THE FULL PRACTICE AUTHORITY INITIATIVE:
LESSONS LEARNED FROM NEVADA

by

Cameron Gene Duncan

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As members of the Doctor of Nursing Practice (DNP) Project Committee, we certify that we have read the DNP project prepared by Cameron Gene Duncan entitled “The Full Practice Authority Initiative: Lessons Learned from Nevada” and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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STATEMENT BY AUTHOR

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SIGNED: Cameron Gene Duncan

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DEDICATION

I dedicate this DNP Project to all of the nurse practitioners in states vying for full practice authority legislation. Access to care is essential to the well-being of all Americans, and full practice authority legislation for nurse practitioners is one way to increase access. Despite previous failures in passing this type of legislation, Nevada has succeeded by learning from the past. My hope is that this project may share some of those lessons, and lead the way to implementing successful legislation in all states across the country.

“It’s failure that gives you the proper perspective on success.” - Ellen DeGeneres

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ABSTRACT

Purpose: Identify specific legislative barriers to full practice authority (FPA) legislation and describe how they were overcome during the 2013 legislative session in Nevada.

Background: Legislative restrictions in 31 states prevent nurse practitioners from practicing to the full extent of their education and training. FPA legislation is introduced, but not often signed into law. A comprehensive literature review revealed multiple barriers to autonomous practice: conflict between medical and nursing roles, lack of nurse practitioner role recognition, financial challenges, and a lack of business knowledge. Barriers caused by policy limitations were most frequently mentioned: limited scope of practice, limited prescriptive authority, limited clinical privileges, credentialing limitations and reduced reimbursement rates.

Methods: This study employed a qualitative, multiple case study design. Semi-structured interviews were conducted with four actively-involved contributors to the 2013 FPA initiative in Nevada. Homogeneous questions were used, guided by the use of a predetermined set of questions based on Kotter's (1995) Change Management Model. Each interview began with the question, "What prompted this movement and why was it introduced at this time?" Participants were asked to identify perceived barriers to FPA legislation, and how they were overcome. Recorded interviews were transcribed into text, which led to thematic analysis.

Results: Repetition of shared perceptions revealed eleven barriers separated into six main themes. 1.) *Vision* includes the barrier of lacking a clear and shared vision. 2.) *Physician Support* includes the barrier of lacking the support of physicians and Organized Medicine. 3.) *Addressing Stakeholders* includes the barriers of the inability to address stakeholders, lack of role recognition and community support, and social media. 4.) *Community Organization Support*

includes the barriers of having a Board of Nursing with a poor reputation, and a lack of support from the Board of Pharmacy. 5.) *Leading Coalition* includes the barriers of lacking a strong, leading coalition lacking history of leadership and legislative experiences, and choosing a legislator without experience, authority, and respect in the legislature and the community. 6.) *Resources* include the barrier of lacking necessary resources including time and preparation.

Implications: The findings of this study may be useful for those living in one of the 31 states without FPA legislation. This is one of the first published studies to identify the importance of literature identifying legislative barriers to FPA, and starts to fill the current gap in the literature surrounding this topic. This information may be invaluable in the preparation and introduction of FPA legislation in other states. The findings may also act as a stepping-stone to addressing the provider shortage in the U.S., and may be instrumental in improving access to care. Further research is needed to identify whether similar barriers found in this study are prevalent in other states with FPA legislation for nurse practitioners.

Introduction

In the U.S. there is a vast and increasing shortage of primary care providers to serve the populations' healthcare needs. The aging population combined with the increase of individuals obtaining health insurance further adds to the shortage of healthcare providers. Currently 65 million Americans live in primary care shortage areas, and adults across the nation are unable to promptly access primary care services (Bodenheimer & Hoangmai, 2010). Between 2005 and 2025, the overall number of necessary primary care visits is projected to increase 29%, secondary to the aging population (Colwill, Cultis, & Kruse, 2008). More specifically, the number of visits to a primary care provider is estimated to rise from 462 million visits in 2008, to 565 million visits in 2015 (Pettersen et al., 2012).

Nurse practitioners (NPs) have been identified as providing an answer to this critical health care shortage. For example, nurse practitioners armed with full practice authority are being touted as the ultimate solution to the shortage of primary care providers (PCPs), thereby improving access to health care (Cronenwett et al., 2011). Currently only 19 states and the District of Colombia allow full practice authority for nurse practitioners (American Association of Nurse Practitioners [AANP], 2014). On June 3, 2013, the Governor of Nevada signed into law Assembly Bill 170, which amended the practice requirements of nurse practitioners in the state (VanBeuge & Walker, 2014). Although the nurse practitioners scope of practice was unchanged, this bill provides nurse practitioners the ability to practice independent of physician oversight and at their full extent of education and training (Scott, 2013).

