Developing Alliances: How Advanced Practice Nurses Became Part of the Prescription for Pennsylvania

Tine Hansen-Turton, Ann Ritter and Brian Valdez

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Developing Alliances

How Advanced Practice Nurses Became Part of the Prescription for Pennsylvania

Tine Hansen-Turton, BA, MGA, JD
Ann Ritter, BA, JD
Brian Valdez, BA, JD
National Nursing Centers Consortium, Philadelphia, PA

The authors describe how advanced practice nurses in Pennsylvania were able to successfully advocate for nursing-related legislative reforms through Governor Edward G. Rendell’s signature health care reform plan (the “Prescription for Pennsylvania”). In addition to discussing advocacy efforts related to a series of nursing-related bills considered by the Pennsylvania Assembly in 2007, the article also describes years of hard work and foundational advocacy conducted by a broad coalition of nurses, which paved the way for the Prescription for Pennsylvania’s reforms. By examining the successful tactics of Pennsylvania’s nurse advocates, the authors conclude that policy makers’ current interest in solving the health care crisis presents a tremendous opportunity for nurses to reform legislation. To seize this opportunity, nurses must learn to speak with a unified voice and build strong relationships with a broad range of bipartisan policy makers, funders, civic leaders, business leaders, and legislative advocates.

Keywords: advanced nursing practice; political action; state legislation; advocacy; Pennsylvania; health reform

As the national debate about health care reform continues, and studies show that Americans are having more and more difficulty accessing health care (Cunningham & Felland, 2008), advanced practice nurses (APNs) have a new opportunity to convince policy makers and thought leaders that their services are essential to solving the nation’s health care crisis. In this article, we discuss the experience of APNs in Pennsylvania, and how they were able to achieve nursing-related legislative reforms through Governor Edward G. Rendell’s signature health care reform plan (the “Prescription for Pennsylvania”). Although APNs have argued for years that increased professional autonomy and recognition can lead to increased access to health care for more Americans, that message alone is not enough to win legislative and regulatory battles. In this article, we outline and discuss the tactics that were employed by a broad coalition of APNs and others to lay the groundwork for success.

APNs and the Prescription for Pennsylvania

In January 2007, Pennsylvania’s Democratic Governor Edward G. Rendell announced the launch of his “Prescription for Pennsylvania” health care reform plan (commonly called Rx for PA) during a public ceremony at the University of Pennsylvania School of Nursing in Philadelphia (Commonwealth of Pennsylvania, 2007). It was one of the first official acts of his second term as governor, occurring just two months after Rendell had won reelection against Lynn Swann, his Republican challenger and a former star of the Pittsburgh Steelers. Coming off a 20-point margin of victory that USA Today described as a “landslide”, Rendell began a two-week statewide tour to spread the word about his signature health care reform plan (Franklin and Marshall College Center for Politics and Public Affairs, 2006; Kaster, 2006).

This was not the first time that the Rendell administration had taken steps to establish health care as one of its high-priority policy issues. Rendell’s first action as governor in January 2003 was to sign an executive order creating the Governor’s Office of Health Care Reform (OHCR), which would go on to develop and spearhead the Prescription for Pennsylvania health care reform plan (Commonwealth of Pennsylvania, OHCR, 2008b). At the same time, Rendell appointed Rosemarie B. Greco, a former banking executive and consultant in strategic planning, to head the OHCR. He also established the
Governor’s Health Care Reform Cabinet to advise the OHCR, comprised of 10 senior appointed officials (including individuals such as the Secretary of Public Welfare, the Secretary of Aging, and the Commissioner of Insurance) (Commonwealth of Pennsylvania, OHCR, 2008a).

One of the first major health care–related accomplishments of the Rendell administration was the passage of legislation designed to increase access to insurance for children in Pennsylvania. Passed in late 2006, “Cover All Kids” was designed to allow more parents to purchase affordable insurance for their children by expanding eligibility for S-CHIP (State Children’s Health Insurance Program) and increasing marketing and enrollment efforts (Capitol Report, 2006). This bill would help lay the groundwork for the insurance reform components of the Prescription for Pennsylvania plan, which would be announced within months of the passage of Cover All Kids.

