Implementing Evidence-Based Health Policy: A Focus on Pennsylvania's Nurse Practitioner Full Practice Authority Legislation

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Abstract

Background: The ability of nurse practitioners to practice to the full scope of their education and training would improve access to healthcare for Pennsylvania's patients. Previous attempts to gain full practice authority in Pennsylvania have been unsuccessful. Evidence-based health policy principles including; use of a strong unified voice, clear, concise messaging, health policy knowledge, strong relationships with legislators, coalitions of stakeholders, and utilization of the media and research, have been shown to have a significant impact on policy change initiatives. The purpose of this scholarly project was to implement evidence-based health policy tools during the reintroduction of Pennsylvania's nurse practitioner (NP) full practice authority bill.
Methods: Using evidence-based health policy principles as a framework, policy strategies were developed. To create a unified message, an evidence-based health policy campaign manual and presentation was developed for the 18 regions of the Pennsylvania Coalition of Nurse Practitioners (PCNP). The manual included the following items: copies of the talking points, roles of the regional representatives, sample letters to legislators, and contact information for the regional representatives and campaign committee. A presentation explaining the legislation, talking points and evidence-based health policy advocacy was prepared and delivered by the regional representatives during the February to April 2015 regional meetings. Nurse practitioners were individually encouraged to meet with their district legislators to increase bill sponsorship and eventually a favorable vote. Talking points were provided to NPs to use during these visits or during phone calls. Draft letters were distributed to NPs that they could hand write or email legislators. As a grassroots movement, members were encouraged to attend the PCNP's Lobby Day to advocate for Pennsylvania's full-practice authority bill on May 12, 2015.
Results: The presentation and manual was delivered to 16 regional groups with a total of 547 NP attendees. At introduction on March 9th, House bill 765 had 20 co-sponsors, expanding to 36 co-sponsors after Lobby Day. Within the Senate, there were 20 co-sponsors of Senate bill 717 when it was introduced by Senator Vance on April 10th, increasing to 21 co-sponsors after Lobby Day. A total of 227 NPs and students attended Lobby Day. Six coalitions were established: one nursing organization, three community groups, and two healthcare organizations.
Discussion: As the Pennsylvania full practice authority bill progresses, evidence-based health policy strategies should continue to be the foundation of the campaign. These strategies supported increased participation in health policy and legislator sponsorship of the bills during this campaign. The strategic plan must include knowledge dissemination to nurse practitioners. NPs are the front-line infantry in this legislative battle and must become more comfortable in the legislative arena. Grassroots strategies and establishing a unified, consistent voice is critical. All of these strategies can be intertwined into other states campaigns for nurse practitioner full practice authority.

Acknowledgements

Throughout this whole doctoral journey, my husband and best friend, David Altdoerffer, has been by my side. He has been the backbone for my sanity, my children, and the day-to-day responsibilities of our home. Thank you for all of your love and support and your daily dedication to our family. Thank you for helping to make the children feel like they have a balanced home. Thank you Christian, Charlize, and Gianna, for being the brightest sunshine weaved throughout every day. I love you all. Whenever David and I were both feeling burnt out, thank you to my family, Ann, Michael, and Jennifer Danese, and mother in law, Robin Altdoerffer, for jumping in and helping with the children and doing the little things. Also thank you to my sister, Jennifer, and my dad, Michael, for being my editors, my grandmother, Darlis Pope, and mother, Ann, for teaching me the caring and compassion of nursing.

Early in the program, Dr. Kathy Buckley, helped with my personal growth into a doctoral prepared nurse. She helped me fine-tune my writing skills and motivated me in my personal and professional growth. Dr. Shannon Idzik, my advisor and Scholarly Project Chair, has helped guide my project and challenged me to develop and implement a health policy project. She has become a career role model with balancing academia, practicing, policy leadership, and motherhood. With her and Dr. Veronica Gutchell's, my other committee member, expertise I learned the DNPs role in health policy advocacy. Thank you to the University of Maryland's DNP program for opening my eyes to new opportunities in nursing and allowing me to mold the program to emphasize experiences of interest.

The Pennsylvania Coalition of Nurse Practitioners, specifically Lorraine Bock, Susan Schrand, Keegan Gibson, and Danielle Altares-Sarik, has provided me with a priceless opportunity. Thank you for sharing your expertise in health policy and allowing me to expand on our mutual passion.

Thank you to Drexel University, particularly Donna Trinkaus and co-faculty members, and The Children's Hospital of Philadelphia, especially Sue Ogle and the rehab nurse practitioners, for their ongoing support and flexibility.

I feel so blessed to have a life surrounded by wonderful friends, family, co-workers, and mentors. Thank you to God.

Implementing Evidence-Based Health Policy: A Focus on Pennsylvania's Nurse Practitioner Scope of Practice Legislation

The Affordable Care Act has increased health insurance access to an estimated additional 32 million patients within the United States (Poghosyan, Lucero, Rauch, & Berkowitz, 2012). It is estimated that in 2020, there will be a scarcity of 45,000 primary care physicians, leaving numerous patients without providers (Poghosyan et al., 2012; Kirch, 2012; Bauer, 2010; Cronenwett & Dzau, 2010). Pennsylvania's (PA's) nurse practitioner full practice authority bill proposes an amendment to the Professional Nursing Law from 1951 (The General Assembly of Pennsylvania, 2013b). The passage of Pennsylvania's nurse practitioner full practice authority bill would allow nurse practitioners (NPs) to practice to the full scope of their education and training (The General Assembly of Pennsylvania, 2013b). If the number of Pennsylvania's current NPs were used more effectively, they would meet the needs of the increased number of patients resulting from the Affordable Care Act (ACA). PA's nurse practitioner full practice authority bill, unfortunately, was held stagnant within the Consumer Protection and Professional Licensure Committee of the state legislative system from July 19, 2013 until it died at the close of the 2013-2014 session (The General Assembly of Pennsylvania, 2013a).

Background and Statement of the Problem

Full practice authority would allow certified registered nurse practitioners (CRNPs) to be independently licensed providers, practicing to the full scope of their training and education, and remove the physician collaborative agreement (The General Assembly of Pennsylvania, 2013b; Gealey, 2011; Lloyd, 2013). Previous attempts to gain full practice authority in Pennsylvania have been unsuccessful. Current barriers to NP practice include: limitations imposed by a collaborative agreement with physicians, numerous signatory barriers, and a decreased

reimbursement rate compared to physicians (Gealey, 2011). The 2013-2014 nurse practitioner full practice authority bill (SB 1063), in addition, requested: (1) allowing verbal orders from CRNPs, (2) decreasing the limitations of specialist referrals, (3) modifying the titling of CRNPs to advance practice registered nurse-certified nurse practitioner (APRN-CNP), (4) increasing contracting, credentialing, and reimbursement for APRNs with managed care organizations and private insurance companies, and (5) eliminating physician only signature blocks on numerous medical forms (The General Assembly of Pennsylvania, 2013b; Gealey, 2011; Lloyd, 2013).

Twenty-one states, including the District of Columbia, have successfully modernized their NP legislation to remove such barriers (American Academy of Nurse Practitioners, 2015). Full practice authority for NPs would allow CRNPs to be independent care providers in Pennsylvania, and ultimately, increase patients' access to care. Access to healthcare is defined as "the timely use of personal health services to achieve the best health outcomes" (U.S. Department of Health and Human Services, 2013, para. 3). Related to the Medicaid expansion following the ACA, 600,000 more Pennsylvanians are now eligible to receive health insurance (The Pennsylvania Coalition of Nurse Practitioners [PCNP], 2015). Furthermore, 2 out of 3 Pennsylvanian primary care physicians already turn away Medicaid patients (Rhodes et al., 2014). Nurse practitioners can be a key component of increasing patients' access to care.

As recommended by the Institute of Medicine's *The Future of Nursing: Leading Change, Advancing Health* (2010), expanding the role of CRNPs has increased access to care for patients, particularly for underserved populations (Heale, 2012; Poghosyan et al., 2012). Most importantly, evidence has shown that CRNPs, the target population of this project, provide evidence-based comparable care and some cases improved quality, with higher patient

satisfaction, and more cost savings than physician counterparts (Bauer, 2010; Budzi, Lurie, Singh, & Hooker, 2010; Shalala, 2010).

Purpose Statement

An analysis of previously effective health policy strategies is beneficial to the implementation of Pennsylvania's full practice authority legislation. The Pennsylvania Coalition of Nurse Practitioners (PCNP), the statewide representative body of 8,700 CRNPs organized - the initial and continuing advocacy campaign of the NP full practice authority Senate Bill (SB) 717 and House Bill (HB) 765, (PCNP, 2014). The purpose of this scholarly project is to provide and implement evidence-based health policy tools with PCNP to advance the progress of Pennsylvania's 2015 nurse practitioner full practice authority bill. The ability of CRNPs to utilize the full scope of their education and training would improve access to healthcare for Pennsylvania's patients.