The purpose of this study is to describe specific legislative barriers to introducing and obtaining full practice authority, and to recognize how those barriers were overcome during the

2013 legislative session in the state of Nevada. A multiple case study was conducted using key informants from the state of Nevada.

Background and Significance

Secondary to the overhaul of the Affordable Care Act, many American's were provided with access to health insurance. From October 1, 2013 to February 1, 2014, 3.3 million people enrolled in the insurance plans provided by the Affordable Care Act (Office of the Assistant Secretary for Planning and Evaluation [ASPE], 2014). On September 19, 2014, President Obama's administration announced that 7.3 million U.S. residents who signed up for health insurance under the Affordable Care Act had paid their first month's premiums. With increasing access to healthcare for U.S. residents, there is an additional need for primary care providers to help remedy the existing shortage (Institute of Medicine [IOM], 2011).

Nurse practitioners have provided health care services to medically underserved populations for several decades now. Nurse practitioners have also been used in primary care and specialty clinics working with physicians. According to Newhouse et al. (2011), nurse practitioners currently serve a vital role in improving patient care by providing high-quality services. Furthermore, multiple studies have found patients seen by nurse practitioners had high levels of satisfaction, superior patient outcomes, and efficient cost-effectiveness in clinical settings (Cook et al., 2014; Kapu, Kleinpell, & Pilon, 2014; Peeters et al., 2014).

Legislative restrictions in many states currently prevent nurse practitioners from practicing to the full extent of their education and training. In fact, currently NPs in 31 states are currently limited by legislative restrictions. Some of these restrictions limit the type of patient a nurse practitioner can see, specify which tests they can order, and constrain their prescriptive

ability (IOM, 2010). Physician oversight is the main factor separating the various types of practice across state lines (Federal Trade Commission [FTC], 2014).

A literature review was performed to explore the various barriers to autonomous practice of nurse practitioners in the United States, and to identify the specific legislative barriers to full practice authority. Multiple barriers to autonomous practice for nurse practitioners were identified and described in the literature. Autonomous practice barriers included a conflict between the medical and nursing roles, lack of nurse practitioner role recognition, financial challenges, and a lack of business knowledge (Naylor & Kurtzman, 2010; Lowe, Plummer, O'Brien, & Boyd, 2012; Dubois, Green, & Aertker, 2014). Barriers to autonomous practice caused by policy limitations were the most frequently mentioned in the literature review, which included limited scope of practice (Russell, 2012), limited prescriptive authority (Nevada State Board of Nursing [NSBN], 2014), limited clinical privileges (Summers, 2012), certification (AANP, 2014), credentialing limitations and reduced reimbursement rates (Hansen-Turton, Ware, Bond, Doria, & Cunningham, 2013).

Despite the evidence of these barriers, there was a gap in the literature identifying specific barriers to explain why full practice authority legislation is not signed into law as often as it is introduced to the legislature. McDonald et al. (2012) reported that the importance of forming a strong alliance is an essential component to introducing legislation. Although it may be implied that a lack of a strong alliance may be a barrier to full practice authority legislation, this was not directly stated. Other behaviors to improve legislation included accessing the media, meeting with legislators personally, and improving public awareness; however, these were not

identified as barriers and were not related to full practice authority legislation (MacDonald et al., 2012; Demarco & Schneider, 2010).

In an opinion article by VanBeuge and Walker (2014), the journey of attaining full practice authority in the state of Nevada was discussed, but did not mention specific legislative barriers. Insight on the process of introducing and successfully implementing in this state was provided, which included five key steps. Although some barriers can be inferred from the article, there was no direct mention of specific legislative barriers to legislation. This project fills a gap in the literature by describing specific legislative barriers to full practice authority.

Method

This study employed a qualitative, multiple case study design. The method was chosen in order to best obtain the perspectives from experts in the field. Further, case study designs can be used to apply some findings to similar settings. It is therefore possible that findings from this study may be used to inform those seeking to move more states toward full practice authority (Hentz, 2012).

Conceptual Framework

In order for nurse practitioners to make an even greater impact on health care access in the U.S. we must continue to work toward removing restrictive legislative barriers. Kotter's (1995) Change Management Model was used to guide this research project, as it has been highly successful as a model to lead change in disciplines such as leadership, information systems, education, and nursing (Anson, 2011; Dolansky, Hitch, Piña, & Boxer, 2013; Quinn, Amer, Lonie, Blackmore, Thompson, & Pettigrove, 2012). This theory is based on the eight most common errors leaders make when trying to implement change (Kotter, 1995). Derived from

those errors, the Change Management Model includes eight steps: establish a sense of urgency, create a guiding coalition, develop a vision and strategy, communicate the change vision, empower broad-based action, generate short-term wins, consolidate gains and produce more change, and institutionalize new approaches (Kotter, 1995).