With the announcement of the Prescription for Pennsylvania reform plan in early 2007, health care once again became the central focus of the Rendell administration. The plan focused on three categories of reform strategies designed to improve the quality, affordability, and accessibility of health care in Pennsylvania. Contained in each category were a variety of health care reform strategies, some of which concerned access to health insurance. However, most Prescription for Pennsylvania initiatives addressed other topics as varied as improving palliative care, reducing hospital-acquired infections, implementing the chronic care model, creating new options for home-based long-term care, and ensuring smoke-free workplaces (Commonwealth of Pennsylvania, OHCR, 2007b).

The accessibility category of health care reform strategies in Prescription for Pennsylvania focused almost entirely on health care providers, including regulatory changes designed to increase utilization of nurse practitioners, certified nurse midwives (CNMs), and clinical nurse specialists (CNSs). In fact, APNs took center stage in the initial push for Prescription for Pennsylvania. Rendell, while promoting the plan in Pittsburgh in January 2007, explained that an underlying concept of Prescription for Pennsylvania was that access to health care would increase if state laws were changed to “free nurse practitioners to do anything they are capable of doing” (Mauriello, 2006, para. 5). During another speech in the weeks following Rendell’s initial announcement regarding Prescription for Pennsylvania, Rendell declared that his health care reform plan would “unleash [the] tremendous potential” of APNs to provide care to more patients (Cholodofsky, 2007). A fact sheet issued by the OHCR at the time that the reform plan was launched included the following brief description of the rationale behind the decision to include APNs and other nonphysician providers (including dental hygienists and physician assistants) in Rendell’s plan:

Prescription for Pennsylvania expands access to quality care in the appropriate setting for the best cost [by] ensuring that all licensed health care providers—including nurses, advanced nurse practitioners, midwives, physician assistants, pharmacists and dental hygienists—can practice to the fullest extent of their training. Pennsylvania consistently lags behind other states in fully utilizing licensed health care providers that are not physicians. Prescription for Pennsylvania will eliminate the barriers in existing laws and regulations that limit the ability of health care providers to practice to the fullest extent allowed by their education and training (Commonwealth of Pennsylvania, OHCR, 2007a).

Initially, the OHCR pushed to have its entire health care reform plan—encompassing all of the varying health care reform strategies described above, and many others—introduced as one comprehensive piece of legislation. This bill, House Bill (HB) 700, was introduced in the Pennsylvania House of Representatives in March 2007, 2 months after Governor Rendell first announced the Prescription for Pennsylvania plan. The bill was referred to the House Committee on Insurance, and a public hearing was held the following month, but it quickly became clear that the bill contained too many controversial components and was unlikely to pass as drafted. Some of the most controversial components included a statewide smoking ban, and provisions related to insurance reform (including a health insurance mandate for employers, insurance reform to prevent denials based on pre-existing conditions, and a modified community rating system for insurers, among others) (Fahy & Barnes, 2008; Worden, 2008).

As a result, a number of single-issue bills were split off from HB 700. Three of those bills were HB 1253, HB 1254, and HB 1255, each designed to further define and/or enhance the scope of practice of certified registered nurse practitioners, CNSs, and CNMs, respectively. Please see Table 1 for brief descriptions of the content of each of the three nursing scope of practice bills that were introduced as part of the Prescription for Pennsylvania health care reform plan. Though some of these restrictions may seem relatively minor, combined they had a great impact on the independent practice of APNs.

The three nursing bills that were part of Rendell’s health care reform plan were among the first to be successfully enacted. All of the pieces of legislation described in Table...
1 were signed into effect by Rendell in front of a standing-room-only crowd at the University of Pennsylvania School of Nursing on July 20, 2007, seven months after the plan was first announced (Commonwealth of Pennsylvania, 2007). In addition, four other pieces of legislation that were part of the initial Prescription for Pennsylvania push were signed on the same day (including bills designed to enhance the scope of practice of physician assistants and dental hygienists, and a bill to reduce hospital-acquired infections).

