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APRNs' Experience in the First Wave of COVID-19 Pandemic: A Qualitative Descriptive Study

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Qualitative Research

APRNs Experiences in the First Wave of COVID-19 Pandemic: A Qualitative Descriptive Study

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Authors' detailed contributions:

- Dr. Roaxanne Spurlark: Data collection, data management, manuscript writing, primary supervisor.
- Sandeep Kaur: Data coding using Dedoose software, data analysis, Thematic Analysis, Results, Discussion, Conclusion
- Sahar Vardy: Data coding using Dedoose software, data analysis, Introduction, Thematic Analysis, Results, Discussion, Conclusion
- Dr. Cheryl Soco: Study conceptualization, data collection, data management, supervision.
- Dr. Shannon Simonovich: Study conceptualization, IRB approval, acquisition of funding, data collection, data management, supervision.

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Abstract

Background

Little is known about the experiences of Advanced Practitioner Registered Nurses' (APRNs) in the initial wave of the COVID-19 pandemic. Becoming familiar with other historical outbreaks is crucial when learning from experiences and how to best move forward with the COVID-19 pandemic and its impacts on APRNs.

Purpose

The purpose of this study is to examine the qualitative experiences of APRNs, who were healthcare providers during the first wave of the COVID-19 pandemic utilizing primary analysis of interview data.

Methodology

This project is a primary analysis of qualitative data collected through semi-structured interview questions. This project is theory-generating; however, it was correlated with the social support theory.

Results

Analysis of the qualitative data showed the following four re-occurring themes: safety, role adaptation and innovation, emotions related to the care provider role and wages lost and gained. Data showed that APRNs can function in multi-faceted roles and how they supported their organizations, communities, and families.

Conclusions

The study results include themes that are synonymous with experiences of advanced practice nurses as care providers during the first wave of the COVID 19 pandemic.

Implications for practice

This study demonstrates the need to support APRNs in various aspects of their care provider role. Investments in their education, career, wages, policies must take place to prevent further loss of APRNs.

Keywords: COVID-19, pandemic, APRN practice, qualitative research, APRN support

Introduction

Background

Little is known about the experiences of Advanced Practice Registered Nurses (APRNs) in the initial wave of the COVID-19 pandemic. Becoming familiar with other historical outbreaks is crucial when learning from experiences and how to best move forward with the COVID-19 pandemic and its impacts on APRNs. Previous pandemics, such as Ebola have demonstrated how a public health crisis wreaks havoc on a healthcare system and the population. McMahon et al., (2016) stated in their study that for Ebola, and future epidemics, frontline healthcare providers (HCPs) are among those that are affected initially, therefore disaster responses should consider the effect on HCPs prior to developing a plan and implementing.

"Nurse Practitioners (NPs) are advanced practice registered nurses (APRNs) who are prepared at the master's or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life" (Nurse Practitioner COVID-19 Survey, n.d.). NP's practice in almost any healthcare settings and have prescriptive authorities in every US state. Since the beginning of the pandemic, almost 17% of APRNs experienced furlough, 3% experienced a layoff or termination and about 1% stated that their practices remained closed. Changes in employment included 40% income reduction and 31% reduction in hours worked. Approximately 63% of APRNs continue to transform delivery of care from in person to telehealth and are 34% cancelling or delaying patient appointments due to the pandemic (Nurse Practitioner COVID-19 Survey, n.d.). All of those factors resulted in delays and disruption to the generic modes of healthcare delivery.

Throughout the first wave of the COVID-19 pandemic, temporary policies to alleviate barriers to practice and increase patient access to APRN providers (Nurse Practitioner COVID-

19 Survey, n.d.). The top three changes that proved to be beneficial were federal telehealth waivers, expansions to services covered and increased reimbursement rates (Nurse Practitioner COVID-19 Survey, n.d.). More than half of NPs stated that state-level suspension of all supervisory or collaborative of practice agreements were beneficial or very beneficial. The surveyed NPs reported the most important investment in research should be made in funding for COVID-19 research, vaccine development and increased funding for healthcare providers and support staff (Nurse Practitioner COVID-19 Survey, n.d.).