Inclusion Criteria

Participants were sought to represent the perspectives of four groups who might have influenced the efforts to full practice authority in Nevada: a physician, a community-based nurse practitioner, a nursing leader or nurse practitioner activist, and a state legislator. In order to best speak to the process of attaining full practice authority, participants were sought who were actively involved in the advancement of full practice authority legislation and attended the legislative hearing for full practice authority legislation in the state of Nevada during the 2013 Legislative session. No participants were excluded due to ages, genders, ethnicities, or races.

Ethical Considerations

The project was approved by the Institute Review Board before recruitment began. Confidentiality and anonymity were ensured throughout the study. Questions were limited to the specific experiences relating to legislative barriers to full practice authority. Pseudonyms were used to de-identify the participants.

Participant Recruitment

Recruitment flyers were sent to three organizations: the Advanced Practice Advisory Board, the Nevada Advanced Practice Nurse Association (NAPNA) and the Nevada State Board of Nursing. Snowball sampling was then used to identify further potential participants including physicians and legislators. Although three physician names were identified as potential

participants, they were either unwilling to participate in the study or were unable to be contacted via phone or email.

Data Collection

Participants and the researcher identified a time and location that was mutually agreeable for the interviews, and at a setting that ensured privacy. Participants were informed about the study and the process and urged to pose questions prior to consenting. The principle investigator obtained all consents.

Four participants were interviewed, and each interview lasted approximately one hour. Homogeneous questions were used and homogeneity was guided by the use of a predetermined set of questions based on the Kotter's (1995) Change Management Model framework. Each interview began with the question: "What prompted this movement and why was it introduced at this time?" Further questions included: "Who were the leaders of this change and who was part of your guiding coalition?"; "Was there a clear vision?"; "How did this vision or lack thereof influence the change?"; "Was there resistance to this change?"; "What was the resistance?"; "How was it overcome?"; and, "Given the barriers you faced in advancing this legislation, how would you suggest those in other states be prepared to face and overcome those challenges?" Further questioning to ensure confirmability was guided based on the participant responses in order to seek clarification. All participants were asked the same questions.

All interviews were recorded using a digital audio recorder. Participants and data were assigned pseudonyms to ensure anonymity. The digital audio recordings were secured on a password-protected computer until transcription was completed.

Data Analysis

Digital audio recordings were transcribed into word format. The researcher listened to all four recordings to verify the accuracy of the transcripts, and then the recordings were destroyed. Content analysis began with the generation of text from the individual interviews. Each transcript was reviewed individually, and terms that were repeated or appeared to be central to concepts described by the participant were identified. Next, all four transcripts were reviewed together and common words, phrases, experiences, and feelings were identified to ensure dependability. To address credibility, the second author analyzed the transcripts in the same manner and then both authors reviewed the findings for commonalities. Finally, the recordings were destroyed after being reviewed by the researchers.

After content analysis was completed, the findings were shared with the participants. Each participant was contacted by telephone so the researcher could clarify slang terms and verify the participant's meaning of specific statements. In addition, each participant was allowed to add and seek clarification of data, and to confirm whether or not they agree with the study findings. This step was performed to increase credibility of the findings. The member checks confirmed the findings of the study, and added further clarification to the use of social media.

Participants

There were a total of four participants included in the study: a nurse leader and administrator, a legislator, a community-based nurse practitioner, and a nurse practitioner activist intimately involved in the legislative movement toward full practice authority. The actual role of each participant is not identified here, in order to protect the anonymity of each participant. In 2011, a similar initiative for full practice authority legislation in Nevada was attempted and

failed. Therefore, the participants included in this study were able to speak to the barriers they experienced during the first effort, and speak to how those barriers were overcome during the 2013 legislative session. Although recruitment included the search for a physician actively involved in the process, no physician volunteered to participate, and several specifically declined. All four participants met the inclusion criteria.

Findings

Multiple barriers to full practice authority legislation were identified in the interviews. The most commonly mentioned barriers to full practice authority legislation were a lack of a clear vision and consistent language, lack of physician support, inability to address all stakeholders, and a lack of a strong coalition. Other barriers mentioned in at least two interviews include a lack of time and preparation, leadership and legislative experiences, nurse practitioner role recognition, and a poor reputation of the Board of Nursing. Finally, a lack of support from the Board of Pharmacy, and social media were also mentioned. The following legislative barriers are listed based on the number of times they were mentioned in the interviews, from most to least occurring. These eleven barriers are also accompanied with a description of how they were overcome during Nevada's Legislative session in 2013.