**Laying the Groundwork: 1998-2006**

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**Act 68 of 1998**

One of the first policy issues to unite Pennsylvania APNs was an effort to create a legislative definition of primary care provider that included nurse practitioners. In 1998, Pennsylvania moved to re-examine the statute governing the operations of the state’s managed care organizations (MCOs). At the time, few state policy makers fully understood the role of nurse practitioners, and the statutes governing MCOs permitted only physicians to act as primary care providers. Pennsylvania’s decision to review its managed care law presented APNs with an opportunity to address this issue.

Nursing groups in Pennsylvania, including the Pennsylvania State Nurses Association, the Pennsylvania Coalition of Nurse Practitioners, the Pennsylvania Chapter of the National Association of Pediatric Nurse Practitioners, the National Nursing Centers Consortium (at that time the Regional Nursing Centers Consortium), and others, quickly implemented a two-pronged strategy designed to educate policy makers and demonstrate the impact that nurse practitioners were already having on the Commonwealth’s health care safety net. While changes to existing law were being considered, APN representatives presented as many as eight different sets of testimony at hearings on the proposed amendments to the insurance law which would come to be called Act 68.

### Table 1

**Summary of Advanced Practice Nursing Bills in Prescription for Pennsylvania Health Care Reform Plan (2007)**

<table>
<thead>
<tr>
<th>Pennsylvania Bill Number</th>
<th>Type of APN Affected</th>
<th>Summary of Bill Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>HB 1253</td>
<td>CRNP</td>
<td>Revised laws to allow CRNPs to perform all functions allowable under their current scope of practice, including, order home health and hospice care; order durable medical equipment; issue oral orders; make referrals for physical therapy, respiratory therapy, occupational therapy, and dietitian services; perform disability assessments for the TANF program; perform and sign initial methadone treatment evaluations; and issue homebound schooling certifications. Established requirement that all CRNPs must maintain a certain level of malpractice coverage, similar to that of physicians providing comparable services.</td>
</tr>
<tr>
<td>HB 1254</td>
<td>CNS</td>
<td>Title recognition for CNSs Defined CNS licensing and education requirements for the first time in Pennsylvania law. Defined CNS scope of practice for the first time in Pennsylvania law. Established requirement that all CNSs must maintain a certain level of malpractice coverage, similar to that of physicians providing comparable services.</td>
</tr>
<tr>
<td>HB 1255</td>
<td>CNM</td>
<td>Granted prescriptive authority to CNMs. Granted CNMs authority to order medical devices and diagnostic tests.</td>
</tr>
</tbody>
</table>

Note: APN = advanced practice nurses; CRNP = certified registered nurse practitioner; CNS = clinical nurse specialist; CNM = certified nurse midwife; TANF = Temporary Assistance to Needy Families.
To increase the level of knowledge among policy makers, nursing groups submitted both written and oral testimony that highlighted the ability of APNs to expand access to health care services for the underserved. Being defined as primary care providers in Act 68 was especially important for APNs, as Pennsylvania was in the early stages of moving from a Medicaid fee-for-service model to a managed care model. At the time was in the early stages of moving from a Medicaid fee-for-service model to a managed care model. At the time, nurses practitioners played a large role in serving Medicaid patients through nurse-managed health centers and other community-based primary care settings. This fact was highlighted in APNs’ testimony to legislators. To further demonstrate their impact on the safety net, APNs and their patients sent thousands of postcards to legislators calling on them to ensure that Act 68 would allow APNs to act as primary care providers.