Unfortunately, the COVID-19 pandemic rapidly spread throughout the world, and several studies showed themes of HCPs with lack of PPE, fear, anxiety, hopelessness, lack of training, risk of transmission, stigma, lack of support, disconnect with leaders in their organization and lack of policies to support the HCPs. Many research studies grouped the experiences of the various HCPs in the COVID-19 pandemic. Research on the experiences of APRNs in the initial wave of the COVID-19 pandemic has not been found. As one of the growing number of HCPs, mainly, primary care, it is crucial to understand their experiences in the initial wave of the pandemic, to support them by transforming current, and developing new policies.

Problem Statement

The pandemic has highlighted the challenges many APRNs have experienced. It is crucial to address their experiences during the pandemic to learn and promote permanent change in policies to support one of the leading healthcare providers in the nation.

The focus of this project will be utilization of primary analysis of interview data previously collected to describe the experiences of APRNs through semi-structured questions.

Purpose of the Study

The purpose of this study is to examine the qualitative experiences of APRNs during the first wave of the COVID-19 pandemic.

Clinical Questions

1. What were the experiences of the APRNs in the USA during the initial wave of the COVID-19 pandemic?
2. What support did the APRNs have?
3. What can be learned from the experiences of the APRNs?

Method

Project Description

This project is a primary analysis of qualitative data collected through semi structured interview questions. This project is theory-generating; however, it was correlated with the social support theory. The aim is to assess and evaluate the participants' answers to aid in developing change to current and future policies to implement in the healthcare system affecting APRNs. All APRNs in the study by Simonovich et al. (2021) were asked the exact same questions to obtain data on their experiences in the first wave of the COVID-19 pandemic. The consolidated criteria for reporting qualitative studies (COREQ), a 32-item checklist was used to ensure detailed and comprehensive reporting of the 100 interviews with nurses, 24 of which were used for this study (Simonovich et al. 2021). COREQ guidelines were followed to describe the study design, analyze and present the findings (Tong et al. 2007).

Variables included in this study are various ages of the participants, years of experience of the participants and participants from various specialties. Semi-structured 1:1 interviews were

conducted over the phone from these APRNs. The interviews were completed and data saturation was achieved between May to September 2020. Interview questions were open ended to obtain data for this qualitative study, therefore the length of the interviews varied. The interview started with collecting personal information from the participant such as age, gender, race, ethnicity, current occupation, education, specialty area practice and their overall experience and experience in their specialty area. The interview continued with inquiring about the nurses' experience initially in the pandemic, their preparation in caring for COVID-19 infected patients and how leadership prepared them to work with the patients. The APRNs were also asked what implications the pandemic had on their nursing perspective, practice, education, and policy (Simonovich, et al., 2021). The list of the questions from the interview can be found in Figure 1.

Sample & Setting

Participants for the study were recruited with convenience sampling, purposive sampling, digital flyer through various social media platforms as well as snowball sampling was used by asking the participants to recruit their colleagues after their interview. The potential participants were told the study was regarding the United States of America nurses' experience during COVID-19. Prospective participants were asked to complete a screening tool that assessed their demographic characteristics and nursing practice background before the interview was scheduled. This tool enabled the team to recruit a diverse sample of study participants. The inclusion criteria were: nurses, all levels of education, all areas of practice, nurses who identify themselves as delivering care during COVID-19 and are able to complete the study in English. Nurses who were not willing to complete the screening or did not give consent to be audio-recorded were excluded. (Simonovich et al., 2021).

Measures

Simonovich et al. (2021) conducted a total of 100 phone interviews that were audio recorded and transcribed exactly. The research team consisted of members that were trained in qualitative methodology to examine the nurses' experiences and conducted the interviews. One team member conducted the interview with one to two trainees present for training purposes. No repeat interviews were performed, and participants did not have access to the transcripts.

The data collection processes, procedures, and formal documentation received proper approval from DePaul University Institutional Review Board located in Chicago, Illinois, USA, Research Protocol #SS041620NUR. All participants who completed the study protocol voluntarily received a gift card for $50 US dollars to an online retailer for their participation (Simonovich et al., 2021).

The data collection procedure as follows:

> All interviews were completed one-on-one via telephone at the participant's convenience. Participants were matched with interviewers from similar nursing background as well as racial and ethnic background as much as possible to build trust and rapport. The information sheet was read, and verbal consent was obtained from each participant before beginning the formal interview. All participants were ensured of the confidentiality of information shared during the interview. All participants were told they may skip any questions or end the interview at any time with no consequences and were given the information for the DePaul University's Institutional Review Board should they have any concerns they would like to report (Simonovich et al., 2021, p. 10).

