused on substantive changes to

clarify information within the transcripts. Additionally, three participants provided validation of the case description created after data collection and analysis was complete.

Summary

This chapter described the case study methodology that was used to explore how stakeholders for NP FPA in one state determined the appropriate time to pursue legislative changes to NP SOP regulations. The study was an embedded single-case design with the units of analyses including the problems, policies, and politics that comprised the policymaking environment during the time in which the stakeholders' decisions were made (Kingdon, 2011). The research protocol, and procedures to collect relevant data were discussed. Strategies outlined for analysis included a comparison of the themes that emerged from the collected data against the theoretical propositions that guided the data collection for the case study. The themes and codes were then further collapsed within the key concepts from the Kingdon (2011) model to develop a case description. The final analytic techniques of pattern identification and explanation building were explained before concluding the chapter with a detailed review of the strategies used to increase the scientific rigor of the case study analysis. The next chapter will present the results of the study.

CHAPTER IV

RESULTS

Introduction

The purpose of this study was to achieve a comprehensive understanding of how stakeholders for nurse practitioner (NP) full practice authority (FPA) in one state determine the appropriate time to pursue legislative changes to NP scope of practice (SOP) regulations. The units of analyses in this single case study were the processes that influenced the decisions made by stakeholders as they determined the appropriate time to pursue legislation to change NP SOP regulations; they included the problems, policies, and politics that comprised the policymaking environment during the time in which the stakeholders' decisions were made (Kingdon, 2011).

This chapter contains the results from the case, and is organized around the techniques that were used to analyze the case. First, the characteristics of the study's sample are summarized. The technique of pattern matching is discussed through the theoretical comparison of the observed patterns from the thematic analysis of the interviews and converging evidence from the other sources of data against the predicted patterns outlined in the theoretical propositions that guided data collection for the case. Third, a case description is provided by further collapsing the themes and codes from the case within major concepts from the Kingdon (2011) model. Finally, the study's results were analytically generalized to the Kingdon (2011) model through the process of

explanation building by using the observed patterns to answer the study's research question: *How do one state's stakeholders for NP FPA determine the appropriate time for pursuing legislation to change NP SOP regulations?*

Sample Characteristics

The final sample for this study included 11 participants. The final sample was within the targeted sample size of 10-20 participants, determined by the previous literature (Duncan & Sheppard, 2015; Jessup, 2013; Rigolosi & Salmond, 2014). Six participants were female and five were male. The mean age of participants was 56 years and the mean number of years of involvement in state NP FPA efforts was 17 years. Six participants held doctorates and five held masters' degrees. Among the nurse participants in the study, three held masters' degrees, four held doctor of nursing practice (DNP) degrees and two held doctor of philosophy degrees (PhD); one participant held both a DNP and a PhD. The professional status categories of participants included NP activists, nursing regulation experts, nursing advocacy experts, NPs who work in the community, nurse educators, representatives of major employers of NPs in the state, a physician, and a state legislator. Participants could choose multiple responses for the professional status category, therefore the numbers within the *professional status* characteristic of Table 2 below do not equal 11 participants.

Table 2. Sample Demographics (n=11)

Characteristic		**(n)**
Age	40-50 years	2
	51-60 years	6
	61-70 years	3
Sex	Male	5
	Female	6
Education (Highest Degree)	Masters	5
	Doctorate	6
Highest Nursing Degree	MSN	3
	DNP	4
	PhD	2
	Not a Nurse[a]	3
Years Involved in State NP Full Practice Authority Efforts	0-10 years	4
	11-20 years	2
	21-30 years	4
	Over 30 years	1
Professional Status	Legislator	1
	NP Activist	4
	Nursing Regulation Expert	4
	Nursing Advocacy Expert	5
	NP who works in the Community	3
	Nurse Educator	3
	Representative of Major Employer of NPs in the State	2
	Physician	1

Note. MSN = Master of Science in Nursing; DNP = Doctor of Nursing Practice; PhD = Doctor of Philosophy; NP = Nurse Practitioner

[a]Includes one physician

Pattern Matching

Thematic analysis of interviews. This section presents the themes and codes from thematic analysis of the interviews, and exemplar quotes to support them. All interviews were conducted one-on-one in person (n = 3) or by phone (n = 8) with the researcher, audio-recorded, transcribed verbatim, validated by the participant, and then coded line by line. Two hundred and five pages of coded transcripts revealed 108 original codes. The original codes were condensed to a final code list that consisted of four themes, 31 codes, and 34 sub-codes after comparing the original codes against the coded transcripts, document data, archival data, and observation data during two subsequent reviews after the data coding. Given the study's small sample size, to promote participant confidentiality, quotes presented from participant interviews have been aggregated and are not attributed to individual participants.

Participants. The first theme identified was participants, which here refers to those involved, either actively or passively, in the processes surrounding the legislative pursuits for NP FPA in the study state. This theme, addressed by all 11 participants, included three major codes: stakeholders, stakeholder attributes, and stakeholder emotions. The three major codes within the theme were identified by all 11 participants.

Stakeholder. A stakeholder was a person, group, or organization with a concern or interest in a particular course of action and the evidence that supports the course of action (Agency for Healthcare Research and Quality [AHRQ], 2014a; Oxford English Dictionary, 2016). All 11 participants in this study were stakeholders for NP FPA, and all 11 spoke about the various stakeholders for NP FPA. An aggregated total of forty-three

different stakeholders (either individuals, groups or organizations) were mentioned in the interviews with this study's participants. Some references were made to stakeholders in a general capacity. For example, one participant stated "So I talked about leaders, physicians, nurses, and the community. Those to me are the primary stakeholders." Stakeholders were also discussed in terms of those who were supportive, opposed, or on the periphery with regard to NP FPA efforts. Nursing communities were noted to be supportive of NP FPA, as reflected by the following participant comments:

> I guess the nursing groups are a pretty major stakeholder that I shouldn't forget even though that seems obvious. But, for the purposes of a complete answer, there are a lot of different nursing groups working on and supporting this legislation, with the [state nurses association] certainly being a leader.

Another participant offered similar remarks:

> Well, from my perspective, obviously, nurses see it as very important, and as a regulator, I see it as, as very important. To be able to fully utilize all nurses, not just nurse practitioners, but all nurses, to their capacity.

All participants, including the physician participant, noted organized medicine, defined by one participant as, "the professional advocacy and medical groups of the medical profession," to be the major opposing stakeholder to NP FPA. This was illustrated by one participant in the following remark: "But the only group working against it is organized medicine, which is predominantly the medical society, but also a couple of the specialty medicine societies." Although organized medicine was opposed NP FPA legislation, four participants, including the physician participant, suggested that

consideration should be given to the thought that organized medicine may not be presenting the full perspective of individual physicians. This perspective was reflected by one participant who stated, "I know so many individual physicians who are so supportive but organized medicine I think holds us back in many ways." A similar comment by another participant was, "We certainly know of individual family physicians who have no opposition to this legislation. Also physicians from some other specialties too." A different participant shared the following reflection:

> I think individual physicians may be less opposed than the professional organizations. And maybe that, maybe your study or, noting what you found in your interviews, if it supports individual physicians saying 'well this is probably okay', may be something that the legislators need to know. If all they hear from are the paid lobbyists of the medical groups.

Periphery stakeholders were described as those who were currently watching the progress of NP FPA activities, but not engaging in efforts for or against the initiative:

> The other stakeholder groups are more the, the periphery type. You know, they're, they're, also not getting involved. But some of them are certainly watching it. Long term care, some of the groups like social workers and psychologists, and therapies. They're, they're watching it, you know, just to, to see what nurse practitioners and APRNs may be able to, to do with them or for them if this is changed. But again, none of those groups have taken an official stance in favor of the legislation.

Finally, NP FPA stakeholders could have multiple roles. A stakeholder's role could change over time during legislative pursuits for NP FPA, or a stakeholder could hold simultaneous roles. For example, the following two quotes came from different participants who described their multiple stakeholder roles: "I think nurse practitioner

activist, nursing advocacy expert maybe, community nurse practitioner" and "But I would be more comfortable, and I don't care if it outs me, to be identified as both. Because, to be honest, I can't separate the two anymore".

Stakeholder attributes. Stakeholder attributes include the qualities or characteristics possessed by stakeholders. All 11 participants discussed various attributes of NP FPA stakeholders. Specific stakeholder attributes mentioned by study participants included stamina, credibility, influence, power, experience, patience, and awareness. One participant explained stamina in the following way, "Because this legislation is going to take time and it's going to take energy, and it's going to take political muscle. And legislators only have so much of that to go around." The same participant made additional comments related to the attributes of stakeholder experience and patience:

> The more politically experienced nurse practitioners completely understand that. Those who are newer to the process usually do not, and that has to be part of the, the education of the nursing organization – just to help prepare for them. To try to proactively battle against volunteer issue fatigue. Which you know, we have seen a little bit of that already. Where people are like, 'Oh, you know we've been talking about this for X number of months. When is, when is something going to happen?' Well, lots of things are happening. It's just not in the form of an up or down vote. So it is harder. It is progress, but it's harder to quantify you know, those soft outcomes. They're not easy to show people, but it's there.

Another participant offered thoughts with regard to stakeholder credibility stating,

> They give the same story as far as nurse practitioners or other advanced practice providers not being qualified enough to lead the team. Despite the fact that we have been practicing for years. I think that there story is getting old. I think that others are seeing the need to step it up.

When reflecting on the attribute of influence, one participant stated, "Well in the past, and it didn't matter who was the majority, I think there still seemed to be a lot of physician influence over the legislature." Additionally, the same participant suggested that the study state was unique because of

> …the hold that the medical society has over so many issues affecting healthcare in our state. They just, maybe it is wrong to look at it as the good old boys network but sometimes that is what it feels like. And they have a lot of money and they have had a lot of influence in the past over our legislature and it's been very difficult to break through that.

However, another participant suggested that influence over the legislature may change, "quite honestly, they may become redundant at a certain point if the only thing that they have to hold up is we're threatening your income."

The attribute of power was discussed in terms of the control that stakeholders have over the progress of suggested policy proposals within the legislature, as noted in the following statement:

> …one of the things that folks may or may not know about, is that committee chair people have tremendous power in the state. In state government. So any time a piece of legislation comes up, it gets assigned to different committees. And one of the most convenient ways for a legislator to side track a bill is just not to bring it up in committee. … And what this does, is this protects your fellow legislators who want cover to be able to say, well, you know, I didn't vote against advanced practice nursing, it just never came up. … Now, we have seen that in two sessions, and it wouldn't surprise me to see it in another. … The Speaker can send the bill to numerous committees. So even if you have one favorable committee member, it usually has to go through a couple of committees. Now, the last time this bill was introduced, it broke the record. I never have seen a bill that from the get-go was asked to go through five committees. That seems to be about two too many from where I'm sitting.