Theoretical Framework

Kingdon's Policy Stream Model (2010) provides a framework to operationalize an evidence-based health policy scholarly project. According to Kingdon (2010), policymaking occurs at the intersection of three streams: problem, policy, and politics. All three independent policy streams must converge at a timely window of opportunity for policymaking to be successful (Kingdon, 2010). The problem stream is the combination of barriers restricting CRNPs' practice and the stagnant movement of Pennsylvania's full practice authority bill. The policy stream directs the review of literature regarding successful policy implementation and creation of a plan to assist PCNP in influencing the passage of Pennsylvania's full practice authority bill. During the political stream, the evidence-based health policy strategies would influence the agenda of sponsors, such as initial sponsors Senator Patricia Vance and

Representative Jesse Topper, and Pennsylvania Medical Society (PAMED) opposition to the bill. In influencing the agenda, this also means superseding the legislator's agenda from other medical bills: suicide prevention continuing education, the scope of pharmacy technicians, and the traveling team physicians' bills.

With each stream being independent, the concepts converge at a window of opportunity, as demonstrated in Figure 1 (Kingdon, 2010). The current implementation of the Affordable Care Act and the passage of similar CRNP full practice authority legislation in other states both contribute to the political environment in Pennsylvania, creating a window of opportunity. Pennsylvania will need to expand their healthcare providers to care for the expansion of insured patients secondary to the ACA (Poghosyan et al., 2012; Kirch, 2012; Bauer, 2010; Cronenwett & Dzau, 2010). The passage of Maryland's full practice authority bill (HB 999 and SB 723) on May 12, 2015, creates a window; as Pennsylvania's nurse practitioners may have an incentive to leave the state to practice to their full training and certification in neighboring Maryland. Kingdon's model of agenda setting provides a framework to guide an evidence-based health policy implementation project (Kingdon, 2010).

Literature Review

A detailed literature review was conducted to identify previously utilized policy change strategies. These evidence-based strategies will be beneficial in the implementation of future health policy legislation, specifically Pennsylvania's full practice authority bill. The literature review and analysis of strategies of other states to pass full prescriptive authority legislation, contributed to the deliverables of this project.

Policy Implementation Tactics

Build relationships. The most common theme that emerged in the literature is the importance that nurses build alliances with policymakers, fellow advocates, and other nursing organizations, starting at the grassroots level (Fyffe, 2009; Gutchell, Idzik, and Lazear, 2014; Hanson-Turton, Ritter, and Valdez, 2009; MacDonald, Edwards, Davies, Marck, & Guernsey, 2012; Oliver, Innvar, Lorenc, Woodman, & Thomas, 2014; Shalala & Vladeck, 2011; Teater, 2008; Teater, 2009). Nursing's positive public reputation is an asset in the policy arena (Shalala & Vladeck, 2011). Friedlaender and Winston (2004) emphasized coalitions with stakeholders are essential to help improve one's position.

In addition, policymakers rely on interest groups, a group of people with a common goal, to help them make informed decisions (Teater, 2008). Interest groups must be credible and personal, and they must maintain a legislative presence (Teater, 2009). Interest groups should also set goals and notify legislators of their purpose in clear, concise messages that demonstrate an understanding of the opposition's views (Teater, 2008).

Be prepared. Preparation is essential for nurses to implement effective health policies. Beyond being knowledgeable on the topic (Teater, 2008; Teater, 2009; Disch, 2014; MacDonald et al., 2012), nursing leaders must be politically savvy and have an understanding of policy as well as navigation of the legislative system (Gutchell et al., 2014; Teater, 2009; Fyffe, 2008). This includes conducting a stakeholder analysis (MacDonald et al., 2012), formulating appropriate actions, and knowing one's own limitations (Friedlaender and Winston, 2004). A strong unified voice with a concise message has proven to be beneficial (Fyffe, 2008; Gutchell et al., 2014; Teater, 2008; Teater, 2009), especially when nursing organizations stand together as

one force (Fyffe, 2008; Gutchell et al., 2014; Hanson-Turton et al., 2009; Shalala & Vladeck, 2011).

Evidence-based focus. Theory and evidence-based practice that is tailored to the audience are integral to policy-making (Gutchell et al., 2014; Disch, 2014). Oliver et al. (2014) conducted a systematic review to determine the barriers and facilitators to policymakers' utility of evidence. Access to evidence and a relationship with policymakers enhanced the utilization of evidence (Oliver et al., 2014). In contrast, lack of time and availability, cost, and policymakers' inadequate understanding of research methods were barriers to utilization of evidence (Oliver et al., 2014). Regardless, science must be applied to policy to impact change (Disch, 2014).

Use technology and media. Numerous advocacy techniques within a wide range of settings are beneficial in policy implementation (Fyffe, 2009; Hall & Reynolds, 2012; MacDonald et al., 2012). For example, utilization of the media is an advantageous tactic (Gutchel et al., 2014). According to Hall & Reynolds (2012), issue-specific television advertising works in locations where voters' views are sympathetic and where legislators are more likely to vote on a topic. Voting by pivotal policymakers that is aligned with the opinions of constituents, moreover, can improve their credibility (Hall & Reynolds). Bergan (2009) also demonstrated a statistically significant effect on legislator voting behavior when contacted by an email lobbying campaign. It should be noted, legislators pay more attention to phone calls and personal meetings than emails (Bergan, 2009).

Synthesis of Findings

Multiple scoping reviews and qualitative studies emerged from a review of the literature on health policy. True experimental studies would not be a practical research method, but expanding research to include a broader sample of legislators, would be beneficial. Although the

described studies focused on different tactics of policy implementation, none were contradictory. In summary, as described in Tables 1 and 2, essential skills to successfully implement policy include: having a strong unified voice with a clear concise message, being knowledgeable, building relationships with stakeholders, and utilizing the media and research (Bergan, 2009; Disch, 2014; Fyffe, 2009; Hansen-Turton et al., 2009; Gutchel et al., 2014; Hall & Reynolds, 2012; MacDonald et al., 2012; Oliver et al., 2014; Shalala & Vladeck, 2011; Teater, 2008; Teater, 2009).

Lessons from Successful States

In the 21 states, including the District of Columbia, where nurse practitioners now have full practice authority (American Association of Nurse Practitioners, 2015), the efforts were lead by nursing organizations. The researched states: Nevada, New York, and Minnesota, all had opposition to gain full practice authority. In reviewing evidence, it is important to focus on populations similar to the population where one intends to intervene. While lessons can be learned from all states that have achieved full practice authority, states with significant opposition are more similar to Pennsylvania who also faces tremendous opposition from the medical society. In particular, lessons from Nevada, New York, and Minnesota were particularly critical. The gained information was added to the evidence-based interventions from the literature review. These collaborative interventions were used to create an evidence-based health policy campaign.

Nevada. Nevada had one of the largest primary care provider shortages in the country, enhanced further with the passage of the ACA. After a four-year battle, in 2013, Nevada passed legislation granting full practice authority for nurse practitioners. The key strategies leading to Nevada's legislative success included: setting key priorities, understanding the APRN's role and

securing a relationship with the state board of nursing, establishing champions in both the state House and, Senate openly discussing the bill to incoming senators, hiring a lobbyist, establishing an effective nurse practitioner team, and working with nursing organizations. Nevada shares their lessons of the benefit of a clear concise message, the strength of letter campaigns and flooding legislators' mailboxes, maintaining communication, following the planned path with small flexible alterations, and being knowledgeable to provide consistent talking points against the opposition (VanBeuge, 2014).

New York. In January 2015, legislation was passed to allow nurse practitioners in New York with over 3,600 hours of practice to practice independently without a collaborative agreement with a physician. This 10-year journey allowed New York's 20,000 NPs to have expanded practice authority. Grassroots efforts of meeting with legislators and providing research of nurse practitioner outcomes proved to be beneficial. Compromising with the addition of an experience requirement and a 6-year provisional period, the bill progressed through the legislative process (Kaplan, 2014).

Minnesota. On May 13, 2014, Governor Mark Dayton signed Minnesota's nurse practitioner full practice authority into law. Minnesota's CRNPs had numerous successful strategies: building credibility with legislators by speaking the truth to overcome the opposition; staying uniformed against the opposition; building coalitions from all nursing organizations within the state; and buying the contact information of APNs from the state board of nursing. Minnesota used Facebook as a method to share the bill's progression and had over 15,000 "likes" when the bill was passed in the Senate. The push to finally pass the bill was a compromise of an addition of 2,080 transition to practice hours (Chesney, 2014).

Methods

Design

Although Pennsylvania's full practice authority legislation could be applicable to all APRNs and health professionals in Pennsylvania, this health policy campaign's sample is focused on CRNPs. PCNP is the statewide representative body of about 1,500 CRNP members with 18 regional groups, who chair the full practice authority bill advocacy campaign (The Pennsylvania Coalition of Nurse Practitioners [PCNP], 2013). The members of PCNP are representative of the population, the total number of Pennsylvania's CRNPs, since the members expand across the state and throughout all CRNP specialties.