The themes for this study were derived from the data collected. Two coders utilized Dedoose software to manage and analyze the data from the study. Descriptive statistics of the study sample was tabulated using SPSS software.

Results

For this qualitative research study, a total of twenty-four APRNs from various locations across the United States were interviewed. Of the twenty-four participants, 16(67%) identified themselves as female, 7(29%) identified themselves as male and 1(0.05%) identified themselves as non-binary. Race amongst the participants, eight identified themselves as White, six Black, five Asian and five Hispanic. A wide variety of clinical specialties were represented with the APRNs interviewed including: 7 emergency room, 5 in outpatient settings, 4 in leadership positions, 2 as certified registered nurse anesthetists, 1 in research, 1 as a community family nurse practitioner, 1 in urgent care, 1 in inpatient med-surg, 1 in the intensive care unit and 1 in women's health. The APRNs in the study had various graduate degrees with sixteen masters prepared APRNs and eight doctoral prepared APRNs. The mean age of study participants was 40 (range 28 to 62). APRNs interviewed had an average of 14 years of nursing experience (range 1 year to 42 years). Detailed demographics can be reviewed in Table 1.

Analysis of the research interviews utilizing Dedoose software showed the following four reoccurring themes: (1) safety, (2) role adaptation and innovation, (3) emotions related to the care provider role and (4) wages lost and gained. Although these APRNs had various exposures through their workplaces and were located across the US they shared similar experiences. This study will show the results of APRN experiences as health care providers during the first wave of COVID. The goal is to highlight these experiences in effort to promote change to support APRNs as care providers. Please see Table 2 to review direct quotes of their experiences.

Theme: Safety

The definition of this theme is to understand the safety implications that the APRN participants experienced throughout the first wave of the COVID-19 pandemic. Safety includes how they personally felt being exposed to COVID-19 patients while in the health care provider role, availability of PPE (gowns, surgical masks, N95 masks, gloves and eyewear), and measures implemented to protect themselves and their families after potential and actual exposure to COVID-19. One APRN stated she was conscientious about disinfecting when entering her home and had '…the least amount of contact with anything that I had at work…'. Another APRN recalled their fear and anxiety in the beginning of the pandemic, but it eased as they gained more knowledge about the virus, however then they '…started getting the asymptomatic people that were testing positive…'. Another participant described her experience below:

> *"And it was a continuous internal mental struggle. And I remember at some point I just had a complete, total mental breakdown where I just would find myself just sobbing and crying because. I'm anxious…and I'm worried about myself. I'm worried about my family. I'm worried about my relatives and people around."*

Theme: Role Adaptation and Innovation

The definition of this theme is APRNs transition and role adaptation in the first wave of the COVID-19 pandemic. Role adaptation and innovation included changing in person visits to telemedicine visits, minimizing provider and patient face-to-face interactions, transforming patient care delivery in terms of patient exams and treatment and lastly utilizing APRNs in bedside nurse roles. Transitioning from their standard daily routine to one that aligns with new pandemic guidelines, proved to be a challenge. One APRN described the changes she made

when seeing patients, '…I really tried to limit the time that I spent in the room with my patient…'. Another participant described their experience below:

> *"But we also need to teach nurses how to use technology…how to use telemedicine. How do you perform a physical exam over…a digital type encounter, especially for advanced practice nurses…not able to do clinicals like they would…a lot of these clinics are shut down".*

Theme: Emotions Related to the Care Provider Role

The definition of this theme is APRNs emotional experiences and its effect on their healthcare provider role during the first wave of the COVID-19 pandemic. The emotions expressed included feeling anxious, overwhelmed, depressed, scared and grateful. Many participants shared they felt fear and anxiety over not having adequate information about COVID and how to protect themselves and their family. One participant confessed they felt depressed, scared, anxious and in addition to having these feelings, 'your family is calling you because apparently you have a degree', the participant felt obligated to answer their questions and concerns. Another participant shared how scared they felt taking care of their patients because of 'how sick and how fast they would decompensate'. One APRN shared the following in the interview:

> *"Emotionally, I think we're dealing with it now. The aftermath of it. I think when you're kind of dealing with it as you go, you don't really know what you're getting into and you don't understand it…you're trying to help the patient."*