Stakeholder awareness was considered in terms of awareness about the practice of NPs and in terms of awareness about suggested legislative changes to the regulation of NPs, summarized by one participant in the following way:

> I think that consumers and community members are understanding more about the way nurse practitioners and other APRNs practice. But I think their awareness around the legislative changes is pretty low. There are some pockets of awareness, usually around the community groups or community members that have an advocacy organization that's involved in legislative activities.

The majority of participants did not think that consumers were aware of legislative efforts for NP FPA, as reflected in one participant's statement, "It's tough to say, I hate to say it. I don't know that your average citizen out there understands any of this. It's still pretty much an in-fight." Two of the 11 participants suggested that the perceived lack of community awareness at the current point in time regarding legislative efforts was not likely to impact the decisions of legislators: "But I don't think people know about any of that and I don't think it is going to affect the legislature that much," and

> Not at this point. If the bill gets to committee and, you know, there's always, there, at the Chair's discretion, you know the legislators can speak, it's almost like a public hearing kind of thing. That's the time to bring in the people from the West and the East and supporting physicians who say, look, we need this.

Stakeholder emotions. Stakeholder emotions, defined as a stakeholder's state of mind derived from their circumstances, mood, or relationships with others, were addressed in all 11 participant interviews. Emotions revealed in the interviews were on a

continuum that included sentiments such as optimism, uncertainty, caution, frustration, and anger. Stakeholder emotions were both expressed by participants during interviews and described by participants when reflecting on the responses of stakeholders to NP FPA efforts. Emotions involved the expression or description of responses to the process of pursuing NP FPA legislation and responses to interactions among the various stakeholders for NP FPA.

Optimism was revealed by five participants as they considered the likelihood of a bill for NP FPA passing during the 2017 legislative session. One participant stated, "I am always hopeful the bill will pass. I don't want…naturally I'm an optimistic person. I am realistic but optimistic." Another offered the following thoughts, "Does that mean it will pass in 17' or 18'? I don't know. I would like to think so. I am cautiously optimistic. But it may very well mean that we have another couple of years." A third participant stated,

> I do think that 2017, the long session is probably our best opportunity for success when we look at the supporting and opposing forces that will be in place for full practice authority for all APRNs in [the state], particularly nurse practitioners.

Ten participants expressed or described the emotion of uncertainty, in some cases, multiple times within a single interview. One participant commented, "The political environment equals extreme uncertainty," and further noted,

> I am embarrassed to tell you that, and I keep up with my reading. Even the periodicals like *Modern Healthcare*. Here is the bottom line, the popular educated, opinion in healthcare is, we absolutely don't know.

Another participant noted, “Now of course we know that often in political arenas that statements are made and prevailing forces change as time goes on, so it, it’s yet to be determined how that will play out.” A different participant noted uncertainty with regard to NP FPA efforts due to the recent change in leadership at the state level in the following comment:

> I really don’t know what legislators think about that. And so, and I don’t know what the changes in a new governor, where we stand with that. I would suspect that [the new governor] would be more accepting of this from his overall political stance, than [the previous governor]. But gosh, I don’t really have no idea.

Three participants showed caution during the interviews. Two participants sought reassurance about the confidentiality of their interviews with statements such as, “I am glad this is a confidential interview,” and “… this is all confidential, right?” While another showed caution by responding, “I mean they’re people that I feel like have been barriers but it’s hard to prove, so I don’t know about mentioning those. I could tell you who they are, but it’s not something I can prove to you.”

Frustration was noted in five participant interviews. One participant expressed frustration in the following way:

> I want to see this resolved and I want to see consumers having access to their choice of health care providers whom they can see at their discretion without having to go through someone else who’s not at all associated with their care. Meaning, a supervising physician. But that they can go directly to the source and their choice of health care provider that they want to see.

Frustration bordering on anger was expressed by a different participant:

> And it's kind of insulting when I have been in practice for seventeen years. And every time I have physician changes, I have to file again to change my collaborating physician on my nursing approval practice form. And I have to go through all of the QI stuff again. And that just seems kind of ridiculous to me. I have been practicing longer than a lot of the providers who have been collaborating physicians.

Also, frustration was expressed by a participant who reflected on the impact that a lack of regulatory change could have on the state, as noted in the comment, "I mean, it's very much nearing the point that not acting on this legislation is irresponsible and putting the health of [the state's citizens] at risk."

Problem. The second theme identified was the problem, defined as subjects that gain the attention of governmental decision makers because they represent issues that are judged to require attention. Seven codes were noted within the theme problem. The codes included: indicator, health care redesign, health resource utilization, practice barriers, urgency, efficiency, and evolution. All 11 participants addressed the code indicator as noted by discussion of one of six different sub-codes. Eight participants discussed the code health care redesign. Seven discussed the code health resource utilization. Practice barriers were mentioned among six of the participants. The codes, efficiency and urgency, were addressed in four interviews. The code evolution was addressed by three participants during interviews. The following discussion will focus on the codes within the themes that were addressed by the majority of participants: indicator, health care redesign, health resource utilization, and practice barriers.

Indicator. Indicator is defined as a variable monitored by governmental and/or nongovernmental agencies that gives information regarding performance or forecasts and

which is used by governmental decision makers to determine current or future needs (Kingdon, 2011; Law, 2016). Participant comments related to the code, indicator, were divided into six sub-codes. Among the six sub-codes, the most frequently discussed were access, economics, and provider supply. Regarding access, one participant commented, "There's great context in the state; we're in desperate straits in terms of access to care, particularly in the rural areas in the East and the West," and further stated,

> Where, increasingly we have citizens in our state who have, you know, health disparities and terrible outcomes and wind up in emergency rooms very sick because there's just nowhere for them to get care. So that's, that's certainly, that's becoming, I guess it's actually been critical for some time but I think it's getting more into the average person's understanding in main-stream.

Another participant offered the following comment about access:

> Well I think we still have a lot of underserved areas in this state. I think toward the east, there are just so many areas that don't have adequate access to the providers of any kind. I think that it actually can be said all across the state. You know, I am the only provider out in the community that I am in. There are no other physicians or anything out there.

A different participant offered the following thought:

> I think that the issues, at least that we hear from workforce data and so forth is, of course the pockets of need, particularly rural parts of [the state] and the underserved areas, such as mental health where it's our belief that allowing full practice authority would help address some of those needs.

Seven participants discussed health care economics within the context of the code indicator. One participant stated, "Perhaps more it is the almighty dollar that is playing

the role as far as reimbursement and limitations on insurance coverage, or even our federal and state dollars and what they will and won't pay for."

Another participant offered the following comment:

> Being able to provide that care inexpensively is going to be really key. And you know, having a primary care work force is a big part of that, so that may dovetail with the legislature's efforts about the nurse practitioner, you know, independent practice thing.

A different interview revealed additional thoughts related to economics:

> For the state, it's really unfortunate to say this, but you know a lot of it is going to come down on the lines of Medicaid dollars and where we have access points to care and how we are gonna take care of these people. These vulnerable populations that can't find physicians and be seen. And how we are going to do that and offer quality care in a cost-effective way and I think it is really going to come down to that. I really do.

Six participants discussed the code indicator in terms of provider supply. Participant comments discussed the shortage of primary care physicians, an inability to increase the number of physicians to meet state demands in a timely manner, the growing numbers of NPs educated within the state and external to the state, and the impact that those NPs could make if regulatory changes enabled better utilization of NPs within the state.

One participant commented, "We have a remarkable lack of primary care doctors." Another participant stated,

> I think that is one of the reasons that [a state school] was able to, twenty years ago, get a medical school. Or twenty-five years ago now. Because they were gonna put docs in these rural areas and they have not been able to do so at the level that needed to happen in order to get primary care out there. And I think at that level of the state, it's very, very important.

A different participant reflected on the number of NPs in the state with the following comment:

> Our statistics show that there's growing numbers of people who want to, within the state even, get an advanced practice degree in nursing. So our universities here are growing, but we also see growing numbers coming in from the outside.

Another participant further noted,

> Especially if there are some changes made to how they are regulated and utilized here. They understand the role they play in access to care and they understand that the physician demand is significant and that no matter what we do here to try to address that, we will not be able to produce the number of physicians we need to meet the care needs of the population.

Health care redesign. Health care redesign was discussed in terms of the changes occurring within health care to address population demands for health care and also control those costs. Comments included a discussion of actual changes that have occurred, goals for health care redesign, the impact of changes on communities and health care providers, as well as thoughts about what still needed to occur with regard to health care redesign. The following thoughts provide a picture of the comments related to the process of health care redesign that was occurring within the state:

One participant noted,

> It is very clear that we are on the presence of a redesign and so it is going to be imperative that we are on the grass roots of that redesign. Or rework. And that includes maximizing our licensure as professional nurses.

Statements from three different participant interviews illustrated the impact of activities surrounding health care redesign on providers within the health care system. One participant stated, "Health care systems are looking at, how can they provide service and how can they provide it in a cost-effective manner?" Another participant mentioned, "Health systems are utilizing advanced practice nurses and nurse practitioners more and more with the limitation on resident hours of work." A third participant reflected,

> I think for the physicians, they are undergoing a cultural change in terms of the population of patients that they are being asked to take care of now. Especially in areas that are utilizing advanced practitioners.

Comments from two participants explained health care redesign efforts in terms of access to care:

The first participant explained,

> You know, their little community hospital may have been closed or incorporated into some other system which then downgraded it to a clinic. The other thing is that their general purpose, GP doc has retired, died. So that's changed the dynamic in their legislative district.

The other participant commented, "We are supposed to have more access, our office is supposed to be open now early and late on certain days to provide more access." This same participant further noted,

> Currently, and I am involved with an accountable care organization and other efforts to change the way medical care is provided. Including, having to pay for it. [The organization] is taking full risk for Medicare patients now and so trying to be more efficient.

A different participant reflected on the difficulty that nurse practitioners have in finding a physician with whom to have a collaborative practice agreement:

> And I think many of the independent physician practices that were out there, are going away. So fewer of those are willing to….are unable to commit to being collaborating physicians.

Another participant noted the changes in health care and commented on regulation of NPs by stating, "You know, and I know that health care has evolved significantly since the inception of the nurse practitioner role here in [the state] and it's time for regulation to catch up with that."