Lack of a Clear Vision

The barrier to full practice authority legislation most commonly mentioned among the participants was the lack of a clear vision. Clarity of the vision was a shared belief of all participants and was described as needing to be "clear," "straight-forward," "easy to understand," "consistent," and "unchanging." The respondents described a clear vision will allow all stakeholders to have an accurate understanding of the purpose of the legislation. The

respondents also agreed to the importance of relating the vision to the needs of the community since the legislators are elected to office to represent their constituents' needs. This relationship should emphasize how the legislation will affect the community and address their needs:

Increase access to care. Increase access to care. Increase access to care. That's all we said. I think people actually got sick of hearing it because that's all we said... At one point, the national term to use for this type of legislation was changed to full practice authority, but we had already started with autonomous practice so we stuck with that term. (Community NP)

Another component of the vision identified by multiple participants was the need to share the vision with all stakeholders. Statements to represent a shared vision included "consistent among everyone in the group," "everyone saying the same thing at all times," and "all stakeholders should have the same ideas about the change." It was explained that communication to share all information about the legislation is essential, but the vision must stay consistent among all members of the coalition and the community. According to the participants, a clear, shared vision can be accomplished by consistent updates and communication among the leading coalition, and sharing that same vision with the community.

Lack of Physician Support

All participants clearly identified a single profession as the main opposition to full practice authority legislation. *Physicians* and *Organized Medicine* were mentioned in relation to all aspects of the legislative barriers. Unanimously, the participants also agreed that the driving force behind the physician opposition was control, power, and money:

The regulatory body for medicine did not support or oppose the bill. It was the medical association and the individual physicians. The association was adamantly opposed to it... They were never going to collaborate, they were going to supervise no matter what. They wanted nurses under their thumb... It was all about control and money. (Legislator)

When participants were asked how they attempted to address the opposition, they described several specific behaviors. First, it was important to address all of the stakeholders, including physicians. According to the participants, some physicians were in support of the legislation, but would not speak openly or publically about their support. The participants also stressed the importance in talking to individuals with influence in the community, in medicine, and in the legislature. Lastly, they agreed in the weight of attending to the interests of the Governor in order to overcome the strong coalition of physicians. For example, leaders in the medical community, who may be physicians, may have more influence on the Governor than specific individuals in the community:

There were a couple of key people in the Nevada State Government, people [from the medical field] who had influence and had his [Nevada Governor] ear who he called... I reached out to those people as did another person who was a key supporter of ours. (Community NP)

Several participants identified specific themes and topics discussed when meeting with these key people. These themes solidified the importance to share the vision amongst all stakeholders, including physicians, and being truthful and straight-forward. The importance of stating the facts of the legislation and the benefits to the community was also emphasized:

First, I had all kinds of things to send. I had some summaries. Some articles. I had all kinds of stuff to send. "Let's just talk." I said "I'm not trying to convince you to do anything. I am just going to give you the evidence. I am going to tell you the way it is." I had a frank conversation with this person and said here is what's really going on... and I said "So you know, you take it under advisement," and in the end this was the person that made the difference. (Community NP)

Inability to Address Stakeholders

Another commonly mentioned barrier by the participants collectively was the inability to have personal contact with each stakeholder. Stakeholders were identified as all individuals in

the community, the patients, nurse practitioners, physicians, and legislators. However, the coalition found it difficult to access all stakeholders to adequately inform them because of the sheer quantity of all those involved. It was also agreed that the legislators who would eventually be voting on the bill were difficult to get into personal contact with:

Another barrier is getting access to them [Legislators]. You know a lot of times you can't get access to these folks because there are so many layers of people that are in there that keep them insulated in a way that you can't actually get to them... I mean she [a legislator] answers her own phone. You know not everybody does that. A lot of people have layers of barriers to getting to them. That's a huge barrier itself... getting to that person. (Community NP)

Despite the barrier of the inability to reach all stakeholders, especially legislators, the participants described methods to contacting them. First, some participants described the lobbyists as one of two key persons to reaching those in the legislature. The lobbyists were seen as the persons who can get information into the legislature, and who can disseminate information back to the coalition. The second person mentioned by the participants was the legislator who sponsored the bill. The coalition in Nevada had direct access to their legislator, and was able to share information throughout the legislative process:

You know your lobbyist is the person. That lobbyist is so keen. They were there and they have the relationships. You have to remember, it's all about relationships. (Community NP)

I had direct access to the ear of everyone who was going to vote on the bill. (Legislator)