Ultimately, the nursing groups’ strategy proved successful. The final version of Act 68 was signed into law by Republican Governor Tom Ridge on June 17, 1998. It included language explicitly authorizing nurse practitioners to act as primary care providers for managed care enrollees. APNs had learned the value of speaking with a unified voice. They had also identified key bipartisan supporters in the General Assembly, like Republican Representative (now Senator) Pat Vance and Democratic Representative Kathy Manderino, on whom they could rely for support in upcoming initiatives.

Nurse Practitioner Prescriptive Authority

In 1998, Pennsylvania was one of only three states in the nation that had not yet granted prescriptive authority to nurse practitioners (Jenkins, 2002). This was due in large part to repeated disputes (and ensuing gridlock) between the Board of Nursing and the Board of Medicine, which at the time had dual authority to regulate nurse practitioners. For more than 20 years the Board of Medicine had resisted attempts to reform the regulations governing nurse practitioner prescriptive authority. However, during and immediately following the Act 68 campaign, APN groups implemented new strategies that captured the attention of former Governor Ridge as well as several key legislators. These strategies helped push the issue of nurse practitioner prescriptive authority to the forefront of policy issues in the Pennsylvania General Assembly.

One of the first things members of the APN community did was to further solidify the unity of their message by forming a group called the Alliance of Advanced Practice Nurses (the Alliance). The founding members of the group included representatives from the Pennsylvania State Nurses Association, the Pennsylvania Coalition of Nurse Practitioners, the Pennsylvania Association of Nurse Anesthetists, the Regional Nursing Centers Consortium (now the National Nursing Centers Consortium), and the Pennsylvania chapters of the American College of Nurse Midwives, the Pennsylvania Association of School Nurses and Practitioners, and the Psychiatric Advanced Practice Nurses of Pennsylvania. Under the banner of “One Alliance, One Voice,” the group quickly initiated a legislative visit and letter-writing campaign designed to highlight the need for nurse practitioner prescriptive authority along with other APN reforms.

In March 1998, APN groups again turned to Representatives Vance and Manderino to introduce HB 50. The bill proposed comprehensive amendments to the state’s nurse practice act that would have not only extended prescriptive authority to nurse practitioners and CNSs, but also would have modified the law governing the practice of certified registered nurse anesthetists. After more than 500 APNs rallied at the State Capitol in Harrisburg, the bill was introduced with 124 cosponsors. Other groups expressed their support for the bill as well, including the Hospital and Health System Association of Pennsylvania, the Chamber of Commerce, and other key business allies. However, the bill quickly lost momentum as the Pennsylvania Medical Society mobilized in opposition, cosponsors began to withdraw, and the bill became stranded in committee hearings (Pennsylvania Coalition of Nurse Practitioners, 1999).

Although the bill was eventually abandoned, the introduction of HB 50 served an important purpose, as it brought the issue of nurse practitioner prescriptive authority to the forefront of the political landscape and helped bring about a series of historic meetings between the Alliance and the Pennsylvania Medical Society. It was the first time the Medical Society had met with a group representing such a diverse collection of professional nurses. With further encouragement and pressure from the governor’s office, the Board of Medicine and Board of Nursing would enter a series of negotiations that would ultimately lead to limited prescriptive authority for nurse practitioners (Jenkins, 2002).

In April 2000, more than two years after the process began, a compromise agreement was reached between the Board of Nursing and the Board of Medicine regarding nurse practitioner prescriptive authority. The approval of both boards meant that nurse practitioners had gained prescriptive authority, but the Alliance was unsatisfied. The regulations contained controversial provisions, including a requirement that a physician could not collaborate with more than two nurse practitioners prescribing medication. Specifically, the Alliance felt that this provision would hinder the practice of nurse-managed health centers operating in medically underserved communities.
In the following months, the Alliance voiced its concerns. Ultimately, the Pennsylvania Independent Regulatory Review Commission disapproved the regulations because they were against the public’s interest, returning them to the Boards of Medicine and Nursing for revisions (Pennsylvania Coalition of Nurse Practitioners, 2000). In December 2000, after yet another series of negotiations, the boards reached agreement on a revised version of the regulations (Jenkins, 2002). The struggle was over, and nurse practitioners in Pennsylvania had won prescriptive authority.