Health resource utilization. Health resource utilization was discussed in terms of how health care providers are used in the health care system. One participant stated,

> The need is growing. So I think everyone is understanding that we need all health care providers functioning at their maximum capacity and that nurse practitioners are a segment of the heath care provider population that is currently being underutilized in this state because of the regulatory structure surrounding them as compared to some other states in the country where they're being utilized at a more effective level.

Another participant noted, "There certainly is still a feeling that most nurse practitioners and PA's even though they have to have supervision, are going to be an important part of access."

A different participant shared thoughts about specific utilization of NPs versus physicians in the following comments:

> I work at an inpatient acute care surgery trauma service area. I am not a trauma surgeon, never gonna be a trauma surgeon. For me, what I do is to make the team as efficient as it can be. And provide the right service at the right time to every patient. That doesn't require a trauma surgeon going in and seeing the patient, making rounds on them every day. If the patient needs to be taken to the operating room for an operative procedure, that is entirely appropriate for the surgeon to do that. But the surgeon doesn't need to be weening patients off of a ventilator. I am capable of doing that. They don't need to be in there adjusting what someone's electrolytes are when those are off. I can take care of those things. …This legislation, if it gets passed, probably is not going to change what I do on a daily basis. It is not going to change my scope of practice. I am still going to collaborate with our trauma surgeons, so nothing is really going to change for me. …

Practice barriers. Practice barriers were discussed by participants in terms of restrictions encountered by NPs due to challenges surrounding the need to have a supervising physician, stipulations related to collaborative practice agreements, and delays in care caused by confusion regarding the role of the NP. One participant noted,

> I think if you are trying to start your own practice, that's where the difficulty comes in. Many of the big systems have limited their providers being collaborating physicians outside of the system. So they can't support someone who is opening their own practice, not in association with that.

A different participant explained the impact that challenges associated with finding a supervising physician has on access to care:

> At [my employer] we have got a program that targets nurses in rural communities and recruits them to come back to school to get their master's degree as a psych mental health nurse practitioner, and the evidence would suggest that people who are in rural communities are more likely to go back to those communities and practice when they are finished with school. And so they have got enhanced skill and experience in treating behavioral health problems. And as we know, there is a shortage of psychiatrists and many counties don't have any psychiatrists. And it is hard to find a psychiatrist who is willing to partner with a psych mental health NP several counties away in order for them to be able to practice. There was a survey among primary health care physicians, in regards to their comfort in supervising APRN's. And they were explicit that they didn't feel qualified to supervise a psych mental health NP who is treating people with some serious behavioral health issues. And it is hard to find a psychiatrist who is willing to partner with the psych mental health NP, who may be several counties away. And that limits the practice opportunities, geographically and the access to care for the citizens in that community who are often in desperate need of behavioral health services.

Another participant explained the physician charge to the NP for agreeing to be a supervising physician, "What we have heard through testimony from a lot of our advanced practitioners in the state, that that fee can be anywhere from ten to twenty-five thousand dollars a year," another participant offered a related thought,

> I think cost for some, there are some physicians who are charging an incredibly high amount. That has been really draining the nurse practitioners that are trying to survive in their own practices.

One participant shared a story with regard to practice barriers due to limitations imposed by collaborative practice agreements. The participant explained,

> I have participated as nurse of the day many times, and it gets back to that practice location part of the collaborative practice agreement. I was manning the first aid station at the general assembly while serving as nurse of the day and a legislator came in and felt he had a condition that required a prescription of an antibiotic. We spent time talking about the condition and strategies to treat it and I had to tell him that I couldn't provide him a prescription because the collaborative practice agreement, the state statute says that I can practice at [my place of employment] but I can't practice at the general assembly, I can't practice as an NP at the full extent of my skill and experience in a setting other than what's identified in that collaborative practice agreement. So, you know, one of few cases where a wealthy, middle aged white man is medically underserved.

Policy development. The third theme identified was policy development. Policy development is defined here as the processes involved in creating solutions to problems. The processes include consideration of the research, analysis, synthesis, and evaluation of information available along with the priorities and recommendations of the various stakeholders for a particular subject. Policy development was addressed by all 11 participants through discussion of one of 17 codes. The codes, evidence, stakeholder priorities, and stakeholder position were noted in all 11 interviews. Policy practice implications were addressed by ten participants. Nine participants discussed the code, regional comparison. The code, softening up, was covered in seven of the interviews. The codes, history and opportunity were each discussed in six interviews. The codes, competing priorities, policy agenda, and organizational policies were each addressed in five of the interviews. Four participants discussed the code, challenges. The remainder of the codes; competing policies, incrementalism, inevitability, policy proposal, and professional accountability were covered in three interviews each.

The findings below will focus on the codes most frequently addressed within the theme: evidence, stakeholder priorities, stakeholder position, policy practice implications, regional comparison, softening-up, history, and opportunity.

Evidence. Forms of evidence discussed by participants included research, regulatory trends, educational trends, health care trends, and national trends. Examples of research evidence were provided in comments related to research comparing NP care with other health care providers, research done within the state on the economic impact of changing the regulation of APRNs, and research done by policymakers outside of nursing related to nursing and APRNs.

One participant explained,

> More than five decades of research have demonstrated that nurse practitioners provide safe and effective care, at least as well, and in some cases better than physician and PA colleagues. Those who are educated in comparable population focuses, such as family practice, internal medicine, etc. The research, again and again demonstrates that. And so, when we look at that and we have nurse practitioners who provide this safe and effective care as well as the other groups of health care providers at a lower cost, I mean, it really is a no-brainer kind of situation of, why are we not doing this?

The same participant further noted,

> Of course, you are aware of the economic study that was done where it showed that first, it would be a budget-neutral initiative for the assembly, which was huge. It would not cost any money um, to have full practice authority from the state's standpoint.

Regarding research done by policy makers outside of nursing, one participant stated, “There are things like the National Governor’s Association and, folks outside of nursing and health policy. You know, the IOM report was a factor in some of that.”

Regulatory trends were explained by a different participant who commented,

> I think the other circumstances are that, I don’t think that there’s a state in the country that’s not – that doesn’t already have full practice authority, and think there’s 22 or 21 states and the District of Columbia that have full practice authority – but all of the rest of them are in some way working on this. This is a main-stream of regulation of nursing practice, advanced practice nursing, across the country. And I think it’s understood as that.

One participant commented on the educational trends of NPs by stating,

> Many nurse practitioners now are prepared, if not at the master’s or graduate level, at the doctoral level. Increasingly we’re having more nurse practitioners educated in DNP programs, educated by nursing faculty and nursing scientists using a nursing paradigm.

Health care trends were explained by a different participant who noted,

> I mean, if you look at the statistics of what physicians, we are producing doctors, but they are not headed toward primary care. They are headed toward specialty areas. And that’s where their education and expertise should be directed. I think the full practice authority is an excellent solution to getting more primary care out there. And even specialized care.

Finally, an example of national trends was shared by a participant who commented, “We have seen in other states, that nurse practitioners were more likely to serve underserved populations, Medicare, Medicaid, shortage areas when they have full practice authority.”

Stakeholder priorities. Stakeholder priorities were discussed in terms of specific stakeholders, changes in priorities that have occurred, and the differences in priorities that various levels of stakeholders may have.

One participant explained,

> However, the tipping point may be when you have legislators who are in areas where a hospital system took over, their local hospital closed, and they don't even have a clinic in their district any more to go to. And, oh, what do you know, their reliable GP is retiring. I've had a legislator say, quote, 'I'm looking for any medical care! I'm not worried about quality, I just want any!' Now, that is certainly a call out of frustration. I'm sure that person want's quality medical care, but they're frustrated that his or her constituents don't have the kind of level of care that maybe their neighbors 50 or 100 miles down the road have merely because of proximity. So, it's a person who gets "mad as hell" because they've had phone calls from constituents who've had to drive enormous distances to get any care, that that person may actually get something out on a committee floor to discuss and move the bill along.

The priorities of the state legislature were noted in the comments from two different interviews. One participant explained, "The chosen leadership are the ones who are moving this stuff. They decide what the priorities are; they decide what the agenda is." Another participant reflected,

> You know, ten years ago, maybe even five years ago, this issue was mostly owned by the Democrats. You would see the more progressive or left-leaning folks jump onto this issue before you would the republican, more conservative types. But now, we're seeing that the issue can cross the boundaries, cross the isle, and there are pieces of this issue that, align well with conservative Republicans.

Regarding the differences in opinion of varying levels of stakeholders, one participant mentioned,

> I really think that part of the issue is that you might ask an individual doctor, 'well how do you feel about a nurse practitioner being an independent practitioner?' and he might say 'well, you know, that's okay, I work with one and she's pretty good' and this sort of thing. But when you look at a professional organization, it's a totally different thing and I can guarantee you that the American Medical Association and probably the [state Medical Society] are not going to look the same from a political standpoint as an individual doctor is.

A different participant stated,

> I think a lot of it has come to this point because of the leadership of national organizations and statewide organizations that are more attuned to looking down the road at what's going to be needed in the future, as opposed to what's needed right now. And so they're part of the drivers of this, not the individual licensee.

Stakeholder position. Stakeholder position refers to the actual stance, either supportive or opposing, that the various stakeholders have taken with regard to NP FPA. One participant noted, "I think most all of nursing supports it." A different participant noted, "I think that from an administrator standpoint and leaders in healthcare, your COOs, your CEOs, they get it and they think it is a great answerability for the redesign." A third participant shared the following comment,

> Well I've actually chatted with several folks at the Medical Society, and the one who was one of the people who was looking at regulation said, we like the joint in joint regulation and we have no intentions to change it. So, it would have to be a forced issue there or management change, or that their priorities could be elsewhere because they're dead set on keeping it.

Policy practice implications. Policy practice implications were discussed in terms of implications of current regulatory policies on provider practice and the potential

implications to practice if policies were changed to allow NPs FPA. Regarding current policy practice implications, one participant noted,

> I guarantee you that if you speak to physicians at the point of care who work day-to-day with nurse practitioners, they will tell you that all of this hullabaloo, if I can use scientific terminology, about physicians having to sign this document and that document and meeting for artificially contrived points of collaboration is simply busy work that does not improve outcomes, it does not improve safety, it simply increases paperwork and busyness and takes time away from the point of care.