Theme: Wages Lost and Gained

The definition of this theme is the financial and benefit implications for APRNs in the first wave of the COVID-19 pandemic. This includes furlough, benefits, PTO and budget cuts. Several APRNs stated that they were compensated well, while others said that their pay decreased. One APRN stated that "… what needs to be done…. compensat[ion] instead [of] lost wages we are still expected to gain more skills to take care of our patients to be enough." Another APRN elaborated on this by stating, '…a lot of our elective cases were canceled…'. One APRN described the aftermath of the financial changes they had experienced below:

> *"We were just so fortunate to have jobs...But the aftermath, I feel like I didn't cope as well when they started taking away certain benefits from us. So they took away our matching 401K. they took away PPO for people who make over a certain dollar amount…and they took away the annual bonus…the work we did was kind of a little less meaningful and it felt like the organization institution itself wasn't really supporting us".*

Discussion

The purpose of this study is to examine the qualitative experiences of APRNs during the first wave of the COVID-19 pandemic utilizing primary analysis of interview data. This study specifically focuses on APRNs' experiences with safety, role adaptation and innovation, emotions related to the care provider role and wages lost and gained. The goal was to analyze their experiences as care providers, what support did they have and what can be learned from their experiences. To date, there has not been a qualitative interview research study that has showed the experiences of APRNs in the first wave of the COVID-19 pandemic. It is our hope that through this study, we can promote change in policies to support APRNs and create a supportive healthcare culture towards APRNs.

A study of frontline healthcare workers, including APRNs, in the United Kingdom by Hoernke et al. (2021) described their experiences of PPE during COVID. The participants in the study shared how limited PPE supply led to increased fear, anxiety, and feelings of despair (Hoernke, et al., 2021). Healthcare workers tried to be more prepared before going into a COVID-19 patient's room to reduce doffing and donning PPE in efforts to conserve supply leading to overheating, dehydration, shorter or no breaks (Hoernke et al., 2021). Another study by Demirci et al. (2020) studied the experiences of nurses taking care of COVID patients in one Turkish hospital, with 3 of the 15 participants having graduate degrees. Nurses stated they were not included in the decision-making process regarding the pandemic and felt worthless. The nurses also experienced increased stress when they had excessive workload, staff shortage, PPE and when organizational support was lacking (Demirci et al., 2020). A study by Intinarelli et al., (2020) found that as the U.S. began to foresee the initial problems with the COVID-19 pandemic, hospitals began preparing for a surge in patient numbers and were concerned of limited PPE supply. As a result, nursing students at the APRN level were denied permission to attend their clinical training experiences. This pandemic has also highlighted the importance of innovative methods to educate our future APRNs. Incorporating telehealth education in APRN programs is another necessity that will aid the students in gaining clinical experience as well as strengthening their skills in telehealth when they become providers.

This study also described the lack of support for APRNs in various aspects of their roles. The pandemic has exacerbated their existing challenges, as well as shown new ones, which makes it critical to take action to support APRNs. One study examined state practice barriers and the effects of the COVID-19 pandemic on APRN practice from June 1, 2020 to September 3, 2020. The study showed that the pandemic affected APRN practice including changes in patient

appointments (cancelled or delayed), fewer new patient visits, fewer preventive and chronic health visits resulting in less revenue for their facility (Kleinpell et al., 2021). Practice barriers were lifted in some states to allow for more care provider availability with less restrictions. The study also mentions that when "there are fewer state APRN practice restrictions, an increased number of APRNs providing care in underserved communities and improved health outcomes are found" (Kleinpell et al., 2021). However, some states reinstated those practice barriers, which could portray the lawmakers showing a lack of appreciation towards APRNs and their sacrifices in the pandemic (Kleinpell et al., 2021).

Another study assessed how Nurse Practitioners (NPs') were able to transition back to in-person care. NPs were obligated/required to modify or take on alternative roles during the pandemic compared to their physician assistant and physician counterparts who continued practice in their traditional roles. The NPs were utilized in nursing roles to optimize resident care while supporting long-term care (LTC) staff during the pandemic (McGilton, 2021). This qualitative, semi-structured data collection interviewed 14 NPs who worked in LTC homes in Ontario Canada during the COVID-19 pandemic (McGilton, 2021). A thematic analysis was then conducted and concluded that innovative models of care are required to move forward in an effort to utilize the ability to utilize NPs in multitude of roles (McGilton, 2021).

Our study showed similar results from historical pandemics. Common themes found included safety measures concerns, emotional distress, financial implications and role changes amongst healthcare workers.