Throughout the campaign, PCNP's campaign leadership held monthly phone meetings to discuss the bill's progression. Pennsylvania's full practice authority bill was reintroduced in both houses of the PA General Assembly. Representative Jesse Topper introduced HB 765 in the House Professional Licensure Committee on March 9th, 2015. Later, Senator Patricia Vance introduced later SB 717, the identical companion bill, in the Senate Consumer Protection and Professional Licensure Committee on April 10th, 2015. Both bills (Appendix) need the support of Pennsylvania's 8,700 CRNPs to advocate for their progression out of both committees. After a majority vote of the associated chamber, the bill must be passed through the other chamber.

An evidence-based campaign manual and PowerPoint presentation were introduced to the board of PCNP, comprised of PCNP leadership and a representative from each regional group. Evidence-based health policy principles including using a strong unified voice with a clear concise message, being knowledgeable, building relationships with stakeholders, and utilizing the media and research, were all used to impact policy change. Upon leadership approval, each regional representative was provided with emailed electronic copies of the manual and

PowerPoint (detailed components in Table 4), and was encouraged to present the PowerPoint at their regional meetings across the state.

Evidence-Based Campaign Manual

An evidence-based campaign manual was created based on the literature review to disburse to Pennsylvania's PCNP members. Within the manual there were two different toolkits – one for all PCNP members and one for regional representatives. The original manual was modeled after PCNP's previous county coordinator manual; however, once reviewed by the hired public and community relations firm, the manual was trimmed down to include a Care of PA campaign summary and talking points, roles of the regional representatives, sample letters to legislators, and contact information for the regional representatives and campaign committee. Within the manual included how to get involved, media opportunities, steps for finding coalition partners, and a lawmaker contact report form to be sent back to the regional representatives. The toolkits were emailed to the regional representatives for member dissemination, and the talking points were posted on PCNP's website for immediate download.

PowerPoint Presentation

With the campaign manual being condensed, a presentation-was created for regional representatives to present to their members. The presentation provided an overview of the Care for PA campaign summary, including talking points, legislative bill sponsors, campaign leadership contact information, and most importantly, evidence-based grassroots advocacy efforts for members. Specific strategies such as having a strong unified voice with a clear concise message, being knowledgeable, building relationships with stakeholders, and utilizing the media and research, were intertwined into the presentation. Research-supported strategies and talking points to support nurse practitioner full practice authority and overcome the PAMED

opposition were included for CRNPs to influence and educate their legislators. Recommendations for building relationships and having interactions with legislators, building coalitions with mutual stakeholders, and utilization of the social media were reviewed in an effort to promote nurse practitioner participation. The regional representatives presented the PowerPoint during the February to April 2015 regional meetings, as specified in Table 3. The meeting times, number of nurse practitioner attendees, and any follow-up needs were addressed via email upon completion of the presentations.

Grassroots

Nurse practitioners were individually encouraged during meetings to meet with their district's legislators, either at the Capitol building or at the legislator's district offices, in addition to hand writing, emailing, or calling their legislators. As a collaborative grassroots movement, members were encouraged to attend the PCNP's Lobby Day to advocate for Pennsylvania's full-practice authority bill on May 12, 2015.

Ethics

A query was sent to the IRB since this was a health policy project, and it was determined to be non-human subject research. Any personal demographic information from contacted policymakers or nurse practitioners was maintained confidential.

Results

The overall outcome of the project was whether or not the bill progressed out of the Senate Consumer Protection and Professional Licensure Committee or the House Professional Licensure Committee immediately following Lobby Day on May 12, 2015. Once a month – in February, March, April, and May specifically – the number of legislative sponsors within the House and Senate were tracked as well to monitor the bills' progression through Pennsylvania's

legislative process (Figure 3). The bill did not move out of committee immediately following Lobby Day, but the continued momentum and support shows a promising outcome for the future. The evidence-based strategies highlighted in the literature were evaluated as summarized in Table 5.

Be Prepared

The evidence-based health policy presentation was presented to 16 of the 18 regional groups across Pennsylvania to educate nurse practitioners on strategies of advocacy and an overview of the campaign to ensure a consistent message to legislators. Within each meeting where presented, as described in Figure 2, the number of NPs ranged from 9 to 103 at each meeting, with a state total of 547 NP attendees. One regional group, Laurel Highlands Nurse Practitioner Association, had technical difficulties, but still presented the content of the presentation, and three other groups, Ches-Mont NP-PA Group, NPs of Central PA, and Mid-State NP Association had the presentation, but used it as supplemental for a question and answer format presentation, and disseminated the presentation after via email.

Building Relationships

Nurse practitioners relayed ideas for coalitions to PCNP's Public and Community Relation's team. PCNP then reached out to build a total of six coalitions, one is a nursing organization, three are community groups, and two are healthcare organizations.

Evidence-Based Focus

Grassroots efforts of writing letters and meeting with legislators, presenting the binder of literature supporting NP care, "liking" and "sharing" PCNP's full practice authority posts on Facebook, and other overall efforts of the campaign were evaluated by the number of legislators who sponsored the bill, as demonstrated in Figure 3. Nurse practitioners rallied at the Capitol

building on May 12, 2015; a total of 227 NPs and students attended. When Representative Topper initially introduced the HB 765 on March 9, 2015, there were 20 representative co-sponsors, expanding to 36 after Lobby Day. Within the Senate, there were 20 senators co-sponsoring the SB 717 when it was re-introduced by Senator Vance on April 10, 2015, increasing to 21 after Lobby Day.

Individual evidence-based grassroots efforts, as summarized in Figure 4, were vast. They consisted of recruiting nurse practitioners and students to participate in advocacy and attend Lobby Day. This included writing a proposal and gaining support of sponsoring organizations. At a large inner city university, the proposal was presented to the assistant dean, the bus was funded through the university, and organized by a faculty member. Students were recruited from senior undergraduate nursing and graduate nursing students, and undergraduate students were offered clinical time for attending. In total, 10 nursing students and three faculty members attended. The students' reflections of their experience of Lobby Day included themes of gratitude, a newfound commitment to health policy, and a "priceless" experience that they plan to attend next year. Numerous organizations, mostly universities, sponsored busses to transport nurses and students to Lobby Day.

Relationships were also built with nursing leadership and government affairs at a large tertiary children's hospital. A group of advanced pediatric providers met monthly to discuss the nurse practitioner legislation and other advocacy topics of interest. Frequent emails were sent to all advanced practice nurses to increase professional involvement and to maintain a consistent knowledge base. In addition, nursing leadership and government affairs presented in front of the medical administration board in an attempt to build a coalition with the hospital and PCNP. Although the administration remained neutral on the topic, the majority was supportive on full

practice authority for nurse practitioners. Overall, they were educated on how full practice authority will provide more flexibility for nurse practitioners to float through the hospital, increase insurance contracting with nurse practitioners, remove barriers to patient care, and maintain collaboration as the tenant of NP practice.

Writing emails and conducting meetings with the legislators in Harrisburg, but also in the local district offices, were beneficial to build relationships and continued to provide information and answer questions from legislators. Beyond legislators, meetings were held with stakeholders within professional organizations, including passionate individual nurse practitioners, the advocacy committee, government affairs, the director of advanced practice nurses, and presenting in front of the medical board. Within nursing organizations, legislative committees met to organize advocacy efforts and encourage nurse practitioner members to participate.

A list of over 100 hard copies and relevant quotations stating the caliber of nurse practitioners' practice was created to be used during Lobby Day. This extensive evidence was summarized as a method to overcome the Pennsylvania Medical Association (PADMED) opposition. Since the PAMED did not make much of a presence at the Capitol, the literature was not used until after Lobby Day. Following Lobby Day, a document was released by the PAMED with a handful of articles against nurse practitioner full practice authority. PCNPs overwhelming summary of evidence plans to be used in a rebuttal news release.

Discussion

Limitations

It is important for consistent communication and clear job responsibilities within the NP advocates and hired third party support staff, especially since Pennsylvania is a large state. PCNP had previously established lobbyist, NP officers, state coordinators, and a hired public and

community relations firm. These individuals constituted the campaign leadership, and the additional of the regional representatives, comprised the campaign committee. Although welcoming of NP individual advocacy, with a full-time CEO, lobbyist, and public and community relations firm, job responsibilities were already defined. After an in-depth campaign manual was created, the public and community relations firm condensed the manual to focus members' efforts. Information for building coalition was removed from the member manual and conducted by a member on the public and community relations team instead. Although this could limit the efforts of individuals, it maintains consistency and communication throughout the campaign.

Regardless of Pennsylvania's campaign leadership including hired specialists, nurse practitioners have less political action committee (PAC) funding, than the medical opposition. For example, the American Medical Association donated $1,936,957 to PACs and $19,650,000 spent on lobby during the 2014 federal election cycle. Of the top 20 medical contributions to PACs totaling $69,988,933, only one of the 20 is a nursing organization (#9 the American Association of Nurse Anesthetists). Nursing organizations cannot compete with the PAC donations of their medical counterparts (The Center for Responsive Politics, 2015).