The following comments from two participants detailed the implications of current state regulations regarding the number of NPs that physicians are allowed to supervise at one time. One participant commented, "There's no limitation on numbers of nurse practitioners being supervised by an individual physician." Another participant shared the following story:

> All of our students have to have a site visit from a faculty member. I visited a site, it was a family practice site, and shortly after arriving, the supervising physician said, 'hey come in my office, I want to talk to you.' And I wasn't sure what was going to happen. He started with, students are doing fine and then proceeded to pull up the medical board listing of his license. And a dozen or so, NP's or PA's with whom he had a collaborative practice agreement. And this particular physician is a pilot, has a small plane, likes to fly, and pointed out that these practices were all over the state. Why he wanted to tell me this, I am not sure but he said that he simply flies into the municipal airport and the NP or PA with whom he has this agreement hops into the jump seat and they sign off on the document that has to be signed twice a year, and then he flies off. The cost of these collaborative agreements is not cheap and does a lot to support his lifestyle and retirement plan. But it doesn't really do anything for the patients in the community where the NP or PA practices. The arrangement that I just described, follows the letter of the law but not the spirit.

Regarding future policy practice implications, one participant stated,

> So we really need to take a strong look at that and ensure that the regulations that are in place are right touch – right touch regulations. So, regulation that appropriately safeguards the public without unnecessarily restricting the competence and the skill that any one clinician can bring to the point of care for consumers.

Another participant commented,

> None of the current legislation that we are proposing, as it is currently written, is the *Nurse Modernization Act*. It does not change scope of practice in any way. It only allows us to do that under the regulation of the board of nursing and without direct physician supervision. It never says anything about, I am never going to collaborate with the physician again. So, physicians collaborate with each other all the time and as an advanced practitioner, in my practice, I am going to continue to collaborate.

A different participant offered thoughts about the need for future policies to promote the safety of the public with regard to the practice of new NPs:

> I don't know about nurse practitioners coming out of their training program and having independent practice. That is a very dicey thing because the level of experience is going to be very different. There is a model of nurse practitioner programs that you take an experienced clinician and then expand their training to be able to diagnose and treat. We have a friend's son, who wasn't involved in healthcare at all and now is going kind of for a direct nurse practitioner program, but he doesn't have any practice experience. There are also nurses that go quickly from their RN into nurse practitioner programs, because they really wanted to be practitioners. So, assuming a level of clinical experience is not going to be acceptable. So, I did read the thing about having some time of supervision after training and after passing the boards and all. I think that will be very important for safety.

Regional comparison. The role of regional comparison within policy development was discussed in terms of the comparisons that legislators make between the state and other states when considering policy proposals. One participant explained,

> I don't think that they're looking broadly enough. They're not looking at best practices nationally. They're looking at what their neighbors do. And I suppose that we can relate that to ourselves. You know, okay, what do the Jones' next door have that I don't have? Or vice versa? But I relate that back to a key conversation I heard in a hearing one time when they were talking about reading levels in [the state]. The legislators were concerned about how we scored, relative to our neighboring states. And my question was, well who has the best reading scores in the nation, and why wouldn't we want to be right up there with the best? And I found out who has the best reading scores and I cannot remember a time at the legislature that they ever wanted to be compared to Connecticut.

Another participant explained the comparisons made by legislators in a different way:

> We have a very schizophrenic general assembly. They want to compare themselves to the states around them when it suits their purposes and they don't want to compare themselves to the states around them when it doesn't. And I think that's true no matter who's in power down there. I don't think it's a republican or a democratic way of looking at things, I think it's just human nature. You want to use the things that support your argument, you don't want to use those that don't. So, but kind of typically in the state, it doesn't do you any good, no matter what you're advocating for, to compare [the state] to New York or California. You might as well just sink your ship when you do that, because, you know, we've got a fairly old, white, and grey general assembly.

Softening up. Softening up is defined as a process whereby policy advocates begin discussions of their proposals and "push their ideas in many different forums" with the goal creating a climate that will allow for the introduction of a proposed change Kingdon (2011, p. 228). Softening up was revealed in participant interviews through discussions of

the various venues in which NP FPA were discussed, the stakeholder groups that were involved in conversations related to NP FPA, the length of time that NP FPA discussions have taken place in the state, and through discussion of areas that participants felt needed to be targeted to increase the likelihood of success for NP FPA legislation.

One participant explained, "I don't think the issues are completely new, I just think they're rising in number, they're rising in their level of importance. Both to consumers and to policy makers." Another participant explained, "Sometimes you have to push that idea out there, let it sit and marinate for a while before you try to move it forward." A third participant made the following statement:

> Prior to that the last bill that was introduced to convey the regulation of advanced practice nursing to the board of nursing was, get this, 2001. … A lot of work has gone into it by professional groups, nursing groups in that intervening fifteen years. But there was a fifteen year gap in the bills.

History. History was discussed in terms of the past events that have contributed to the current state of the NP role since its inception in the state and how those past events have impacted initiatives for NP FPA. One participant explained,

> We've had physician supervision since day one and we've been doing it longer than anybody but Colorado. We're the second state in the Union that authorized the practice of nurse practitioners. So we have this 40-year or so model that has just been so entrenched and we have learned, like all nurses do, you learn to make whatever you have work. We make it look easy when it's not. And so now, you know, medicine says, well, what's broken? And I would say, working for 40 years, what's broken? It's kind of hard to say what's broken. And that's part of our uniqueness is we've been doing this for 40 years. And so we have 40 years of bad habits to break.

A different participant offered some related comments, stating,

> You have to drill down even further and recognize that it's the socio-political impact that is holding the current regulatory model to a restrictive model rather than a full practice model. It's not based on safety or outcome measures, it certainly is not based on economics. It's simply because this is the way that it has always been in [the state].

Opportunity. The code, opportunity, was apparent in participant responses related to the first question on the interview guide, which asked participants to share their thoughts as to whether the 2017 legislative session would be the time for the state to grant NPs FPA through legislative changes to NP scope of practice regulations. Responses that fell within the code, opportunity were best explained by the comments of one participant who stated,

> So the question of when's the right time is now! Every time's the right time. There is no hugely bad time unless you just went in and had a huge win and what the legislators are saying is, we've already given you so much, don't come back for a while, you know.

Politics. The final theme identified was politics; defined as the electoral, partisan, or pressure group factors used to obtain the support of important interest group leaders. Four codes were noted within this theme: strategies, stakeholder relationships, leadership, and national influence. Strategies and stakeholder relationships were mentioned in all 11 participant interviews. The codes, national influence and leadership, were each covered in five participant interviews.

Strategies. The code, strategies, included six sub-codes to categorize the various explanations given about specific approaches that stakeholders have included within their plans for pursuing NP FPA in the state. The six sub-codes identified were: resources (nine participants), persistence (eight participants), cohesion (seven participants), preparation (six participants), compromise (six participants), and constituent stories (four participants).

One participant stated,

> I think one important factor that is helping build the momentum here is that the nursing groups are organized, collaborative, working together. Just going hand in hand day by day, and not competing with one another or working in silos. I think that's been really, really important.

A second participant emphasized, "We just have to keep putting it in front of them, have to keep showing them what we do, have to keep showing them studies. Keep moving forward." A different participant offered additional thoughts with the comment,

> I see so many issues that don't have anything to do with health, that are taking two, and three, and four sessions to get through, but you finally get there. …You win over more hearts and minds, your arguments get better, your positions get better, your strategy gets better, and that's what it's about.

Stakeholder relationships. Stakeholder relationships were discussed in terms of the relationships among stakeholders within the policy arena and external to the policy arena. One participant reflected,

> I really feel that our nurses and doctors work well together, for the vast majority of folks. Thousands of them work together, and the number of complaints we get from doctors or nurses regarding others' practice is miniscule relative to the thousands that work together successfully.

Another participant mentioned, "If these decisions were based on evidence, it would have happened a long time ago. I think they are based on relationships and a political influence." In a related comment, another participant stated,

> Any professional who appears to be in a position to be utilized in a greater capacity, there's opposition from certain segments against that. And it's significant and it is such that legislators, even some of those who support the APRN legislation are very careful about their choices in how they approach this issue. I think that I'll, I'll just stop with that.

Convergence of evidence. This section will organize the document data, archival data, and direct observation data around the themes that emerged from the thematic analysis of the interviews. To provide an audit trail, data collected in the form of documents, archival data, and observation data was cataloged and coded in a document titled, *Data Reference List*. Notes related to specific data pieces within the listed sources were made in a third column within the document. For an example section of the data reference list, see Appendix C.

Participants. Information supporting the theme, participants, was observed in document data from the various stakeholders for NP FPA. State level stakeholders were noted in the state medical society briefings and legislative summary, the NP-focused publications and legislative platform from the nurses association, the state research report and related media that covered the report, the medical practice webpage, and the state

medical journal issue that focused specifically on nursing. National stakeholders were apparent in the VA final rule on APRNs and the AMA response to the final rule. The VA is a national stakeholder because of the impact that NP FPA will have on the delivery of care in the VA health system throughout the US. The AMA is a national stakeholder given that it is the largest association of physicians in the US and that it expressed is opposing view, specifically stating in its response to the VA final rule that they were "disappointed by the VA's decision to allow most advanced practice nurses within the VA to practice independently of a physician's clinical oversight". Archivatl data related to this theme was noted in both the state health professions data book and the reports from NP survey data obtained from the BON. Both of the nurses association meetings observed addressed the theme, participants. Stakeholder attributes and emotions were addressed within articles of the NP-focused nurses association publications, the state medical society briefings and legislative summary, the state medical journal issue focused on nursing, both of the observed nurses association meetings, and one email from an NP activist directed towards members of the nurses association.

Problem. Information supporting the theme, problem, was observed in document data from the state economic study research report (the report included a description of the supply and demand for health care services in the study state) and related media that covered the report, the BON report (which began by stating the barriers created due to inconsistent regulation of APRNs), the state medical journal issue that focused on nursing, the medical practice webpage (which advertised the range of fees charged by practicing physicians for supervising NPs), and the NP-focused nurses association

publications. Archival data from the state health professions data book and the reports from NP survey data obtained from the BON supported this theme through presentation of the actual numbers of providers in the state, in addition to data from the two observed nurses association meetings which discussed specific practice barriers created by current regulation and plans for updating regulation to reflect health care trends.

Policy development. Information supporting the theme, policy development, was observed in almost all of the document data, including the ten state legislative bills (which supported the code, policy proposal, within this theme). One document, an email from a nursing advocacy expert confirming an NP activist group financial contribution to the nurses association, is the only document that did not address any of the codes which comprised the theme, policy development. Archival data from the state health professions data book and the reports from NP survey data obtained from the BON supported the code, evidence, within this theme through presentation of the numbers of providers in the state. Data from the observed nurses association meetings supported this theme, and specifically addressed the codes, stakeholder priorities and policy proposal through discussion of the nurses association's goals for the 2017 legislative session and plans for seeking bill sponsors for legislation with provisions that support FPA for NPs.