This is the first qualitative interview study of APRNs in the first wave of the COVID-19 pandemic. This study will help future APRNs better prepare and anticipate needs and changes for future pandemics. This research study is novel in its use of a qualitative study to understand

the unique experiences of APRNs as care providers and is not without limitations. One limitation is that, while our analysis was very rigorous, we did not go back to the APRNs interviewed to confirm the things that were presented in this paper. A second limitation of this study is that the data was only captured from May 2020 to September 2020. While our data captured early APRNs experiences, it is not necessarily exemplar of all APRN experiences or of those APRNs that are experiencing currently in the latest waves of the pandemic.

Further studies are required for a more detailed overview on the effects on APRNs during the first wave of the COVID-19 pandemic. This can be done by following up with each participant to assess if their thoughts, feelings and responses have changed over the last two years of the continuing pandemic. Additionally, assessing the long-term effects on APRNs regarding safety, role adaptation and innovation, emotions related to the care provider role and wages lost and gained can be studied. It would also be beneficial to inquire about feedback provided by APRNs regarding future pandemic planning.

Clinical Implications

Recognizing the value of APRNs in the healthcare system is vital for quality of care. APRNs can function in multifaceted roles to support the changing needs of their institutions. Investments need to take place to prevent further loss of APRNs, as many do not feel supported and some leaving their practices to seek jobs elsewhere. APRN education and experience allow them flexibility and adaptability to meet population needs such as in telemedicine in the pandemic era. To accomplish this goal, policies need to be in place for healthcare institutions in order to educate and train APRNs. The pandemic has shown the adaptability of APRNs to cross train amongst the various nursing role positions, both bedside and as the provider.

Conclusion

The purpose of this study was to examine the qualitative experiences of APRNs during the first wave of the COVID-19 pandemic by analyzing the data which showed the following themes: safety, role adaptation and innovation, emotions related to the care provider role, and wages lost and gained. This study has shown the changes in APRNs professional careers and their ability to adapt in a pandemic. The results of this study revealed that with a lack of support will risk a loss of APRNs in practice, loss in knowledge and experience which is vital as APRNs continue to transition to the evolving healthcare system. Practice development policies need to be created to support APRNs in developing standardized roles to alleviate the negative effects experienced during the first wave of COVID-19 pandemic in the event of future pandemics.

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Figure 1

Interview Questions

- What is your age? Gender? Race? Ethnicity?

- Where do you currently practice? (including name, physical location, type of hospital)

- What is your professional degree and current role?

- Specialty area of practice?

- How many years of nursing experience do you have in general? In your specialty?

1) Tell us about your experience beginning with when you first learned of COVID-19... (take us back to that time.)

2) How did you prepare yourself to work with COVID-19 patients? (mentally, emotionally, physically)

3) How did the nursing leadership in your department prepare you to work with COVID-19 patients?

4) How did your institution prepare you to work with COVID-19 patients?

5) Tell us about PPE use during COVID-19

    a. Has this changed over time? If so, how?

6) How do you feel taking care of COVID-19 patients?

7) How are you coping?

    a. Has this changed over time? If so, how?

8) What support are you receiving from your department?

a. Institution?

b. Community?

9) How has working with COVID-19 patients changed your nursing perspective?

10) What implications does the COVID-19 pandemic have for nursing practice?

11) What implications does the COVID-19 pandemic have for nursing education? (Prelicensure and/or Graduate-level)

12) What implications does the COVID-19 pandemic have for nursing policy?

a. Within healthcare institutions?

b. With regard to national leadership?

13) Finally, what further comments related to COVID-19 and nursing would you like to share with us?

Table 1

Area of Practice	Race/Ethnicity	Gender	Degree	Age	Years of Experience
Research - ED	Black	Female	DNP FNP	52	21
ICU	White	Male	DNP AGNP	33	10
CRNA	Asian	Male	DNP CRNA	37	11
FNP, Leadership	White	Female	DNP	54	33
WHNP	White	Female	MSN	28	6
ER NP	Asian	Female	MSN	32	1
ER NP	Black	Female	NP	44	20
Med-Surg	Hispanic	Female	MSN	28	3
CRNA	Black	Female	MSN	43	20
FNP	Hispanic	Female	MSN	38	10
ER NP	White	Male	DNP	36	15
ER NP	Black	Female	MSN	31	6
ER NP	Asian	Female	MSN	39	10
Urgent Care	Hispanic	Female	MSN	36	10
ER NP	Hispanic	Male	MSN	37	10
ER NP	White	Male	MSN	37	6
Outpatient-FNP	Black	Male	MSN	62	42
Outpatient	Black	Female	DNP	37	5
Outpatient	Asian	Female	DNP - FNP	45	13
Outpatient-FNP	White	Non-Binary	MSN	34	9
Leadership	White	Female	MSN	57	34
Leadership and NP	White	Female	DNP	39	18
Leadership	Asian	Female	MSN	36	13
Community FNP	Hispanic	Male	MSN	41	7