The policy debate over prescriptive authority highlights the importance of having the support of the Governor’s office when proposing statutory or regulatory change. The Ridge administration worked closely with the Boards of Medicine and Nursing in the drafting of new regulations, and the Governor’s involvement helped the process move along more rapidly than it might have otherwise. Another important factor was the face-to-face meeting that took place between the Alliance and the Pennsylvania Medical Society. In the future, APNs would again rely on support from the Governor’s office and face-to-face communication with physician groups to earn scope of practice reforms under Prescription for Pennsylvania.

The End of Dual Regulation

The third major victory of the Alliance prior to Prescription for Pennsylvania was to ensure that the Board of Nursing had sole authority to regulate advanced nursing practice. For 27 years (from 1975 to 2002), nurse practitioners were the only group of professionals in Pennsylvania required to answer to two different regulatory Boards (Jenkins, 2002). As highlighted by the struggle for prescriptive authority, working collaboratively with the Board of Medicine was sometimes difficult. Regulations often had to go through many revisions before the Boards of Medicine and Nursing could agree on a final version.

In 2001, the Alliance approached Republican Senator Jane Earll in an effort to address the issues created by the system of dual regulation. In November of that year, Senator Earll introduced SB 1208. The main purpose of the bill was to end the authority of the Board of Medicine to regulate nurse practitioners and place the profession under the sole jurisdiction of the Board of Nursing. After its introduction in the Senate, the bill was referred to the Consumer Protection and Professional Licensure Committee, where it was stalled.

The Alliance again engaged in a grassroots campaign of letter writing, legislative visits and mass rallies. Thanks to continuing advocacy by Senator Earll, the bill was voted out of committee in June 2002, and received a vote for final passage from of the full Senate in October. After its passage in the Senate, the bill was sent to the House where it was revised based on input from several physician groups, the Governor’s office, and Representative Vance, among others (Pennsylvania Coalition of Nurse Practitioners, 2002). After the addition of these amendments, the legislation was unanimously approved by the full House.

On the last day before the legislative session ended, the amended version of SB 1208 was sent back to the Senate. At 6:40 p.m. that night, just prior to the close of the session, the Senate voted unanimously to approve the amendments offered by the House (Pennsylvania Coalition of Nurse Practitioners, 2002). Governor Mark Schweiker signed the bill in December 2002, effectively ending the era of dual regulation and giving the Board of Nursing sole authority to regulate nurse practitioner practice in Pennsylvania.

The Alliance again saw the value of nurturing bipartisan support and building strong relationships with key legislators. Senator Earll’s support of the bill was a key factor in its success. In 2002, she was slated to become the Republican nominee for lieutenant governor in the general election which took place later that year (Earll, 2008). Although the Republicans did not win the election, her position on the ticket helped to win support for the bill among Republican legislators.

In addition to ending dual regulation, SB 1208 also clarified nurse practitioner scope of practice. The changes offered by the legislation indicated that nurse practitioners could fill the role of primary care providers and emphasized their ability to function independently. It would be this ability of nurse practitioners to expand access to primary care that would later capture the attention of Governor Rendell, who took office in 2003.

Governor Rendell’s First Term

Although the practice environment for APNs in Pennsylvania had improved significantly, in 2003 there was still much work to be done. During Governor Rendell’s first term, the Alliance began building a relationship with the new administration, as its members pressured the legislature to continue making reforms. Prior to the Prescription for Pennsylvania, the major issue facing APNs was that the state’s laws and regulations had not been updated to accommodate their expanding role. For example, until 2004, the law stated that only physicians could sign the form certifying that a person was entitled to a disability parking placard, even
though both nurse practitioners and physicians were qualified to perform the placard examination. Thus, if a nurse practitioner performed the disability assessment examination, she would have to ask her collaborating physicians to sign the form. Although this gap in the law was relatively small, when added with other inconsistencies, it made it difficult for nurse practitioners to act as primary care providers. Many legislators agreed that these inconsistencies should be corrected, but also feared that making all of the necessary changes would lead the legislature down a slippery slope of never-ending revisions.