Regardless of the funding discrepancy, the consistent evidence-based health policy tactics infiltrated nurse practitioners in Pennsylvania. While the presentation was disbursed to Pennsylvania's nurse practitioners, there were some technical difficulties and overlapping presentations. The Laurel Highlands Nurse Practitioner Association had technical difficulties, but presented without the presentation and disseminated after the meeting. Alternatively, the Ches-Mont NP-PA Group, NPs of Central PA, and Mid-State NP Association presented in a question and answer format and sent the presentation as supplemental. In addition, Susan

Schrand, the CEO, presented her own presentation with similar information at a meeting. Consequently, although it was easy to track the number of members attending the regional group meetings, it was difficult to track the number of NPs and students the presentation was circulated to via email.

In conjunction with barriers to disseminating the presentation, nurse practitioners might not have interest in policy advocacy. Historically there is a gap between nurse practitioners and health policy. Many nurse practitioners feel more of an obligation to patient care over attending Lobby Day, regardless if they are interested in the legislation. In an effort to overcome this practice-policy gap, many undergraduate and graduate nursing students were invited to attend Lobby Day. If students are exposed to a legislative experience, hopefully they will integrate policy advocacy into their routine practice.

If replicated again without time restraints, a few changes would be made to improve the process. More nursing students would be encouraged to attend from a wider range of universities across the state to cause a more permanent health policy footprint. In addition, expanding efforts to recruit hospital coalitions might be beneficial. If increasing beyond health organizations like Geisinger Hospital, other health systems and their communities would follow. With more support from hospitals and health systems, hospitals would be more supportive of NP professional advocacy.

Implementations for Health Policy

As Pennsylvania progresses to become a full practice authority state, evidence-based health policy strategies should continue to be the foundation of the campaign. These include having a strong unified voice with a clear concise message, being knowledgeable, building relationships with stakeholders, and utilizing the media and research. Evidence-based grassroots

advocacy efforts are essential for establishing relationships and having interactions with legislators, including building coalitions with mutual stakeholders. Once the tactics are recognized, part of the strategic plan must include knowledge dissemination to the nurse practitioners, which are the front-line infantry in this legislative battle. With a toolkit, presentation, or face-to-face presentation, the nursing-health policy gap starts to close. Nurses become more comfortable with the legislative arena, are more knowledgeable on the grassroots strategies, and establish a unified, consistent voice.

All of these strategies can be intertwined into other states campaigns for nurse practitioner full practice authority. Evidence shows that these strategies work and is supported by the participation and sponsorship during this campaign. From the tactic of knowledge dissemination to the overwhelming binder of literature supporting nurse practitioner practice, this campaign model is generalizable to other states. Nurse practitioners need to continue to share their legislative journeys to facilitate policy change.

Conclusion

Although the bill has not become a law, nurse practitioners in Pennsylvania will not stop until they have full practice authority. Full practice authority is not just a professional mission for NPs to utilize the full scope of their education and training, but more importantly, it would improve access to healthcare for Pennsylvania's patients.

Lessons learned from this project expand on themes from previous literature. Evidence-based health policy tactics are beneficial in implementing the policy, but also for educating legislators on the literature supporting policy proposals. Regardless of the current outcome, Pennsylvania is a large state, and it is humbling to witness the impact and 'noise' nurse practitioners can make when there is structure and consistency within a campaign. The strategies

used within the Care of PA campaign can be utilized within other state's journeys for nurse practitioner full practice authority.

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Table 1

Level of Evidence

Date	Authors	Evidence type	Sample	Results	Limitations	*Rating strength/ quality
2009	Bergan	Quasi-experimental field experiment of a grassroots smoke-free workplace e-mail lobbying campaign -Matched pair design	Randomly assigned legislators for the New Hampshire distributed into a control group (n=71), legislators not contacted, and the treatment group (n=72), legislators contacted by activists from the American Cancer Society and the Campaign for Tobacco-Free Kids. Both groups with similar constituents	Results -There is a statistically significant effect on legislator voting behaviors that were contacted by the emailing lobbying campaign. -Legislators spend more attention to phone calls and personal meetings over emails.	-Focuses on smoke free workplace legislation, not health care -Legislators from the same district and party can influence one another -Weak external validity since New Hampshire has smaller districts, less organized opposition, and few constituents	II/A
2014	Disch	Evidence from opinion of authorities	An overview of evidence-based advocacy by the American Academy of Nursing	Findings -The American Academy of Nursing recommends evidence-based advocacy in conjunction with Friedlaender and Winston's outline (2004): 1) Chose a message routed in science 2) Determine and know	Not a scientific study	V/B

				audience 3) Chose evidence and action, which is appropriate for audience 4) Clear and concise message tailored to delivery method 5) Understand own limitations and collaborate to improve position 6) Evaluate -These steps have been applied in numerous foci by the Academy		
2009	Fyffe	Ethnography qualitative study	Individual observations during the policy Florence Nightingale study tour in the USA and England and experience with a senior nurse in the government, a professional organization, and health care	Themes -Public health leaders must posses skills in politics and policy -Nurses are stronger as a unifying force -Nursing organizations must work together -Coalitions with stakeholders are essential -Utilize the media	One researcher's findings	III/A
2014	Gutchell, Idzik, and Lazear	Scoping review	Extensive literature review recommending policy implementation tactics for nurses	Findings -Be prepared -Political savvy NP leadership -Grassroots targeted to key stakeholders	Not a scientific study	V/A

				-Build relationships with policy makers -To initiate the process utilize 1) theory, 2) evidence, 3) others' experiences -Use the media -Clear concise, unified message		
2012	Hall & Reynolds	Descriptive study	Television advertising of the 2003 Medicare prescription drug bill were catalogued in the top 100 media markets compared with state congressional delegates votes	Results -Issue television advertising works in locations where voters' views are sympathetic and where legislators are more likely to vote on a topic. It helps to mobilize policymakers who are already allies on a topic. -If sharing constituents' opinions, pivotal policymakers can vote in a way to maintain credibility with constituents	-It is the first article analyzing issue advertising. -Television mapping doesn't correlate with congressional geography, which questions the precision of the statistics. -Unable to set a control	III/A
2009	Hansen-Turton, Ritter, and Valdez	Scoping review	Reflection on lessons learned for NPs to successfully implement policy	Findings -Build strong alliances within the nursing community -Build relationships with policy makers -Find new allies -Unified voice	Not a scientific study	V/A
2012	MacDonald, Edwards, Davies,	Scoping review	Analysis of evidence from advocacy by non-for profit	Findings -Use numerous advocacy methods	-Not a scientific study -Case comparisons and longitudinal	V/A

	Marck, & Guernsey		organizations and nursing organizations	-Stakeholder analysis -Use of evidence -Use numerous settings and tactics -Create relationships	research are needed	
2014	Oliver, Innvar, Lorenc, Woodman, & Thomas	Systematic review	145 studies identified barriers and facilitators to the use of evidence of policymakers	Results -Use of evidence facilitators includes access to evidence and relationships with policymakers -Barriers to using research evidence include lack of time and availability, policymakers not skilled in research methods, and cost	The frequency of factors were counted, but not weighed. Most studies had simple methods. No methodological analysis or double-screen or double-code of studies.	I/A
2011	Shalala & Vladeck	Scope review	Recommendations for nurses to advance the IOM report, "The Future of Nursing: Leading Change, Advancing Health"	Findings -Nurses must become actively involved. -Nurses must create allies. -Nurses must be unified. -Nurses must take advantage of the positive public reputation.	Not a scientific study	V/B
2008	Teater	Qualitative study	Individual interviews with 9 state legislators randomly selected from the Ohio General Assembly: 2 Republican representatives, 2 Republican senators, 2	Themes -There is a necessity for interest groups and legislators to collaborate in order to help legislators make informed decisions. -Legislators rely on interest groups who have a clear concise message.	Replication with different legislative bodies would increase study credibility.	III/A

			Democratic representatives, 3 Democratic senators	-Interest groups must build relationships with legislators. -Legislators expect interest groups to be knowledgeable about their and the oppositions message.		
2009	Teater	Qualitative study	Individual interviews with 9 state legislators randomly selected from the Ohio General Assembly: 2 Republican representatives, 2 Republican senators, 2 Democratic representatives, 3 Democratic senators	Themes -An effective special interest group starts at the grassroots level, has a set goal, has a membership foundation, notify legislators of the group's purpose, build relationships (be credible, personal, and have a presence)	Replication with different legislative bodies would increase study credibility.	III/A