Table 2

Themes	Quotes
Safety	"…you just never knew when you were going to encounter a COVID patient … the only time we would ever encounter the patients with covid is one if we were intubating them or if we were doing a surgery case…we'd intubate them, we'd wait 30 minutes,…we have to wait 30 minutes after we extubated them." "…making sure I had alternate scrubs to wear to work because usually I use my own scrubs so making sure I get disinfected when I get home…and the least amount of contact with anything that I had at work…" "I would say in the beginning I was a little scared…I think the anxiety itself went down as we started knowing a little bit more of the virus…And then when we started getting the asymptomatic people that were testing positive". "And it was a continuous internal mental struggle. And I remember at some point I just had a complete, total mental breakdown where I just would find myself just sobbing and crying because. I'm anxious…and I'm worried about myself. I'm worried about my family. I'm worried about my relatives and people around." "I think PPE use is probably the most stressful thing because like, right from the beginning, there was concern that there is going to be specifically like a N95 shortages…definitely would increase your risk for infection." "So we couldn't put those patients with anybody…we'd to have to go to a specific room that a door… a negative pressure room…So we're holding a lot of patients in their cars. And sometimes I would go see a patient out there and I feel like I wasn't doing an assessment like the right assessment because…you're outside they have their AC on, they have their car on, it's 90 something degrees outside…"
Role Adaptation & Innovation	"It's hard because I love what I do. But…if we were to get hit again, I'm thinking about taking a leave of absence…I'm considering not going back to work. "

	"But we also need to teach nurses how to use technology…how to use telemedicine. How do you perform a physical exam over…a digital type encounter, especially for advanced practice nurses…not able to do clinicals like they would…a lot of these clinics are shut down". "You guys in the military…they tell you to do stuff. And whether you agree with it or not, you just you do it…whether it's the most-safest way or whether it's the one hundred percent right way is was not something that we questioned…I wasn't one of the colleagues that tried to push back and fight with the upper administration as much as some of my other peers did." "When we were seeing so many COVID patients where we had to see patients in their cars because we only had so many rooms that were negative pressure rooms or private rooms…" "I think it's made us realize how important telehealth is...how flexible it has made our trajectory and the services we're able to provide…it's just evolving the developing world right now…" "…I really tried to limit the time that I spent in the room with my patient, which is very unusual for me to. I usually spend a lot of time educating people." "I would go in, I would get what I needed. I would leave, I would go back to give them a plan and then try to get them out as quickly as possible."
Emotions Related to the Care Provider Role	"I feel protected, I feel safe, I feel confident with all the tools and supplies that my institutions have given me as far as being prepared and feeling comfortable going in, I think at first it was a little bit unnerving for everybody going into these rooms and kind of the fear of the unknown…I think transparency was key…" "…I feel like I'm coping fairly well. It's just more of, you know, the stressors outside of work with, you know, setting these limitations that I have two little ones, both under three…they just don't understand…the repercussions of covid-19…" "I was mentally ready for it because I thought…this is what I signed up for whatever happens, like this is what I want to do and take care of people…try to ask around, like, what was the hospital going to do or like what was the plan in case it finally got to our unit."