The disability placard issue was resolved in 2004 through the passage of HB 1912, which was introduced by Representative Vance to amend the motor vehicles statute to allow nurse practitioners to sign the certification form (Commonwealth of Pennsylvania, 2004). However, there were other statutes and regulations to be updated, and the strategy of addressing each issue one at a time through legislation was frustrating and time-consuming. APNs recognized the need for a comprehensive piece of legislation that could make all necessary revisions at once.

In February 2005, the Alliance published a white paper that laid out all the areas of the law that needed to be revised in order for nurse practitioners, CNSs, nurse anesthetists to practice to the full extent of their training (Alliance of Advanced Practice Nurses, 2005). The document also clearly provided the rationale for the Alliance’s position that the increased utilization of APNs would lead to increased access and a general reduction in overall health care costs, noting:

Advanced Practice Nurses are positioned to significantly expand the capacity of the Pennsylvania health care delivery system. . . . Pennsylvania has already acted to create a statutory foundation for Nurse Practitioners and Nurse-Midwives to perform their full scope of practice. . . . Barriers to performing their scope of practice continue, despite statutory authority. Outdated state statutes and regulations, third party payer provider contract rules, and confusing federal funding rules, restrain nurse practitioners from providing their full scope of care to needy individuals. It is in the Commonwealth’s best interest to alleviate these restraints, freeing Advanced Practice Nurses to provide care to people in a satisfying as well as cost effective way and in a wide variety of underserved health care settings. (Alliance of Advanced Practice Nurses, 2005)

The white paper was brought to the attention of staff at OHCR and its suggested changes quickly became the blueprint for the Prescription for Pennsylvania’s APN reforms (Plant, 2007).

Also in 2005, a new ally entered the picture as Take Care Health Systems (Take Care, 2008) began to establish itself in Pennsylvania as an operator of retail-based health clinics. Because Take Care’s clinics were primarily staffed by nurse practitioners, the company was aware of the regulatory barriers to effective nurse practitioner practice in Pennsylvania, and was willing to devote company resources in the effort to reform laws. In addition to providing public relations in support of the plan (at a time when this emerging model of care was already receiving media attention as the next big thing in health care), Take Care clinics in the Pittsburgh suburbs also served as press-friendly sites for Rendell’s stump speeches in support of increased utilization of APNs and his health care reform plan (Cholodofsky, 2007; Freudenheim, 2006).

Allies from outside of the health care industry were also a welcome addition to the efforts. Private academic institutions with nursing schools and health systems helped APNs in Pennsylvania make the case for policy change. For example, the University of Pennsylvania put effort and resources into developing relationships with key policy makers in Harrisburg. Funders such as the Independence Foundation also supported nonprofit nurse-managed health centers throughout the process, and helped convene meetings with key members of the governor’s staff. By developing relationships with community allies with an interest in improving the regulatory environment for nurse practitioners, the nursing community was able to build a stronger case for legislative change.

Lessons From Pennsylvania

The work of the Alliance in the first term of the Rendell administration paved the way for success during his second term. Prescription for Pennsylvania would give nurses the comprehensive legislative vehicle they needed to address almost all of the barriers to APN practice in Pennsylvania. However, the success of the nursing component of Prescription for Pennsylvania was not inevitable, by any means. In fact, the mere inclusion of provider issues in a state health care reform plan was unprecedented at the time (Aiken, 2007). In many ways, the most important and crucial policy work came months and years before the Prescription for Pennsylvania plan was officially introduced, as nursing groups and supporters throughout Pennsylvania developed relationships with policy makers and educated legislators about the untapped potential of APNs to provide care. So, what lessons can be learned from the Pennsylvania experience?
Lesson #1: Building Strong Alliances Within the Nursing Community

Having a unified nursing community was crucial to the development and eventual success of Prescription for Pennsylvania’s nursing provisions. As noted above, the Alliance of Advanced Practice Nurses worked to raise awareness of the contributions of APNs from different specialty areas and develop talking points about barriers to practice. The collaborative process of creating advocacy documents (such as the Alliance white paper) and mutually identifying important issues ensured that nursing leaders throughout the state were able to speak to policy makers with a unified, coherent voice about the issues that mattered most to them.