Note: * Newhouse, Dearholt, Poe, Pugh, & White, 2007

Table 2

Literature Review Findings

Authors	**Clear concise message.**	**Build relationships with legislators.**	**Be knowledgeable about topic/ Be prepared.**	**Back with evidence.**	**Email Campaign/ Use the media.**	**Be knowledgeable about politics/policy.**	**Nurses as a unified force.**
Bergan (2009)					+		
Disch (2014)	+	+	+	+			
Fyffe (2008)	+	+			+	+	+
Gutchell et al. (2014)	+	+	+	+	+	+	+
Hall et al. (2012)					+		
Hanson-Turton, et al. (2009)		+					+
MacDonald et al. (2012)		+	+	+			
Oliver et al. (2014)		+		+			
Salvador (2010)							
Shalala et al. (2011)		+					+
Teater (2008)	+	+	+				
Teater (2009)	+	+	+			+	

Table 3

Timeline for Scholarly Project

Goal	2014		2015				
	Nov	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**
Finalize Project Proposal	X	-	-	-	-	-	-
Submit query to the IRB Committees	-	X	-	-	-	-	-
Present Proposal and Secure Committee Approval	-	X	-	-	-	-	-
Present PowerPoint to Regional Organizations	-	-	-	X	X	X	-
Track Legislative Sponsors (once a month)	-	-	-	X	X	X	X
Prepare for Lobby Day						X	X
Prepare Final Scholarly Project Manuscript	-	-	-	-	-	-	X

Table 4

Components of Manual and PowerPoint Presentation

Manual	**PowerPoint Presentation**
Care for PA summary	Care for PA summary
How to be a regional representative	Talking points
How to get involved	Legislative leaders
Media opportunities	Evidence-based health policy strategies: How to get involved
Finding Coalition partners	-Tell your story
Care for PA Talking Points	-Meeting with policymakers
How to contact a lawmaker	-Build coalitions
Sample letter to a lawmaker	-Write handwritten letters
Lawmaker contact report	-Use the social media
	-Attend Lobby Day 2015
	Campaign leadership contact information
	Encouraged communication between members and regional reps

Table 5

Manual and PowerPoint Strategy Evaluation

Strategy	**Evaluation**
PowerPoint disbursement	Number of members at presentations and emailed
Talking Points, draft letters, and list of abstracts supporting caliber of nurse practitioners	Number of legislators who sponsor the bill
Accepted coalition letters	Number of coalitions
Grassroots efforts	Number of CRNPs attending Lobby Day
Information sheet for building relationships, interacting with legislators, utilization of the media, number of CRNPs who contact or meet with legislators	Bill progression

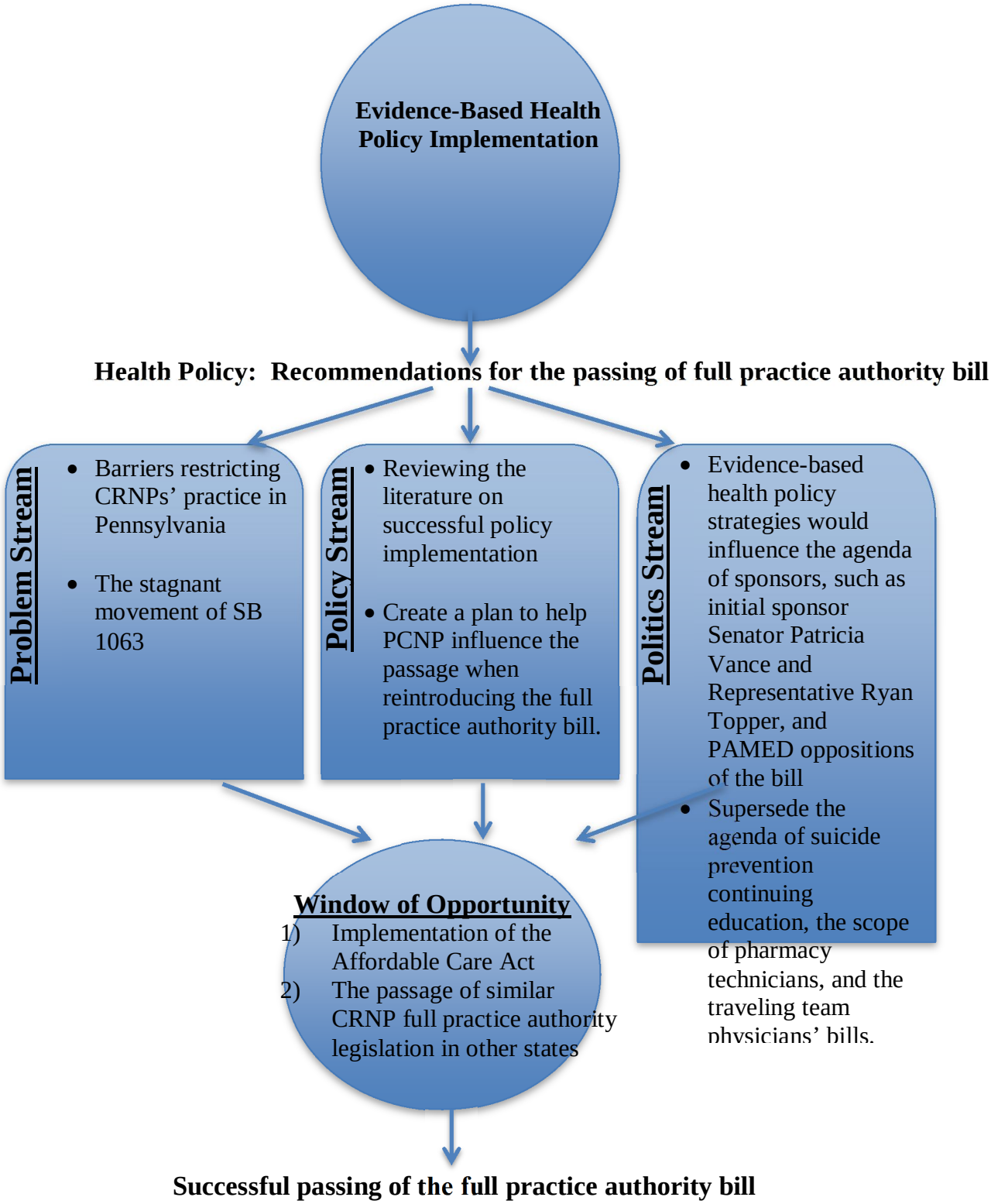


Figure 1. Adapted Kingdon's Policy Streams Model (2010) to demonstrate the operationalization of evidence-based health policy implementation

Figure 2. PCNP Regional Group Presentations

Figure 3. Legislative sponsors

- Updated toolkit, which PCNP completed
- Meetings with PCNP, member of Campaign Committee
    - Day with President, Lorraine Bock
    - Coffee, dinner, phone conversations, emails with CEO, Susan Schrand
    - Monthly campaign committee meetings
    - Monthly regional representative meetings
- Created PowerPoint with Evidence-Based Policy Tactics describing the Toolkits and Legislation
    - Sent to all groups to have regional reps present statewide
    - Presented at NAPNAP
    - Followed up with regional reps
- Legislative Council
    - Monthly leadership council meetings
    - Monthly NAPNAP Child Health Policy Learning Collaborative calls
    - Proposal and NAPNAP bus to Lobby Day
    - 50th Anniversary Letter sent to all Philadelphia schools/hospitals
- Drexel University
    - Proposal to the Dean, pitched to the Assistant Dean
    - Bus funded
    - Brought 10 nursing students, 3 faculty to Lobby Day, invited to informational conference call, guiding through legislative process
- The Children's Hospital of Philadelphia (CHOP)
    - Met with Advanced Pediatric Provider Advocacy and Director of NPs at CHOP
    - Worked with Government Affairs to try and have CHOP become a hard support instead of a soft support, presented in front of the CHOP medical administration board-> remaining neutral
    - Letter to President and COO, Madeline Bell
    - Became chair of APP Advocacy Council
- Grassroots
    - Wrote letters to district rep and senator
    - Meetings with district rep and senator
    - References of quality of NP care for Lobby Day-> holding as rebuttal media
    - Recommended coalitions (National Nursing Consortium continued support)
    - Liked and shared on social media
    - Attended May 12th Lobby Day and evening before Campaign reception
    - Key Meetings with Lobbyist and CEO

Figure 4. Individual grassroots efforts

Appendix

House Bill 765/Senate Bill 717

PRINTER'S NO. 961

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 765 Session of 2015

INTRODUCED BY TOPPER, MURT, BARRAR, BOBACK, CAUSER, COHEN, DIAMOND, FARRY, FREEMAN, GABLER, GIBBONS, GINGRICH, J. HARRIS, M. K. KELLER, REGAN, SANKEY, SAYLOR, SIMS, WARD, WARNER, MILNE, MUSTIO, RADER, M. DALEY, DiGIROLAMO AND LEWIS, MARCH 23, 2015