Lack of a Strong Coalition

A lack of a strong coalition leading all aspects of the legislation was identified as a barrier to full practice authority legislation for nurse practitioners. According to the participants, the roles of the leading coalition include ensuring continuous, transparent communication with stakeholders, educating the community and legislators regarding the legislation, and assistance in

writing the policy. Other responsibilities of the coalition identified by the respondents included addressing the concerns of all of the stakeholders, and answering all questions consistently and appropriately. These two actions contribute to increased transparency of the leading coalition, which is a vital component to successfully implement change (Salmella, Eriksson, & Fagerstrum, 2011). Multiple participants also identified a need for the leading coalition to be focused solely on the task at hand: full practice authority legislation:

Nevada Advanced Practice Nurse Association created itself. They seceded from NNA [Nevada Nurses Association] because NNA had their priorities and advanced practice nurses had a different set of priorities. So they separated and they just started doing baseline relationship building and introduction of the idea, the concept. And [they] worked with AARP and worked with the Alzheimer's test group, and worked with AANP-the national association, worked with NCSBN, worked with Planned Parenthood. I mean everybody got everybody on board. (Leader)

Lack of Time

Three participants identified a lack of time as a barrier to full practice authority legislation. One component of this barrier was attributed to the amount of time the legislature was in session. In Nevada, the legislature is in session lasts for 120 days. Terms used to describe this lack of time included "short legislative session," "off session," and "so little time." Other terms to describe this time included "limited," "too fast," and having "too much to do in so little time." Several participants identified the inability to contact legislators during the off-time for needed education, and a limited amount of time to educate the community prior to the introduction of the legislation:

There was so much to do before this bill was going to be heard, but we didn't have much time. Back in 2011... it was clear that the legislators had no idea what nurse practitioners did, so we had quite a bit of educating to do. (Community NP)

To overcome the barrier of limited time, the participants universally described the importance of sharing responsibilities and assigning tasks to various members of the coalition. This sharing of workload provided for broad-based action, addressing all of the necessary components surrounding the legislation. In addition, the participants emphasized the importance of knowing who from the leading coalition would be responsible for specific tasks when they present. This allowed the most qualified person, pertaining to each task, handle the responsibility when it presented. This sharing of responsibilities results in increased performance among teams (Nicolaidis et al., 2014).

Lack of Preparation

Three participants identified a lack of appropriate preparation as a barrier to full practice authority legislation arising from the limited time available to accomplish all of the necessary tasks. Per the participants, preparation included the process of educating the stakeholders and preparing legislation. Other preparation mentioned was the necessity to network with legislators and the community, managing the social media aspects of the legislation, responding to emails, meeting with lobbyists, and many other tasks. The participants also explained that a large team, or coalition, is necessary to manage all of the necessary tasks and responsibilities. Outlining tasks and delineating responsibilities were identified as the most effective methods to overcoming this barrier:

We had to divide it up quite a bit pretty quickly. [Name] took over the interactions with lobbyists and legislators... She handled the legislative campaign down here [Southern Nevada], basically stayed in touch with our... lobbyist down here and also ran interference with all of the Legislators and Assembly people. My job was to write many of the talking points and memos... I also handled e-mail correspondence. (NP Activist)

Lack of Leadership and Legislative Experiences

Three participants believed their personal and professional experiences in leadership and legislation helped in passing full practice authority legislation. They explained their experiences in policy writing, networking, and working with legislators helped to make this legislation successful. When asked how best to ensure successful sponsorship of a full practice authority initiative in other states, two participants identified specific key players. Both the legislator and the community-based nurse practitioner recommended having a legislator who is experienced and successful, respected, and commands authority present the bill:

They [leading coalition members] are the sage, they are the older folks that when they talk everybody stops... there was a commercial on TV called E.F. Hutton and they would say when E.F. Hutton speaks everyone listens. This guy who was E.F. Hutton would start talking and like it would be a really noisy room and it would go totally silent. That's the kind of person you need to say "Here is the deal guys," and everybody would listen because that person was that authority. So that's the kind of people, those are kind of people that you need to have. (Community NP)

The second key player mentioned was someone on the leading coalition who had a plethora of leadership experiences, and experience in working successfully with teams. This ability to lead was described by multiple participants as a key component to ensuring all facets of the legislation was attended to in a timely, accurate manner. This belief is aligned with Salmella, Eriksson, and Fagerstrum (2011) identification of the need for leaders to act as coordinators of the various aspects of change. The participants also mentioned that this key player should have experience in networking, working with legislators, and motivating the community for action and support for legislation or community needs.