Politics. The theme, politics, was supported by document data which included the medical society briefings, the state medical journal issue that focused on nursing, the NP-focused nurses association publications, and the email from a nursing advocacy expert confirming an NP activist group financial contribution to the nurses association. Observation data from the observed nurses association meetings supported this theme,

and specifically addressed the code, stakeholder relationships. Archival data from the state health professions data book and the reports from NP survey data obtained from the BON did not address any of the codes within this theme given that the focus of both sources of archival data was the presentation of information related to the supply of providers in the state.

Comparison with theoretical propositions. This section will present the theoretical comparison of the observed patterns from the thematic analysis of the interviews and converging evidence from the other sources of data against the predicted patterns outlined in the theoretical propositions that guided data collection for the case. Both propositions were supported by observed patterns within the data collected for the case. Specific data sources that addressed each proposition are presented below:

Proposition 1. The first proposition stated that the current problems, available policy alternatives, and political environment in the study state would influence NP FPA stakeholders to decide that the 2017 legislative session would be the appropriate time to introduce legislation to pursue changes to NP SOP regulations.

Observed patterns from 11 participant interviews revealed four major themes associated with the pursuit of NP FPA within the state: participants, problem, policy development, and politics. These themes were triangulated with the document data, archival data, and observation data collected during the study's data collection period. Proposition one was addressed through the four identified themes:

The theme, participants, included codes which described the stakeholders involved in NP FPA efforts, their attributes, and emotions. The theme, problem, included

major codes which provided evidence of problems within the state that, in the view of participants, should be addressed by policy makers. Specific codes that described the problem included the code, indicator, and its related sub-codes, health care redesign, health resource utilization, and practice barriers.

The theme, policy development, was comprised of seventeen codes. Policy development was considered to be the processes involved in creating solutions to problems. The processes included consideration of the research, analysis, synthesis, and evaluation of information available along with the priorities and recommendations of the various stakeholders for a particular subject. A policy proposal introduced in the form of a bill was only one of the many codes identified within the policy development theme. Participants within the interviews for this study did make specific comments reflecting decisions that 2017 legislative session would be the appropriate time to introduce legislation for NP FPA. The participant comments were supported by sources of data collected within the document data and observation data.

The theme, politics, included two major codes which were discussed by participants in all 11 interviews: strategies and stakeholder relationships. The code, strategies, included six sub-codes to categorize the various explanations given about specific approaches that stakeholders included as they made plans for the pursuit of NP FPA in the state. The code, stakeholder relationships was discussed in terms of the relationships among stakeholders within the policy arena and external to the policy arena and how those relationships impacted stakeholder decisions to introduce legislation for NP FPA within the state.

Proposition 2. The second proposition stated that the case would show that the 2017 legislative session would present an open window of opportunity for introducing legislation for NP FPA.

Observed patterns from the themes, policy development and politics, most directly addressed proposition two. *Stakeholder relationships* among legislators and stakeholders in support of NP FPA were aligned during the time leading up to and including the beginning of the 2017 legislative session. Legislative bill sponsors were found among legislators in both the state House and Senate; on February 13, 2017, *policy proposals* in the form of companion bills with the title, *An Act Updating and Modernizing the Nursing Practice Act*, were introduced in both legislative houses.

Case Description

The case description will collapse the themes and codes within concepts from the Kingdon (2011) model: how the problem became a priority, how communities supported or opposed the issue and the politics involved, and the process of softening up leading to the open window of opportunity for introducing legislation for NP FPA (Kingdon, 2011; Rigolosi & Salmond, 2014).

The problem. The study state was described as one with rural areas and areas of underserved populations within urban areas where access to health care is an increasing problem. Additionally, the demand for health care in the state is continuing to increase because of growth in the population. The problem became a priority among the state's NP FPA stakeholders because there are not enough health care providers in the state to meet the demand for health care services. The health care provider shortage will continue

to be a problem, especially with regard to primary care providers, as the number of physicians who choose primary care careers continues to decrease. Health care redesign is occurring in the state to address the demands for health care and better utilize all health care providers in a more efficient, cost-effective manner. However, stakeholder uncertainty exists regarding the impact that decisions at a national level will have on the redesign and provision of health care at the state level. The number of NPs in the state is increasing. More NPs are graduating from NP programs in the state, however not all of those NPs are going into primary care. Nurse practitioner SOP regulations have not kept pace with the health care industry redesign that is occurring. The current NP SOP regulations are a barrier to fully utilizing NPs in a cost effective manner to provide increased access to care within the state's health care system.

Supportive and opposed communities. An aggregated total of forty-three different stakeholders (either individuals, groups or organizations) were mentioned in the interviews with this study's participants. The nursing community and its related organizations were the major stakeholders supporting NP FPA. Organized medicine was identified as the major stakeholder opposing NP FPA in the state, although participants suggested that individual practicing physicians within the state may not share the same position as organized medicine. Additional stakeholders are following the issue, but have not publically voiced a position in support or opposition of NP FPA due to the complexity of relationships among NP FPA stakeholders within the state.

Supportive. The nursing community support of NP FPA in the state was evidenced by several variables in addition to statements made by study participants. The

following mission statement was observed on the state nurses association's website: "The [Nurses Association] serves the changing needs of its members, addresses nursing issues, and advocates for the health and well-being of all people." The priorities of the nurses association (which represents NPs in the state) and the official position of the nurses association were clearly documented in the association's *2017-2018 legislative, regulatory, and political platform* and its many legislative updates available through the association's website. Efforts to increase the financial resources available to pay for lobbying efforts for NP FPA within the state were clear beginning in April, 2005 as NPs formed the NP political action committee (NP PAC) when it raised an initial $3000 during a state wide NP conference. The 2013 annual issue of *NP News* reported that $151,780 had been raised by the NP PAC as of 2013 through donations from 500 contributors. In 2008, the nurses association's board of directors approved a $50 assessment to its NP members, paid with member annual dues, to be used to support additional lobbying efforts by the nurses association associated with APRN issues (Bush, 2008). In 2015, the nurses association increased their lobbying resources by hiring an additional lobbyist assist with advocacy efforts. In 2016, the nurses association noted that 20.5% of member dues were used towards the nurses association's lobbying efforts.

In addition to the nurses association's hired lobbyists, other methods were used to show stakeholder support of NP FPA efforts in the state. Opportunities were arranged through the nurses association for nurses (including NPs) to meet with their legislators to discuss the health care related problems in the state and how NP FPA could address some of the state's identified problems. Such opportunities included: nurses night at the

legislature, nurses day at the legislature, nurse of the day at the legislature, NP advocacy day at the legislature, and the weekly APRN presence at the legislature (the most recently arranged opportunity). Furthermore, in the summer of 2016, a meeting of the state's joint legislative oversight committee on health and human services was scheduled to discuss evidence from a study commissioned by the nurses association to assess the potential the economic benefits to the state of less restrictive regulation of APRNs. Finally, the nursing community's support of NP FPA was clear in the legislative bills filed at the urging of the nursing community related to NP practice beginning in 1993, with enactment of a bill titled, *An act to Remove Barriers in Insurance policies and Plans to Provide for Reimbursement to Advanced Practice Registered Nurses Providing Services Within the Scope of their Practice*. The most recent of these bills was noted to be the two companion bills filed in both the state House and Senate on February 13, 2017 under the title, *Modernize Nursing Practice Act*. If enacted, the *Modernize Nursing Practice Act* will update the state's practice laws to reflect the abilities of all APRNs (including NPs), based on their education, training, certification, and continued competence.

Opposed. Organized medicine was identified as the major stakeholder opposing NP FPA in the state. The history of the opposition of organized medicine was best explained by a statement contained within a publication from the state's medical society that included a summary of the 2015 bill with provisions for NP FPA: "The [medical society] has fought for years to protect the physician supervision requirements to maintain patient safety standards in [the state's] medical laws" ([Identifying information removed] Medical Society, p. 17). Although the specific financial resources and

strategies used by organized medicine over the years within the state to actively oppose NP FPA were not apparent in the data collected for this study, it should be noted that state bills in 2001 and 2013 that were introduced to bring regulation of NPs solely under the authority of the BON did not pass; neither did either of the 2015 companion bills that contained NP practice provisions aligned towards a FPA model. Historically, the position presented by organized medicine in opposition to NP FPA was one that emphasized a concern of safety. However, the following quote from a 2016 state medical society publication suggested that the argument posed by organized medicine may be changing from one that voices safety concerns to one that suggests their views on the appropriate structure for health care redesign within the state:

> Supervision gives a statutory structure to the team-based care model that has been shown to be successful in [the state]. As we move to more value-based arrangements of care delivery, those teams are going to be even more important. [The state's] physicians stand ready to assist the State in that transformation.

Politics. Organized medicine in the state has a historically strong opposing presence and influence within the state's legislature as it related to NP FPA efforts. Such presence and influence was noted by the comments of several study participants and the lack of progress of any of the previously introduced state bills related to NP FPA. The presence and influence of nursing communities within the legislature has increased from previous years, evidenced by participant comments and the earlier description of the nursing community's efforts to increase their resources and available opportunities to speak with legislators about NP FPA.

Relationships among the organized medical and nursing communities within the state have been heated as they relate to NP FPA efforts. According to one study participant, during the 2001 effort, leaders from the organized nursing and medical communities met to discuss nursing's plans to introduce legislation. Leaders from the organized medical community conveyed their opposition to the nursing leaders. However, when the 2001 bill was filed and referred to the health committee, leaders from organized medicine reached out to the nursing leaders and arranged a follow-up meeting explaining that they should discuss ways to resolve the issue without involving the legislature. The organized nursing leaders sent a request to the chair of the health committee to pull the bill from the committee's agenda in anticipation of the proposed meeting with the organized medicine leaders. The medical and nursing leaders met a few times, however no resolution was accomplished, and the window of opportunity to have the bill heard that session was lost. Similar meetings between the organized nursing and medical communities have not taken place since that time. The next time a related bill was filed by the nursing community was in 2013. The 2013 bill titled, *An Act Amending the Nursing Practice Act to Authorize the Board of Nursing to Regulate Nurse Practitioners and to establish Certain New Fees Related to Regulating Nurse Practitioners,* was referred to committee on rules and operations of the Senate, where it remained due to legislator inaction.