REFERRED TO COMMITTEE ON PROFESSIONAL LICENSURE, MARCH 23, 2015

AN ACT

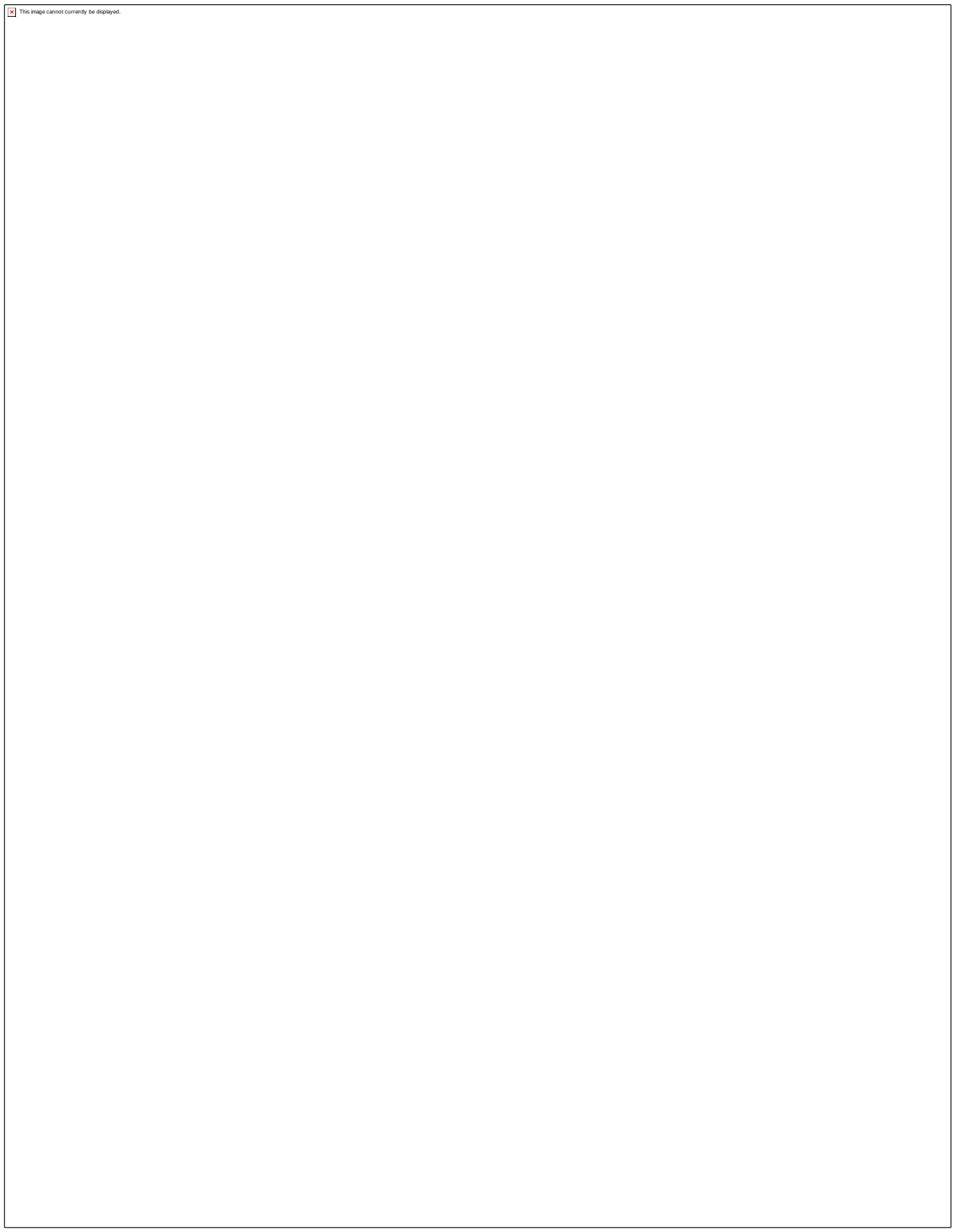
Amending the act of May 22, 1951 (P.L.317, No.69), entitled, as amended, "An act relating to the practice of professional nursing; providing for the licensing of nurses and for the revocation and suspension of such licenses, subject to appeal, and for their reinstatement; providing for the renewal of such licenses; regulating nursing in general; prescribing penalties and repealing certain laws," further providing for definitions; and providing for licensure as a certified nurse practitioner.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 2(1), (10), (13) and (14) of the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law, amended or added June 29, 2002 (P.L.651, No.99) and December 9, 2002 (P.L.1567, No.206), are amended and the section is amended by adding paragraphs to read:

Section 2. Definitions.--When used in this act, the following words and phrases shall have the following meanings unless the context provides otherwise:

(1) The "Practice of Professional Nursing" means diagnosing



(The General Assembly of Pennsylvania, 2015b)

and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of medical therapeutic or corrective measures, except as performed by a certified [registered] nurse practitioner acting in accordance with rules and regulations promulgated by the Board.

* * *

(10) "Medical nutrition therapy" means the component of nutrition therapy that concerns determining and recommending nutrient needs based on nutritional assessment and medical problems relative to diets prescribed by a licensed physician or certified nurse practitioner, including:

(i) tube feedings;

(ii) specialized intravenous solutions;

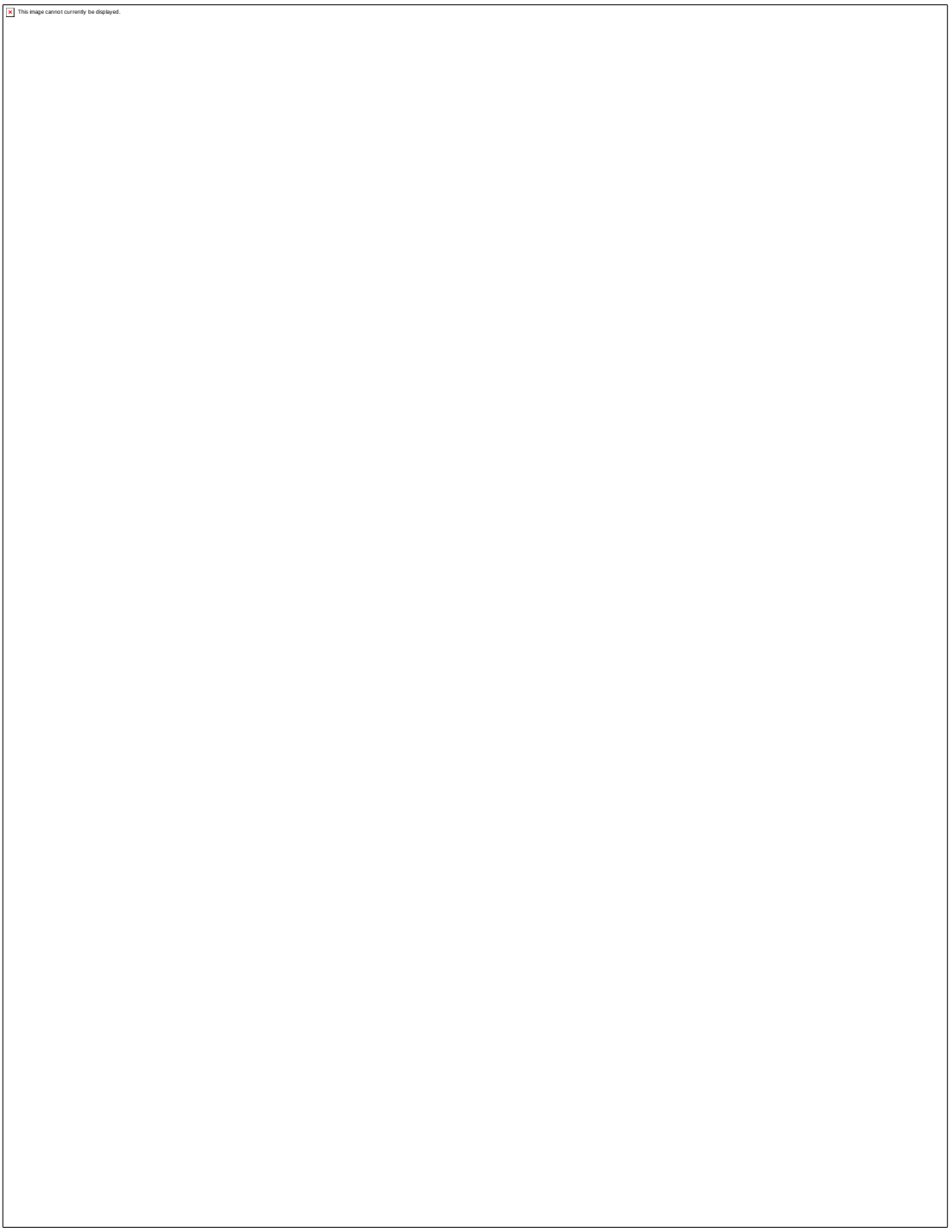
(iii) specialized oral solutions; and

(iv) interactions of prescription drugs with food or nutrients.