Lack of Role Recognition and Community Support

Community and legislator education about the role and function of nurse practitioners was identified in multiple interviews as important components to the advancement of full practice authority legislation. The participants echoingly mentioned the need to describe what nurse practitioners do, explain how they can influence the community, and define nurse practitioners scope of practice and education. Multiple participants shared essential components regarding how to educate the community, gain their support, and ensure clear role recognition for nurse practitioners. This process was described as needing to be simple, concise, and easy to understand for those who are not in the medical field. Other descriptors used included creating handouts that are able to read quickly, less than one page in length, and designed for people to read on their own time:

You need to spend a couple of years educating people about the role of nurse practitioners and the issue years before introducing the bill... [educate] your grassroots, grasstops, the activist groups, the progressive groups, and the legislators... the city council, your county commissions, school boards with school nurses... you're going to want to educate everyone on what nurse practitioners actually do and how important they are in the access to care spectrum. (Legislator)

Two participants also emphasized the need for the leading coalition to encourage the community members to talk to their representatives as a way to convey community support. Descriptors of this action included “talk to legislators,” “discuss the needs of the community,” and “activate the grassroots and get them talking.” One participant identified the need for nurse practitioners to talk with their legislators to explain their role, education, and day-to-day activities in the community as one of their constituents:

I think that it would be great if we could get the nurse practitioners to talk to every single legislator, their senate and their assemble member in their office during their downtime and tell them what they do. ‘I am your constituent. I live in your district. This is who I am

and this is what I do. This is what my day looks like. I see patients who have diabetes and this is what I do. Come visit me at my practice. Come see what I do.’ I think that is a real way to make it human and so that people are engaged. (Community NP)

Poor Reputation of the Board of Nursing

The Board of Nursing is the sole regulating body for nurse practitioners in the state of Nevada. A poor reputation of the Board of Nursing (BON) was mentioned in several interviews as a potential barrier to full practice authority legislation because of their role in regulating the licensure of nurse practitioners. Several participants described the Nevada State Board of Nursing reputation as “good,” “strong,” “consistent,” “able to oversee the nurse practitioners,” and “protecting the community.” Some participants emphasized the need for the Board of Nursing to maintain a strong reputation through refraining from conflicts, and by securing strong relationships with other organizations and the community:

The Board of Nursing must maintain a history without regulatory conflicts and must work diligently to secure strong relationships with the community and with every other health related entity possible. (Leader)

Lack of Support from the Board of Pharmacy

A lack of support from the Board of Pharmacy was mentioned in one interview emphasizing the importance in having its support. Statements used by this participant involved the need to acquire support of the board of pharmacy and recognizing that pharmacy has to support prescribing privileges to gain community and legislative support. Comments relating to prescriptive privileges were also mentioned in relation to the Board of Pharmacy as they regulate prescribing privileges in the state of Nevada. To overcome this barrier, the leading coalition must create and hold close relationships with the Board of Pharmacy when introducing full practice authority legislation. It was also identified as important to educate the Board of Pharmacy

regarding the various components of the legislation to ensure their concerns are addressed prior to the hearings:

We contacted and worked closely with the Board of Pharmacy to address their concerns and educate them about the legislation prior to the hearings. (NP Activist)

Social Media

Social media was mentioned during an interview when it was described as a “double-edged sword.” The interviewee further described it as a resource that could educate and mobilize the community if it is used effectively. It was also emphasized that social media can quickly disseminate information that is not accurate. According to the participant, social media was kept from becoming a barrier by updating all stakeholders in support of the bill, so rumors would not be broadcast. In retrospect, they would ensure the coalition would update the supporters more frequently to prevent rumors and inaccurate information from being broadcast to the public:

Social media is a great way to get people involved, but rumors can spiral out of control very quickly. Once it’s out there you can’t take it back. So, keep your constituencies updated all the time because if you don’t update them they will make something up and then it will be what you don’t want people to hear... Also, work close with your team so that when a rumor gets out you can squash it quickly. (Community NP)

Discussion

In this study, the researcher sought to acquire insight regarding the barriers to full practice authority legislation, and to broaden the understanding of how those barriers were overcome in Nevada during the 2013 Legislative session. According to Kotter’s (1995) Change Management Model, these barriers must be overcome in order to successfully implement change. A total of twelve significant barriers to full practice authority legislation were identified in the four interviews. For a clear understanding of the barriers, their relationships with one another, and how they may be overcome, these barriers are separated into six main groups: (1) vision, (2)

physician support, (3) addressing stakeholders, (4) community organization support, (5) leading coalition, and (6) resources.

Vision

A lack of a clear vision has been extensively covered in the literature as an essential component to introducing change in any environment. In an article by Franco and Hasse (2010), a lack of a clear vision was directly identified as a factor to poor performance and failure. That was echoed in this project as all participants described the lack of a clear, shared vision to be one of the primary reasons the bill has not progressed in the past. Further, they felt that in the 2013 effort to obtain full practice authority, their vision was clearer, simple, straightforward, consistent, completely supported by the coalition, shared with all stakeholders, and relatable to the community and their needs.