Softening up. Kingdon (2011) described softening up as a process whereby policy advocates begin discussions of their proposals and "push their ideas in many different forums" with the goal creating a climate that will allow for the introduction of a

proposed change (p. 228). The softening up efforts for NP FPA within the state began after the twelve year gap between the 2001 and 2013 legislative bills. Even though it languished in committee, introduction of the 2013 bill provided an opportunity for supportive stakeholders to begin a new, ongoing dialogue with legislators about NP FPA which continued through the 2017 legislative session. Recommendations in publications such as the 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*; the 2012 National Governors Association report, *The role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*; and the 2014 Federal Trade Commission report, *Policy Perspectives: Competition and Regulation of Advanced Practice Nurses* provided additional context from which to continue conversations about NP FPA with legislators.

In 2015, a state specific economic impact study [conducted by a health economist and commissioned by the state nurses association and certified registered nurse anesthetist (CRNA) association] was published. The study's focus was the economic impact to the state of less restrictive regulation of advanced practice nurses. Publication of the study coincided with the 2015 legislative session in which companion bills with provisions for NP FPA were introduced. A difference between the 2013 bill and the 2015 companion bills was the inclusion of other APRN roles, clinical nurse specialists (CNSs) and certified nurse midwives (CNMs), in addition to NPs. The inclusion of additional APRN roles showed a more cohesive effort on the part of advanced practice nurses in the state than previously introduced bills. Again, the 2015 bills never made it out of the initial committees to which they were referred. However, during the summer of 2016, a

meeting of the state's joint legislative oversight committee on health and human services was scheduled to discuss the 2015 economic study. The meeting provided an opportunity for supporting and opposing stakeholders to further discuss their positions related to reducing the restrictive regulation of APRNs within the state.

Sponsors for the 2015 bills affirmed their intent to introduce similar bills in the 2017 legislative session, pending their re-election in 2016. The 2016 election cycle brought changes to the elected officials leading the state. Many experienced legislators retired from the legislature; one of the 2015 legislative bill sponsors was not re-elected; 19 new members were elected to the state House; with the addition of another nurse, three nurses (including one nurse practitioner) were in the House; and five new members were elected to the Senate. New committee chairs were assigned to important committees within both the House and the Senate, Republicans held the majority in both legislative houses, and a new Democratic governor defeated the previous republican governor in the gubernatorial race.

As noted in the interviews with this study's participants, a strategy that stakeholders for NP FPA in the state adopted was one of persistence, with the understanding that it may take several legislative sessions before an introduced bill leads to an actual change in regulatory policy. After the election and prior to the beginning of the 2017 legislative session, the state's APRN legislative strategy group met with the nurses association's lobbyists to discuss their strategy for 2017. The group's stated goal for 2017 was to reintroduce the *Modernize Nursing Practice Act* bill with APRNs having FPA as a result of the bill. Also during this time, on December 12, 2016, the Department

of Veterans Affairs (VA) published its final rule on APRNs. The final rule amended the VA medical regulations to permit FPA of three APRN roles within the VA health system when those providers act within the scope of their VA employment: NPs, CNSs, and CNMs. Full practice authority was not granted to CRNAs in the final rule, but the VA asked for public comment regarding the inclusion of FPA for CRNAs in future VA rulemaking (Department of Veterans Affairs, 2016).

Noting the Republican majority in both legislative houses, Republican legislators were pursued to become primary bill sponsors for 2017 bills. Supportive stakeholders voiced hopes that the bills' focus on changing the regulation of APRNs to a model of less restrictive regulation would speak to those in elected office with views that less regulation is better. On February 13, 2017, *policy proposals* in the form of companion bills with the title, *An Act Updating and Modernizing the Nursing Practice Act,* were introduced in both legislative houses. The 2017 bills included provisions for all four APRN roles. The Senate version of the bill had three republican primary sponsors, two of which were primary sponsors of the Senate bill introduced in 2015. The House version of the bill had three republican primary sponsors and one democrat primary sponsor. The democratic House bill sponsor is the legislature's only nurse practitioner; all three republican sponsors were primary sponsors of the House bill introduced in 2015.

Explanation Building

This section will analytically generalize the study's results to the Kingdon (2011) model through the process of explanation building by using the observed patterns from the study to answer the study's research question: *How do one state's stakeholders for*

NP FPA determine the appropriate time for pursuing legislation to change NP SOP regulations?

Data from the thematic analysis of the interview transcripts was triangulated with the document data, archival data, and observation data collected for this study and then used to address the study's theoretical propositions. The observed patterns in the data supported the predicted patterns in both theoretical propositions as previously explained in the section, *comparison with theoretical propositions*. Data analysis revealed a final code list with four overarching themes, 31 codes, and 34 sub-codes; each item within the final code list was considered by the study state's stakeholders for NP FPA as they determined the appropriate time for pursuing legislation to change NP SOP regulations. Ultimately, after consideration of all of the items in the code list, stakeholders in the study state determined that the 2017 legislative session was the appropriate time to pursue legislation to change NP SOP regulations. The stakeholders' decision was evidenced by the introduction of companion bills titled, *Modernization of Nursing Practice Act*, with provisions for NP FPA on February 13, 2017 in both of the state's legislative houses.

Generalization to the Kingdon (2011) model. The Kingdon (2011) policy stream model proposed that the three streams of problems, policies, and politics occur separately and simultaneously; when the streams converge at a critical point in time, an *open window* of opportunity is formed through which policy advocates can move their interests forward on the governmental agenda, with the goal of placing a particular

solution on the decision-making agenda where it can potentially result in an ultimate change in policy (Kingdon, 2011).

Data from this study suggested that merging of the three streams was actively taking place during the data collection period, creating an open window of opportunity for NP FPA legislation in the study state. The introduction of the *Modernization of Nursing Practice Act* bills on February 13, 2017 was evidence that the subject had been placed on the governmental agenda. Before it is placed on the decision-making agenda during the 2017 legislative session, the proposal will be considered and compared against alternatives (including the alternative of doing nothing) in terms of its technical feasibility, fit with dominant values and the current mood within the state, its budgetary workability, and the political support or opposition that it might experience (Kingdon, 2011, p. 19).

Summary

This chapter presented the results from the case study beginning with a summary of the characteristics of the study's participants. Presentation of the results continued by focusing on the technique of pattern matching that was used during analysis, which presented results from thematic analysis of the interviews, convergence of themes with other sources of data (document data, archival data, and observation data), and a theoretical comparison of the results with the study's guiding propositions. Thematic analysis of the interviews revealed four final themes, *participants, problem, policy development, and politics*. The four final themes were supported through triangulation with the other data sources: document data, archival data, and observation data. All four

themes supported proposition 1, which stated that the case would show how the current problems, available policy alternatives and political environment in the study state would influence NP FPA stakeholders to decide that the 2017 legislative session was the appropriate time to introduce legislation to pursue changes to NP SOP regulations. Proposition 2, which stated that the case would also show that the 2017 legislative session presented an open window of opportunity for introducing legislation for NP FPA, was supported by the themes, policy development and politics.

Next, the case description collapsed the study's themes and codes within concepts from the Kingdon (2011) model. Through the case description, the study state was described in terms of how the problem became a priority, the communities that supported or opposed the issue, the politics involved, the process of softening-up, and convergence of the three streams which lead to an open window for introducing legislation with provisions that supported NP FPA in the study state.

Finally, analytic generalization of the study's results to the Kingdon (2011) model occurred through explanation building by using the observed patterns of the study to answer the research question: *How do one state's stakeholders for NP FPA determine the appropriate time for pursuing legislation to change NP SOP regulations?* The final code list included components categorized within the themes of participants, problem, policy development, and politics, that were considered by the study state's stakeholders for NP FPA as they determined the whether the 2017 legislative session was the appropriate time to pursue legislation. Data from the study suggested that the policy streams described by Kingdon (2011) were actively merging during the data collection period, creating an open

window of opportunity for NP FPA legislation in the state. Chapter five will discuss the findings from the study and present limitations of the research. It will conclude with a discussion of implications for future nursing research, practice, education, and policy.

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to achieve a comprehensive understanding of how stakeholders for nurse practitioner (NP) full practice authority (FPA) in one state determined the appropriate time to pursue legislative changes to NP scope of practice (SOP) regulations. This research used an embedded single case study design, guided by the Kingdon (2011) policy stream model to answer the study's research question: *How do one state's stakeholders for NP FPA determine the appropriate time for pursuing legislation to change NP SOP regulations?* Relevant data for this study included interviews with 11 of the study state's stakeholders for NP FPA, document data, archival data, and observation data. Qualitative analysis of the data was guided by Yin (2014), and revealed four themes which included the components considered by the study state's stakeholders as they determined the appropriate time to pursue legislation to change NP SOP regulations: participants, problem, policy development, and politics.

This final chapter will discuss the significant findings from the study and present limitations of the research. Next, implications for future nursing research, practice, education, and policy will be presented before concluding with a discussion of the study's significance within the literature on NP FPA efforts.

Significant Study Findings

Sample

The final sample for this study was comprised of 11 participants, including one physician. Inclusion of a physician participant in this research is significant in that this is the first study identified in the literature related to NP FPA in which physician input has been obtained. Duncan and Sheppard (2015) attempted to recruit physician participants for their study on Nevada's FPA initiative, but were unable to find a physician who was willing to participate, stating that several physicians "specifically declined" (p. 611). Study participants described organized medicine as the "professional advocacy and medical groups of the medical profession," which in the state was noted to be "predominantly the medical society, but also a couple of the specialty medicine societies." Given that physicians are major stakeholders for NP FPA and organized medicine was noted as the main opposing group for NP FPA efforts, an understanding of the similarities and differences between the views of organized medicine and practicing physicians is a necessary piece missing from the research literature related to NP FPA.

Another notable finding among the sample for this study was the average 17 years of experience among these stakeholders for NP FPA efforts within the study state. The length of time that the study participants had been involved in NP FPA efforts supports comments from the literature that the journey to the end goal of NP FPA may take several years, requiring patience and persistence from stakeholders who support NP FPA legislation (Rigolosi & Salmond, 2014; VanBeuge & Walker, 2014). Comments from the literature were further supported by reflections from several of this study's participants

who noted the long history of ongoing efforts towards NP FPA in the state, and from the legislative bills included as document data in this study. The first of the legislative bills was one that passed in 1993 and removed barriers to in insurance policies and plans in order to facilitate direct reimbursement to advanced practice registered nurses (APRNs) in the state for the services that they provided.