* * *

[(13) "Collaboration" means a process in which a certified registered nurse practitioner works with one or more physicians to deliver health care services within the scope of the certified registered nurse practitioner's expertise. The process includes all of the following:

(i) Immediate availability of a licensed physician to a certified registered nurse practitioner through direct communications or by radio, telephone or telecommunications.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required by any applicable Federal or State law to be dispensed only by prescription.

(20) "Proprietary drug" means a non-prescription, non-narcotic medicine or drug which may be sold without a prescription and which is prepackaged for use by the consumer and labeled in accordance with the requirements of the statutes and regulations of the Federal Government and this Commonwealth.

(21) "Licensed independent practitioner" means any practitioner licensed under this act to provide care and services, without direction or supervision, within the scope of the practitioner's license.

Section 2. Section 2.1(l) of the act, added December 9, 2002 (P.L.1567, No.206), is amended to read:

Section 2.1. State Board of Nursing.--* * *

(l) Any powers and duties imposed on the State Board of Medicine or jointly imposed on the State Board of Medicine and the State Board of Nursing, with respect to certified [registered] nurse practitioners, by or pursuant to law or regulation shall, after the effective date of this subsection, be exercised solely by the State Board of Nursing. This subsection shall not apply to 49 Pa. Code §§ 21.283(4) (relating to prescribing and dispensing drugs) and 21.321 (relating to performance of tasks without direction; performance of tasks without training; other) unless the State Board of Nursing promulgates a regulation to exercise the duties imposed on the State Board of Medicine by those sections.

Section 3. Sections 3.1(b) and 7(b) of the act, amended or added June 29, 2002 (P.L.651, No.99), are amended to read:

Section 3.1. Dietitian-Nutritionist License Required.--* * *

(b) Nothing in this section shall be construed to require or

preclude third-party insurance reimbursement. Nothing herein shall preclude an insurer or other third-party payor from requiring that a licensed dietitian-nutritionist obtain a referral from a licensed physician, certified nurse practitioner, dentist or podiatrist or that a licensed dietitian-nutritionist file an evaluation and treatment plan with the insurer or third-party payor as a precondition of reimbursement.

Section 7. Graduates of Schools of Other States, Territories or Dominion of Canada.--* * *

(b) The Board may issue a [certification to registered nurse practitioners who have] license as a certified nurse practitioner to a registered nurse who has completed a course of study considered by the Board to be equivalent to that required in this State at the time such course was completed or who is licensed or certified by another state, territory or possession of the United States or a foreign country as deemed equivalent to Pennsylvania's [certification] licensure requirements in accordance with the [joint] rules and regulations of the [Boards of Nursing and Medicine] Board.

* * *

Section 4. Section 8.1 of the act is amended by adding a subsection to read:

Section 8.1. Certified Registered Nurse Practitioners; Qualifications.--* * *

(d) The authority of the Board to certify a licensed registered nurse as a certified registered nurse practitioner shall expire on the effective date of section 8.8.

Section 5. Section 8.2 of the act, amended July 20, 2007 (P.L.318, No.48), is amended to read:

Section 8.2. Scope of Practice for Certified [Registered] Nurse Practitioners.--(a) A certified [registered] nurse practitioner [while functioning in the expanded role as a professional nurse] shall practice within the scope of practice of the particular clinical specialty area or population focus in which the nurse is [certified] licensed by the [board] Board. Notwithstanding any other provision of law, a certified nurse practitioner is entitled to all of the following:

(1) To practice as a licensed independent practitioner within the scope of practice of the particular clinical specialty area or population focus in which the nurse is licensed by the Board.

(2) To be recognized as a primary care provider under managed care and other health care plans.

(3) To be reimbursed directly by insurers and other third-party payors.

(b) A certified [registered] nurse practitioner may perform acts of medical diagnosis [in collaboration with a physician and] in accordance with regulations promulgated by the [board] Board.

(c) [Except as provided in subsection (c.1), a] A certified [registered] nurse practitioner may prescribe medical therapeutic or corrective measures if the nurse is acting in accordance with the provisions of section 8.3.

(c.1) [Except as limited by subsection (c.2), and in] In addition to existing authority, a certified [registered] nurse practitioner shall have authority to do all of the following, provided that the certified nurse practitioner is acting within the scope of [the certified registered nurse practitioner's collaborative or written agreement with a physician and] the

certified [registered] nurse practitioner's [specialty] certification:

(1) Order home health and hospice care.

(2) Order durable medical equipment.

(3) Issue oral orders [to the extent permitted by the health care facilities' by-laws, rules, regulations or administrative policies and guidelines].

(4) Make physical therapy and dietitian referrals.

(5) Make respiratory, speech and occupational therapy referrals.

(6) Perform disability assessments for the program providing Temporary Assistance to Needy Families (TANF).

(7) Issue homebound schooling certifications.

(8) Perform and sign the initial assessment of methadone treatment evaluations[, provided that any] and order [for] methadone treatment [shall be made only by a physician].

[(c.2) Nothing in this section shall be construed to:

(1) Supersede the authority of the Department of Health and the Department of Public Welfare to regulate the types of health care professionals who are eligible for medical staff membership or clinical privileges.

(2) Restrict the authority of a health care facility to determine the scope of practice and supervision or other oversight requirements for health care professionals practicing within the facility.]

(d) Nothing in this section shall be construed to limit or prohibit a certified [registered] nurse practitioner from engaging in those activities which normally constitute the practice of nursing as defined in section 2.

Section 6. Sections 8.3 and 8.4 of the act, added December

9, 2002 (P.L.1567, No.206), are amended to read:

Section 8.3. Prescriptive Authority for Certified [Registered] Nurse Practitioners.--(a) A certified [registered] nurse practitioner may prescribe medical therapeutic or corrective measures if the nurse:

(1) has successfully completed at least forty-five (45) hours of coursework specific to advanced pharmacology at a level above that required by a professional nursing education program;

(2) is [acting in collaboration with a physician as set forth in a written agreement which shall, at a minimum, identify the following:

(i) the area of practice in which the nurse is certified;

(ii) the categories of drugs from which the nurse may prescribe or dispense; and

(iii) the circumstances and how often the collaborating physician will personally see the patient] practicing within a clinical specialty area or population focus in which the nurse is certified; and

(3) is acting in accordance with regulations promulgated by the [board] Board.

(b) A certified [registered] nurse practitioner who satisfies the requirements of subsection (a) may independently prescribe and dispense [those categories of drugs that certified registered nurse practitioners were authorized to prescribe and dispense by board regulations in effect on the effective date of this section, subject to the restrictions on certain drug categories imposed by those regulations. The board shall add to or delete from the categories of authorized drugs in accordance with the provisions of section 8.4] proprietary and non-proprietary drugs, subject to any restrictions imposed by Board

regulations or by Federal law.

Section 8.4. [Drug Review Committee.--(a) The Drug Review Committee is hereby established and shall consist of seven members as follows:

(1) The Secretary of Health or, at the discretion of the Secretary of Health, the Physician General as his or her designee, who shall act as chairman.

(2) Two certified registered nurse practitioners who are actively engaged in clinical practice, appointed to three-year terms by the Secretary of Health.