Physician Support

Resistance to full practice authority legislation from physicians is evident throughout the literature and the media nationwide. Highly prominent was the American College of Physicians response to the Institute of Medicine's Future of Nursing Report where they identified full practice authority legislation for nurse practitioners "lead[ing] to changes that could harm patient care" (2010). In this study, all of the interview participants stated that a lack of physician support of this legislation was a strong barrier to full practice authority for nurse practitioners. Also significant, the researcher's inability to recruit a physician to participate in the study due to their refusal to cooperate is aligned with this barrier.

To overcome this barrier, the leading coalition used a multi-faceted approach to gain support of physicians in both an indirect and direct way. First, the coalition sought to seek

support of multiple community organizations, especially those involved in the medical arena. Organizations involved in the medical care of the community should be approached and educated about how full practice authority legislation will affect their organization. Often times, these organizations are composed of physicians. Next, despite the resistance of the physician organizations as a whole, specific members of these organizations should be reached out to as they may have strong influence in the decisions of the organization. Also, be prepared to quickly respond to the talking points of the opposition. According to VanBeuge and Walker (2014), physicians in Nevada presented negative and misleading information about nurse practitioners. This information needs to be quickly and effectively clarified and disseminated to all stakeholders.

Addressing Stakeholders

Multiple barriers identified in the interviews are grouped in this section due to their relationships to addressing stakeholders: inability to address stakeholders, lack of role recognition and community support, and social media. According to Kotter (1995), to successfully implement change, all stakeholders must be addressed. The same rule applies when introducing full practice authority legislation. Many methods must be utilized to address all of the stakeholders given the stakeholders include every individual in the community: physicians, legislators, nurse practitioners, other providers, and patients.

It is essential to educate all stakeholders regarding the role of the nurse practitioners and the services they provide. This education can be done via personal communications or handouts. All personal communications and handouts must be clear, concise, straightforward, and consistent. Handouts must be easy-to-read for the layperson without a medical background, use

short sentences, and use pronouns like “you” to engage the reader, include short words, avoid abbreviations, and exclude jargon (Osborne, 2010). The participants in this study reiterated these necessities when educating stakeholders in the community of the legislation.

Transparency and communication with all stakeholders, with an emphasis on community and the legislators is ideal. One way to accomplish this, beyond the use of personal communication and handouts, is with the use of social media. Social media, if used appropriately and managed closely, may be an excellent way to educate the community regarding the various components of this legislation. Although social media was identified as a barrier in the interviews, it was also described as a “tool” for education that can be “very effective if it is monitored closely” (Community NP).

Community Organization Support

A strong reputation of the Board of Nursing is essential to the success of full practice authority legislation. A strong reputation of the Board of Nursing should be maintained because in most states they are the sole regulating body for nurse practitioners. A long-standing history of upholding regulations and ensuring safety for the community is essential in gaining support from both the community and other professional organizations. Further, the Board of Pharmacy may be opposed to full practice legislation and not support the legislation if the Board of Nursing could not reliably oversee nurse practitioners with prescribing privileges. This also depicts the importance of ensuring that the professional organizations that publicly support the full practice authority legislation do not have poor rapport with the community, legislators, or any other stakeholders.

Leading Coalition

Creating a leading coalition is a vital component to effectively leading change. According to Kotter (2007), this leading coalition should be organized and composed of individuals with authority, strong leadership abilities, and successful legislative experience. The group should have a shared commitment and enough power to lead the change, and should be encouraged to work as a team without a hierarchy (Kotter, 2007). This need to form a team was exemplified in the interview with the creation of a strong leading coalition. Further, Nevada Advanced Practice Nurse Association (NAPNA) was created by nurse practitioners involved with introducing full practice authority legislation to the legislature. Many of the members of NAPNA were well known in their community, had previous experience with health-related legislation, and were leaders in their community or place of employment. Also part of the leading coalition was a legislator who had experience with practice act legislation, and a history of spearheading successful legislation.

Gleaned from this study, there are some major pitfalls when creating a guiding coalition. First, the team must be composed of people with a strong history of working with teams (Kotter, 2007). The people on the team should not be persons with direct authority of other people forming the coalition (Kotter, 2007). When choosing a legislator, choose someone with experience, authority, and respect in the legislature and community. The team should delegate all responsibilities and tasks to ensure all angles of the legislation are addressed timely and appropriately. All members of the coalition should network and build relationships in the community and should clearly and consistently share the vision with the stakeholders, including the community and legislators (Kotter, 2007).