Themes

Data analyses for this study revealed a final code list with four overarching themes, 31 codes, and 34 sub-codes; each item within the final code list was considered by the study state's stakeholders for NP FPA as they determined the appropriate time for pursuing legislation to change NP SOP regulations. Ultimately, after consideration of all of the items in the code list, stakeholders in the study state determined that the 2017 legislative session was the appropriate time to pursue legislation to change NP SOP regulations. The stakeholders' decision was evidenced by the introduction of companion bills with provisions for NP FPA. The bills titled, *Modernization of Nursing Practice Act*, were introduced on February 13, 2017 in both of the state's legislative houses. The following are significant points gleaned from the study's identified themes:

The decision-making process of stakeholders related to determination of the appropriate time to pursue NP FPA is a complex endeavor which includes intertwined relationships among multiple stakeholders with various priorities, resources, and influence related to policy decisions. The study state's NP FPA stakeholders could serve in multiple roles over time related to NP FPA efforts; they could also serve in

simultaneous roles, which added another layer of complexity to the relationships among stakeholders for NP FPA.

The reasons identified by this study's NP FPA stakeholders for pursuing NP FPA legislation were similar to those identified in the literature on states that have already passed NP FPA legislation (Duncan & Sheppard, 2015; Madler, Kalanek, & Rising, 2012; Madler, Kalenek, & Rising, 2014; Matthews et al., 2010; Rigolosi & Salmond, 2014). These included problems related to access to care and barriers imposed by outdated NP SOP regulations. Such barriers impede the ability of health care systems to fully utilize NPs according to their education, training, certification, and continued competence when addressing patient needs for access to high quality care that is both efficient and cost-effective.

While previous reports on NP FPA efforts included information on the strategies that stakeholders in other states viewed as leading to their successes, and even some description of barriers encountered, little focus was given to the actual history involved in developing the policy proposals that were put forth (to include history of the NP role within each state and history of the relationships among NP FPA stakeholders within the each state). Findings from the present study begin to address this gap in the literature.

Case Study Methodology and the Kingdon (2011) Policy Stream Model

Case study methodology. Use of the embedded single case study design according to Yin (2014), coupled with the Kingdon (2011) policy stream model provided an enhanced lens with which to evaluate the phenomenon of stakeholder decision-making among the study state's stakeholders for NP FPA as they determined whether the time

was appropriate to pursue legislation for NP FPA. The embedded single case study design allowed the researcher to explore this contemporary phenomenon in depth and within its real-life context. Additionally, the design provided a guide for focusing the data collection and analyses related to this complex issue. Furthermore, the design provided a venue, the case description, which enabled the researcher to account for the role of history in addressing a policy issue that may span over decades before legislation is enacted into law (Madler, Kalanek, & Rising, 2012). Specific findings related to the role of history illuminated in the case description included the fact that the nursing profession is evolving in its political proficiency, but should continue to strengthen its political expertise in order to remain a valuable resource to policy makers as they consider health related legislation. An additional finding that was revealed through the case description included realization on the part of nursing stakeholders that it was time to change the strategy with which they pursued NP FPA legislation. Earlier endeavors suggested a "wait for the perfect moment" perspective on legislative pursuits. This perspective was evidenced by the twelve year gap in the introduction of legislation related to NP FPA after defeat of the 2001 bill. The introduction of related legislation during the last three consecutive legislative long sessions (2013, 2015, and 2017) provided evidence of the shift in strategy to one that suggested a perspective of "create the perfect moment". This perspective was further evidenced by specific comments from participant interviews that conveyed a dedication to persistence and patience with regard to the continued pursuit of NP FPA within the state.

Kingdon (2011) policy stream model. The Kingdon (2011) policy stream model provided a theoretical framework with which to generalize the findings from this study. Study findings reflected decisions made by stakeholders at one historical point in time, however, through Kingdon (2011), they were generalized to a model that described the policy making process more broadly within the context of the three streams of problems, policies, and politics. Recall that the three streams move through time independently and simultaneously; merging at distinct points to form an open window of opportunity in which policy advocates can move their interests forward on the governmental agenda, with the goal of placing a particular solution on the decision-making agenda where it can potentially result in an ultimate change in policy (Kingdon, 2011).

Data from this study suggested that merging of the three streams was actively taking place during the data collection period for the study, signaling the potential for an open window of opportunity for NP FPA legislation in the study state. The introduction of the *Modernization of Nursing Practice Act* bills provided evidence that the subject of NP FPA had been placed on the governmental agenda. Before being placed on the decision-making agenda during the 2017 legislative session, the proposal will be considered and compared against alternatives (including the alternative of doing nothing) in terms of its technical feasibility, fit with dominant values and the current mood within the state, its budgetary workability, and the political support or opposition that it might experience (Kingdon, 2011, p. 19). Given the limited period in which a policy window is open, and that the opportunity for action by policy entrepreneurs is constrained to this short time before the policy window closes, specific reflection on the policy stream of the

Kingdon (2011) model suggests that the decision made by the study state's NP FPA stakeholders to introduce the two bills at the beginning of the 2017 legislation poised them in a position of readiness with a suggested policy proposal to avoid missing a potential opportunity (Kingdon, 2011).

Limitations

As with all research, the findings from this study should be interpreted with an understanding of the study's limitations. One limitation was the role of the researcher, who collected the data and performed analysis of the transcripts, which may have influenced the transcript analysis. This limitation was addressed by validating the transcribed interviews with participants, and validating the codes and themes with the dissertation committee, which included two qualitative experts. A second limitation was related to the use of case study methodology. In case study methodology, the researcher must have an understanding of the issues being studied before conducting the study; this understanding may have biased the researcher toward supportive evidence regarding the issue and away from contrary evidence (Yin, 2014). The case study protocol was developed to address this concern (See Appendix A). Within the protocol, the use of a research log was outlined. The research log was used to track thoughts and decisions about data sources, sampling choices, and analytic techniques used during the process of inquiry (Yin, 2014). Thoughts and concerns recorded in the log were discussed during frequent meetings with the dissertation chair and other committee members to validate emerging ideas that occurred while conducting the study.

Implications

The findings from this study are intended to add to the research literature by providing a comprehensive view of how stakeholders for NP FPA in one state determined the appropriate time to pursue legislative changes to NP SOP regulations. The findings have implications in the areas of nursing research, practice, education, and policy.

Research Implications

Several research implications became clear during the process of completing this dissertation. The first of which is to replicate this study in another southeastern state and then conduct a comparative case analysis between the two cases. Such research could shed light on a question that is still unanswered: What makes states in the southeastern United States unique with regard to stakeholder decisions surrounding the pursuit of NP FPA?

A second implication for future research is the inclusion of additional physician perspectives in future research related to NP FPA efforts. Several of this study's participants commented that there may be a difference in the views presented by organized medicine with regard to NP FPA versus those of practicing physicians. The physician perspective presented in this study was from a participant who was not a member of the state medical society; the participant specifically mentioned having differing views from those presented by the state medical society on various issues. Future research on NP FPA efforts which includes the views of physicians, both those who are members of their medical society and those who are not, may provide valuable

information to policy makers regarding the position and priorities of this stakeholder category, which has been described as a major opponent to NP FPA legislation.

A third research implication is to include the perspectives of other advanced practice nursing roles in future research related to policy pursuits for regulatory changes that promote full practice authority. This study focused on the perspectives of stakeholders for NP FPA. The reason for this focus was that historically in the study state, organized nursing communities for each individual advanced practice role engaged separately when pursuing legislation related to their specific role. However, the case description noted that the 2017 bills introduced in the study state included provisions for all four advanced practice nursing roles. Study participants suggested that a unified front on the part of all advanced practice roles towards pursuing regulatory changes would strengthen their efforts for legislation that supports FPA for all advanced practice nurses. Given that FPA for all APRN roles is outlined in the APRN Consensus Model Act and Rules, an understanding of how each of the four APRN roles decide whether the time is appropriate in their state to pursue legislation for FPA, either as an individual advanced practice nursing group, or as a unified effort including all four APRN roles, would strengthen the research literature related to the topic.

A final research implication of this dissertation is the value of using the case study design in nursing research. The case study design is an innovative method to employ in nursing research situations where an extensive view of the research phenomenon necessitates the use of multiple sources of evidence (Jessup, 2013). According to Yin (2009), the case study design is appropriate for research situations in which "a how or

why question is being asked about a contemporary set of events, over which the investigator has little or no control" (p. 13). While this is certainly applicable to situations that explore nursing as it relates to the development of health policy, the method could prove valuable in a wide range of other systematic investigations of phenomena that relate to nursing.

Practice Implications

One of the findings from this study concerned the health care system cost related to the fee charged by supervising physicians to NPs for maintaining the currently required supervisory relationship and related collaborative practice agreement. The specific fee range discussed by participants mentioned charges that ranged from ten to twenty-five thousand dollars per year to each NP with which a physician agreed to supervise. A website for a medical practice within the study state was found to suggest supervision of NPs as one entrepreneurial project in which its physician members could participate. The website further suggested that income earned from supervising good, experienced NPs was almost passive income for physicians. One study participant commented on the practice implications of the charge for the supervisory relationship by stating,

> We want to talk about controlling cost, let's take a piece of that out that in many cases only represents one signature on one piece of paper, once or twice a year. And that is the extent of the oversight.

This finding is noteworthy because it represents one area in which policy makers could directly impact the cost of health care delivery. This point should be deliberated

along the other factors when considering legislation for NP FPA – if NPs were granted FPA, the need for the supervisory relationship would no longer exist, and therefore, neither would the fee charged for the relationship.

Education Implications

Findings from this study have implications for nursing education, specifically related to the political competency of nurses. As leaders within the health professions' community, nurses are obligated to serve as reliable sources of information to policy makers on health-related issues. This study can be used as reference within the profession to increase nurses' understanding with regard to components that are involved when making decisions to engage in processes for the development of health policy; just one part of the education that nurses should pursue to increase their political competency.

Under the previous section that discussed nursing research implications, it was noted that future nursing research would benefit from inclusion of the case study design among the potential methodologies used to explore nursing-related phenomena. Perhaps a reason for its infrequent use within nursing research is that it is not taught in nursing methodology courses in most programs. Therefore, a second implication for nursing education is the recommendation to teach case study design in nursing methodology courses.

Policy Implications

The stated goal for implementation of the APRN Consensus Model across every state in the US was 2015 (NCSBN, 2017a). As of March 2017, the study state received a score of 14 out of 28 possible points regarding its status towards implementing major

components within the APRN Consensus Model for all APRNs within the state. The state's current score signals that it is half way towards full implementation, but that there is still work to be done before it is aligned with recommendations in the APRN Consensus Model (NCSBN, 2017c).