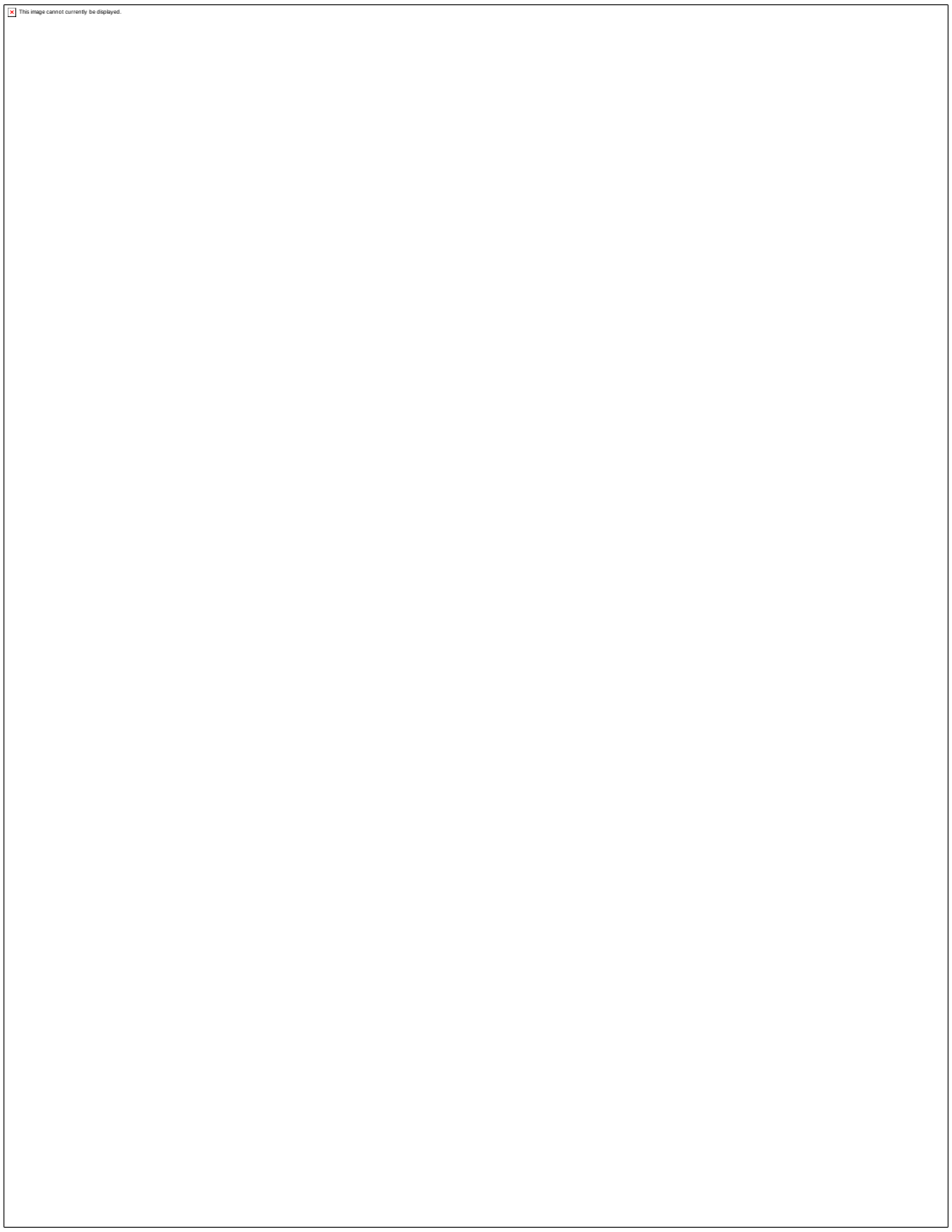
(3) Two licensed physicians who are actively engaged in clinical practice, appointed to three-year terms by the Secretary of Health, at least one of whom shall, at the time of appointment, be collaborating with one or more certified registered nurse practitioners in accordance with section 8.3(a)(2).

(4) Two licensed pharmacists who are actively engaged in the practice of pharmacy, appointed to three-year terms by the Secretary of Health.

(b) (1) The board shall submit to the Drug Review Committee any proposed change to the categories of drugs that certified registered nurse practitioners were authorized to prescribe pursuant to board regulations in effect on the effective date of this section. The board shall not change, by addition or deletion, the categories of authorized drugs without prior approval of the Drug Review Committee.

(2) Within sixty (60) days of a submission by the board under paragraph (1), a majority of the Drug Review Committee shall vote to approve or disapprove the proposed change.

(3) If a majority of the Drug Review Committee fails to vote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meets the following criteria:

(1) Holds a current license in this Commonwealth as a registered nurse.

(2) Is a graduate of an accredited, Board-approved master's or post-master's nurse practitioner program.

(3) Holds current certification as a certified nurse practitioner from a Board-recognized national certification program which required passing a national certifying examination in the particular clinical specialty area or population focus in which the nurse is seeking licensure by the Board.

(c) (1) An initial license pursuant to subsection (a) as a certified nurse practitioner shall expire on the same date as the nurse's then-current license as a registered nurse is scheduled to expire. Such license as a certified nurse practitioner shall thereafter be renewed biennially on the same date as the nurse's license as a registered nurse.

(2) An initial license pursuant to subsection (b) or section 7(b) as a certified nurse practitioner shall expire on the same date as the nurse's then-current license as a registered nurse is scheduled to expire. Such license as a certified nurse practitioner shall thereafter be renewed biennially on the same date as the nurse's license as a registered nurse.

(3) As a condition for biennial renewal by the Board of a license as a certified nurse practitioner, the nurse must do all of the following:

(i) Maintain a current license in this Commonwealth as a registered nurse.

(ii) Maintain current certification through a Board-recognized national certification program in the particular clinical specialty area or population focus in which the nurse

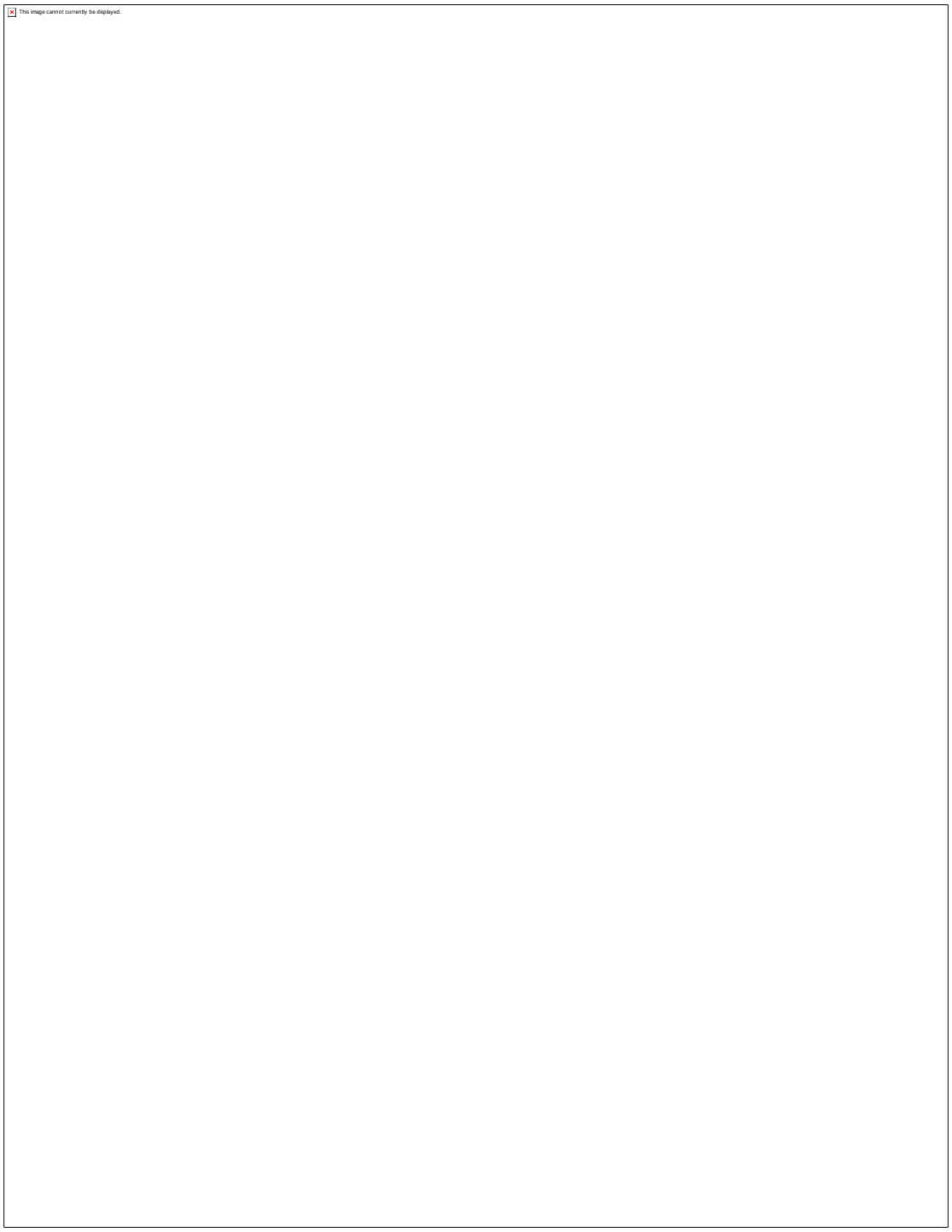
is licensed as a certified nurse practitioner by the Board.

(iii) In the two years prior to renewal, complete at least thirty (30) hours of continuing education approved by the Board. In the case of a certified nurse practitioner who is prescribing medical therapeutic or corrective measures pursuant to section 8.3, that continuing education must include at least sixteen (16) hours in pharmacology in that two-year period.

(d) The Board shall establish a procedure by which a license as a certified nurse practitioner may be amended prior to the biennial renewal date in order to authorize a nurse to practice in a particular clinical specialty area or population focus in which the nurse was not certified on the effective date of this section or on the date on which the nurse's current license as a certified nurse practitioner was issued or renewed. The Board shall authorize a certified nurse practitioner to practice in an additional clinical specialty area or population focus only if the nurse holds current certification from a Board-recognized national certification program which required the passing of a national certifying examination in the additional clinical specialty area or population focus.

(e) (1) The use of the terms "certified registered nurse practitioner," "registered nurse practitioner," "certified nurse practitioner" and "nurse practitioner" in any other act shall be deemed to include a person licensed as a certified nurse practitioner pursuant to this section or section 7(b).

(2) A registered nurse who is licensed by the Board as a certified nurse practitioner in a particular clinical specialty area or population focus is entitled to use the title "advanced practice registered nurse-certified nurse practitioner" and the letters "A.P.R.N.-C.N.P." It shall be unlawful for any other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