Resources

In order to successfully implement full practice authority legislation for nurse practitioners, multiple resources need to be accessed. Two specific resources mentioned in this study include time and preparation. Without ample time or preparation, the full practice authority legislation may not be successful. In order to overcome the barrier of a lack of time, a similar bill was pulled in Nevada in 2011 because there was not enough preparation on all fronts. Consequently, the coalition at that time postponed presenting the full practice authority legislation. Instead, they opted to introduce a bill to require nurse practitioner national certification as a requirement for licensure in Nevada (VanBeuge & Walker, 2014). This action put Nevada nurse practitioners in the spotlight, and improved the transparency of nurse practitioners in the community and legislation.

Postponing the introduction of the full practice authority legislation in 2011 also provided the coalition with more time to prepare for a successful introduction of the bill in 2013. When introducing legislation, many tasks need to be accomplished to be prepared. To do this, the leading coalition created a separate organization from the Nevada Nurses Association, solely to focus on the vision of this legislation. As evidenced in Nevada, tasks and responsibilities should be delineated to various persons who are equipped to carry them out. Some of these tasks may include networking, speaking with various legislators, contacting local organizations, responding to emails, creating webpages for information sharing, and other duties. Delineating responsibilities will ensure that the tasks will be completed quickly, and that everyone will know whose responsibility new tasks should be completed by.

Study Strengths and Limitations

Using a case study design, it was possible to look at the various perspectives of the same phenomenon: legislative barriers to full practice authority and how they were overcome during the 2013 Legislative session in Nevada (Hentz, 2012). Specific, meaningful characteristics of life events were identified using a case study qualitative method (Yin, 2009). In an attempt to ensure the reliability and validity of these research findings, and to reduce any possible biases, the four components of trustworthiness will be discussed. According to Lincoln and Guba (1985), credibility, dependability, transferability, and confirmability must be considered in quantitative research. Therefore, consideration and implementation of all of these components were implemented into this study.

Credibility was ensured when the researchers evaluated the data from each interview twice by analyzing the responses to look for similarities from within and across the study participants (Lincoln & Guba, 1985). Credibility was also increased by having a second researcher analyze the transcripts and by performing member checks prior to publishing the findings (Houghton, Casey, Shaw, & Murphy, 2012). It is also important that dependability was ensured with the use of a clear purpose statement, a discussion of the recruitment and selection of participants, describing data collection and analysis, and by using multiple interviews representing various perspectives of one phenomenon (Lincoln & Guba, 1985). A thorough description of the population interviewed, a clear description of recruitment and inclusion criteria, and the performance of multiple interviews ensures transferability (Lincoln & Guba, 1985).

Confirmability was ensured when the researcher attempted to seek clarification and description of the participant's definitions, slang terms, and metaphors (Lincoln & Guba, 1985). The University of Arizona Institutional Review Board approved this study, and three University of Arizona College of Nursing representatives reviewed the findings. Maximum variation was obtained through the participants themselves by including a community-based nurse practitioner, a nurse practitioner activist, a nursing leader, and a state legislator.

One limitation to the study was the inability to interview a physician for inclusion in the study due to the inability to find a physician willing to participate in the study who met the inclusion criteria. A second limitation of the study was the role of the researcher who served as the researcher and performed the analysis of the transcripts. The researcher role could have influenced the analysis of the transcripts. However, this was addressed with the second author reviewing and analyzing the transcripts as well.

Implications for Research

Further research is needed to identify whether similar barriers found in this study in the state of Nevada are prevalent in other states with full practice authority legislation for nurse practitioners. Qualitative studies to explore the various barriers that may have presented in those states may be essential for the advancement of full practice authority of nurse practitioners in other states seeking to implement similar legislation. Similar studies interviewing key informants of multiple states may also add to the literature base and improve the transferability of these findings. Finally, the inclusion of physicians in this research will provide another viewpoint to the barriers to full practice authority legislation that may prove useful.

Implications for Practice

The findings of this study are intended to be useful for those living in one of the 31 states without full practice authority legislation. This is one of the first studies to identify the importance of literature identifying legislative barriers to full practice authority, and starts to fill the current gap in the literature surrounding this topic. This information may be invaluable in the preparation and introduction of full practice authority legislation in other states. The findings may also act as a stepping-stone to addressing the provider shortage in the U.S., and may be instrumental in improving access to care.

Conclusion

Across the United States, there is a severe shortage of primary care providers available to care for the aging and increasing population. Nurse practitioners equipped with full practice authority are trained and educated to provide efficient, effective primary care to the community. Restrictive legislation on nurse practitioners must be lifted in order to increase access to care for all Americans. Legislators, nurse practitioners, nurse leaders, and other healthcare decision-makers must overcome the legislative barriers to bring full practice authority to every state.

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