Right touch regulations, defined by one study participant as regulations that "appropriately [safeguard] the public without unnecessarily restricting [the] competence and the skill that any one clinician can bring to the point of care for consumers," have the potential to permit organizations within the health care system more flexibility in designing interdisciplinary health care teams that focus care around the needs of the patients that they serve.

Health care redesign is happening, which will include a restructuring of resources to provide care in a more efficient, cost-effective manner. According to a 2013 article about value-based health care in the *Harvard Business Review*,

> Providers that cling to today's broken system will become dinosaurs. Reputations that are based on perception, not actual outcomes, will fade. Maintaining current cost structures and prices in the face of greater transparency and falling reimbursement levels will be untenable.

The article further commented that all health care stakeholders have essential roles to play in health care redesign, acknowledging that resistance and disruptions to proposed changes would occur, but that leaders, and clinicians specifically, must place the needs of patients over clinicians' desire to maintain traditional practice patterns (Porter & Lee, 2013). National leaders for nursing regulation and policy have committed

to their part in this health care redesign, specifically regarding the regulation of NPs and all APRNs, evidenced by creation of the APRN Consensus Model (APRN Consensus Work Group & NCSBN, 2008). Stakeholders for NP FPA within the study state have committed to their part in this health care redesign at the state level through their decision to pursue legislation to change the state's SOP regulations with the goal of facilitating more options for patients in the state's redesigned health care system. It is time for policy makers in the state to commit to their part in the state's health care redesign by acting on the policy proposals that have been placed before them.

Conclusions

The decision-making processes of stakeholders related to determination of the appropriate time to pursue NP FPA is a complex endeavor which includes intertwined relationships among multiple stakeholders with various priorities, resources, and influence related to policy decisions. This study is important for nursing in that it is the first known study to provide a detailed explanation of how stakeholders for NP FPA in one state determine the appropriate time to pursue legislative changes to NP SOP regulations. It is also the first study related to NP FPA identified within the literature to include a glimpse of what at least one practicing physician who supervises NPs may think about legislative pursuits for NP FPA, a voice that has been mysteriously absent from the research literature on the topic. Findings from the study are useful to the study state in that they may serve as a self-assessment of the state's current political environment and readiness for legislative pursuits according to the Kingdon (2011) model. Additionally, the findings can be used as a reference to increase the competency with which the nursing

profession pursues the policy process for FPA legislation. Furthermore, they can serve as a guide to other states regarding the assessment components to consider when making decisions to pursue related legislation.

This study enhances the available literature that discusses state legislative pursuits for NP FPA. The studies done by Pruitt and colleagues (2002), Duncan and Sheppard (2015), and Rigolosi and Salmond (2014), were all conducted with states that already passed NP FPA legislation and therefore provided insight into the strategies that those states used in their pursuits of FPA legislation. The study state for this research, located in the southeastern US, has not yet passed FPA legislation, but is currently within the policy pursuit process. The findings from this study will add to the blueprint described by Rigolosi and Salmond (2014) by providing information about the components involved when a state's stakeholders decide on the appropriate time to pursue legislation for NP FPA.

Summary

This dissertation study is the first known to use an embedded single case study design, guided by the Kingdon (2011) policy stream model to provide a detailed account of how stakeholders for nurse practitioner full practice authority in one stated determined the appropriate time to pursue legislative changes to nurse practitioner scope of practice regulations. The final chapter for this dissertation began by discussing the study's results in terms of its significant findings and then continued by presenting the limitations of the research. Next, implications for nursing research, practice, education, and policy were

enumerated and the chapter concluded with a discussion of the study's significance within the research literature related to NP FPA efforts.

In the United States, many states have revised their nurse practice acts to include provisions that promote full practice authority for nurse practitioners. Such revisions reflect the expanded qualifications and abilities of nurse practitioners and provide a mechanism by which to better utilize the full scope of nurse practitioner services that are available to address growing demands for access to health care. At the close of 2016, 21 states and Washington D.C. (42%) had FPA for NPs (Heisler, 2017). The study state for this research is one of the few that remain with the restrictive, joint regulatory model of NPs. Stakeholders within the state have decided that now is the time to pursue policy changes that promote FPA for NPs and have made recent attempts to change the state's regulatory model to one that facilitates NP FPA. However, success has yet to be reached.

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APPENDIX A

CASE STUDY PROTOCOL

A. Overview of the Case Study

1. Purpose of this Study

    To formulate an in depth understanding of how stakeholders for nurse practitioner full practice authority in one state determine the appropriate time to pursue legislative changes to nurse practitioner scope of practice regulations.

2. Study Questions

    How do one state's stakeholders for nurse practitioner full practice authority determine the appropriate time for pursuing legislation to change nurse practitioner scope of practice regulations?

3. Theoretical Framework

    a. Kingdon Policy Stream Model (Kingdon, 2011)

4. Role of the Protocol

    a. To clarify, guide, and standardize field procedures

5. Creation of Research Log

    a. For reflective journaling to record and track researcher thoughts and changes in thinking throughout the case

b. To track thoughts and decisions about data sources and sampling choices within the case
c. To track thoughts and decisions about selection of analytic techniques
d. To track thoughts and decisions about emerging themes and conclusions from data analysis

B. Data Collection Procedures

1. Access to case study sites

a. Researcher is the former Director of Nursing Practice and Education at the study state's nurses association, a current member of the nurses association, and has access to executive staff, leadership, and other members of the nurses association.
b. Researcher approached nurses association's Chief Executive Officer and Board of Directors regarding this research. The Chief Executive Officer and Board of Directors granted agreed to facilitate access to relevant association documents, members, and staff for this research.
c. Researcher approached the Executive Director of the state Board of Nursing regarding this research. The Executive Director of the state Board of Nursing agreed to facilitate access to relevant documents and staff for this research.

2. Human Subjects Protection

a. Researcher made an application to the University of North Carolina at Greensboro Institutional Review Board (IRB) upon approval of study proposal by the

dissertation committee. The university IRB determined that the research did not constitute *human subjects* research as defined under federal regulations [45 CFR 46.102 (d or f) and did not require IRB approval.

b. Informed consent was obtained from all participants prior to enrollment in study.

3. Sources of Data

a. Documents from the state nurses association pertaining to legislative efforts.

b. Articles and reports appearing within the past 15 years in mass media.

c. Archival data from the state's 2014 Health Professions Data Book (published in 2016).

d. State BON report submitted by a BON ad hoc committee. Archival data in the form of information within reports generated from NP approval to practice surveys.

e. Other data sources identified by study participants that have relevance to the case.

f. Interviews with the following NP regulation stakeholder group representatives in the state: state legislators, NP activists, nursing regulatory experts, nursing advocacy experts, NPs who work in the community, nursing educators, physicians, and major employers of NPs within the state.

The researcher will sample within this group until saturation is reached.

g. Relevant legislative bills filed within the last 25 years.

h. Observation of two nurses association member organizational unit meetings that took place during the study's data collection period.

C. Guide for the Case Study Report

1. Potential journals for publication:
    a. Journal of Nursing Regulation
    b. Policy, Politics, & Nursing Practice
    c. Journal of the American Association of Nurse Practitioners
    d. The Journal for Nurse Practitioners
2. Final themes from thematic analysis of interviews and additional sources of data.
3. Evaluation of stakeholder decisions related to the nurse practitioner full practice authority effort in the study state, according to the Kingdon (2011) model.

APPENDIX B

INTERVIEWEE TRANSCRIPT VALIDATION

I have read the transcript of the interview conducted by Catherine Moore, doctoral student at the University of North Carolina at Greensboro, related to the following research study: ***When is the Appropriate Time to Pursue Nurse Practitioner Practice Legislation? A Case Study***

(1) I agree that the interview was transcribed accurately and have no corrections, clarifications, or additions to the transcribed interview.

Signed: _____ Date: _____

(2) I agree that the interview was transcribed accurately and would like to comment on the transcribed content according to the line number indicated on the enclosed transcript.

Signed: _____ Date: _____

Transcript Line Number	**Interviewee Comments**

Please return this comment sheet to Catherine Moore at the following email address: cmwalsh@uncg.edu. The comment sheet provides validation for the research study being conducted by Catherine Moore. Thank you.

APPENDIX C

TABLE 3. DATA REFERENCE LIST EXAMPLE

Reference	**Related Theme/Code**	**Notes**
North Carolina Board of Nursing APRN Advisory Committee. (2011). *Report to the NC Board of Nursing*. Retrieved from http://www.ncbon.com/myfiles/downloads/aprn-advisory-committee-final-report-to-board.pdf	Policy Development/ Evidence; Problem/ Practice barriers	
H457. Reg. Sess. 1993-1994. (N.C. 1993). Retrieved from http://www.ncleg.net/Sessions/1993/Bills/House/PDF/H457v5.pdf	Policy Development/ Policy proposal; Problem/ practice barrier	Bill title: AN ACT TO REMOVE BARRIERS IN INSURANCE POLICIES AND PLANS TO PROVIDE FOR REIMBURSEMENT TO ADVANCED PRACTICE REGISTERED NURSES PROVIDING SERVICES WITHIN THE SCOPE OF THEIR PRACTICE. **This became law, ratified 7.15.1993**

Reference	Related Theme/Code	Notes
Rickets, T. C. , Williams Jr., J. W., Powers, B., DeFriese, G. H., Neelon, F. A., Copeland, D. D. … Blackwell, P. (Eds.). Future of Nursing in North Carolina. *North Carolina Medical Journal, 72* (4), 277-324.	Participants/Stakeholders; Problem/ Practice barriers, health resource utilization, health care redesign, Indicator – access, provider supply, economics; Policy Development/ stakeholder priorities, softening-up, Evidence – regulatory trends, educational trends, health care trends, national trends; Politics/ stakeholder relationships	The journal Editor in Chief makes the following comment: "In the articles, there is a pervasive sense of both aspiration and frustration as nursing tries to take on the problems facing health care professionals of all types. Nurses seek to rise to the challenge society has given them to improve health care amidst the realities of the complex economics of health care."

Reference	Related Theme/Code	Notes
North Carolina Board of Nursing (2016). Nurse Practitioner Report.	Participants/ stakeholders Problem/ Indicator – provider supply Policy development/ Evidence – educational trends, Health care trends (practice areas and activities of NPs within the state)	Report compiled from NP survey data obtained from approval to practice surveys of NPs within the state. The report includes information about the demographics of NPs within the state (including education), the practice characteristics of NPs within the state, and the practice activities of NPs within the state.
10.26.2016 NP Activist Conference Call	Participants/ stakeholders, stakeholder emotions Problem/ Practice barriers Policy Development/ stakeholder priorities Politics/ stakeholder relationships, strategies - resources	