	"So most of my visits are I'm anxious, I'm depressed, I'm scared…But then you come home and your family is calling you because apparently you have a degree and now you take your whole family and they had their questions and concerns." "Emotionally, I think we're dealing with it now. The aftermath of it. I think when you're kind of dealing with it as you go, you don't really know what you're getting into and you don't understand it…you're trying to help the patient…" "Open to having conversations about debriefing or just venting or that kind of thing to kind of just unplug from it, because I think that I think it is very vital for our job, because a lot of the people that have gone out of emergency medicine that I know of, it just said it was just too much you know. COVID aside, like emergency medicine is very stressful." "…the most scary part was how sick and how fast they would decompensate. "
Wages Lost & Gained	"... the first step is to step up to the plate on what needs to be done…. compensat[ion] instead [of] lost wages we are still expected to gain more skills to take care of our patients to be enough." "…a lot of our elective cases were canceled. So we are only doing urgent and emergent cases in the OR. And if the patient was covid positive, the case really had to be emergent for us to do it." "But basically the reason why those APP's were furloughed is because they weren't they weren't producing enough revenue during that time…nurse practitioners and the PA's…they were really generous at the beginning. They said if you came down with covid, then we would pay for the time you were off from the coronavirus the two weeks." "We were just so fortunate to have jobs...But the aftermath, I feel like I didn't cope as well when they started taking away certain benefits from us. So they took away our matching 401K. they took away PPO for people who make over a certain dollar amount…and they took away the annual bonus…the work we did was kind of a little less meaningful and it felt like the organization institution itself wasn't really supporting us".

	"…the behavioral health services… that have…stepped up and offered individual and group counseling. [If] we…had symptoms, We ha[d] 14 days of pay while [we] were quarantined."

Appendix

Qualitative Research

Abstract -Structured 250 words: Background, purpose, methodology, results, conclusions, implications

Text Word Count- 5,000

References-50

Figures/Tables-5

Essential Manuscript Components:

The following section details specific elements of manuscript preparation required at the time of submission. See table for specific word counts and formatting requirements for each manuscript type.

Cover Letter: The cover letter must contain the title of the manuscript, a statement about authorship as described previously and attestation that the manuscript is submitted for the sole consideration of the JAANP and the material has not been published in any form previously. The name, address, home and work telephone numbers, fax number, and e-mail address of the author responsible for correspondence regarding the manuscript should be included in the cover letter.

Prior/related publications: If the material has been presented at a conference or is part of a larger study (e.g., a subgroup analysis), that should also be stated. Please attach copies of all previously published articles from the study. If articles have been submitted elsewhere but not published yet, please summarize the differences between the manuscripts in the cover letter. If the paper reports findings from a clinical trial that has been registered, include the registration information. If the paper requires special consideration related to the NIH Public Access Mandate, please alert us with a statement in the cover letter.

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Following the title should be a list of all authors, in the order in which they will appear in published form, along with institutional roles and affiliations. The contact author must be clearly identified (this does not have to be the first author) along with complete contact information. Alternative email addresses and phone numbers are helpful, in case we encounter difficulty contacting you.

The role each author filled in the development of the manuscript must be identified in a separate statement in the Title Page. For example, Mary Jones developed the instrument and performed all the analyses; Susan Smith wrote the initial draft of the manuscript; both authors developed the research project, collected chart data, and revised the manuscript for final submission. See the ICMJE Authorship Criteria if you have difficulty deciding what roles must be included in an authorship statement.

Any disclaimers required by Federal law (e.g., military, Federal Government) should be included on the title page.

Abstract: The abstract (the first item in the main document) must be copied into a designated abstract field during the submission process. Reviewers receive the abstract from this field when they are asked to perform a review – so it is the first impression you make on a reviewer. See table above for specific elements and structure of abstracts by article type. Do not use citations or references in the abstract.

NOTE: For tips about improving your abstracts see Pierson, *Journal of the American Association of Nurse Practitioners*: July 2016 - Volume 28 - Issue 7 - p 346, doi: 10.1002/2327-

6924.12392; Pearce & Ferguson, *Journal of the American Association of Nurse Practitioners*: August 2017 - Volume 29 - Issue 8 - p 452–460, doi: 10.1002/2327-6924.12486

Keywords: Keywords are placed at the end of the abstract and are essential to discoverability of your work. Please select four primary keywords that highlight your article's key points (more than four terms are allowed). JAANP is indexed in Medline/PubMed and CINAHL, so the controlled vocabulary of MeSH terms (http://www.nlm.nih.gov/mesh/meshhome.html) is a good place to start to find the most useful words to highlight your work. For more tips on selecting keywords, see Pearce, Hicks, & Pierson, *Journal of the American Association of Nurse Practitioners*: April 2018 - Volume 30 - Issue 4 - p 179–181, doi: 10.1097/JXX.0000000000000048

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References: Beginning June 1, 2020, The *Publication Manual of the American Psychological Association (APA) 7th edition* is the style manual used by the *JAANP* to format citations, references, headings, and other matters. The use of electronic bibliographic citation managers (such as EndNote™) is acceptable. For examples of APA format for references and citations see http://www.apastyle.org

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