Lesson #2: Building Relationships With Policy Makers

Over the course of many years, nursing groups built relationships with Republican and Democratic policy makers throughout the state. In addition to identifying and nurturing relationships with General Assembly members on both sides of the aisle, earning the support of sitting Governors was utterly crucial to policy advocacy efforts. By providing high-quality, succinct, trustworthy, and lucid information about APNs to policy makers, the nursing community was able to build the case for legislative change. By developing relationships with legislators and executive branch members with significant political capital, the Alliance was also able to ensure that when legislative momentum began to lag and bills stalled, it did not signal the end of reform efforts.

Lesson #3: Finding New Allies

Strong support from the private sector was important to the success of Prescription for Pennsylvania’s nursing reforms. Having learned the value of private sector support when the Chamber of Commerce supported prescriptive authority for nurse practitioners in 2000, nurses in Pennsylvania again sought to identify new allies to support Prescription for Pennsylvania.

Conclusion

As more states attempt to create comprehensive health care reform initiatives, will they follow Pennsylvania’s lead and consider nursing issues? Evidence suggests that states are beginning to look beyond health insurance issues in their health reform plans; however, there is also no guarantee that this change of approach will lead to increased attention to nursing.

One of the first states to attempt health care reform, Massachusetts, focused almost entirely on access to health insurance (Steinbrook, 2006). However, it is becoming clear that increased access to health insurance does not necessarily mean increased access to care, especially if there are not enough primary care providers to meet the needs of the newly insured. As a result, Massachusetts’s primary care physicians are now feeling significant strain because the provider population has not increased to meet the demands of Massachusetts’ newly insured patients (Sack, 2008). In an attempt to address this pressure, Massachusetts nurse practitioner advocates began to pursue legislative changes in early 2008 that would improve the practice environment for nurse practitioners (Croasdale, 2008). One of these legislative proposals, a law designed to require Massachusetts insurers to recognize nurse practitioners as providers and reimburse them at the same rate as physicians, was passed in August 2008. The President of the Massachusetts Coalition of Nurse Practitioners noted that one of the arguments in favor of the bill was, “If NPs can carry their own panel of patients, then you are exponentially increasing the number of primary care providers in the state” (Spader, 2008, para. 8).

A more recent gubernatorial health care reform plan in California showed some effort to consider nursing issues. In California, A.B. 1x1 (which failed in January 2008, thanks in large part to opposition to its provisions regarding mandated health insurance) would have convened a Task Force on Nurse Practitioner Scope of Practice comprised of nurses, physicians, and other individuals appointed by the Governor (Health Care Security and Cost Reduction Act, 2007). A.B. 1x1 stated that the nurse practitioner scope of practice recommended by the task force would have been adopted by the state in 2009, thus bypassing the legislature (and any turf battles among professional associations that may have occurred there). Although the bill ultimately failed, the content of California's A.B. 1x1 suggests that consideration of nurse practitioner scope of practice issues made up at least some part of Governor Arnold Schwarzenegger’s concept of comprehensive health care reform (State of California, Office of the Governor, 2007).

As evidenced by the Pennsylvania experience, strong advocacy and alliance-building efforts (both within the nursing community and outside of it) can have a great impact on the success of legislative reform efforts. In addition, the success of Prescription for Pennsylvania also rests with the OHCR, and its focused team of professionals who were willing to recognize and address established health care traditions that were behind the times. By speaking with a unified voice and building
solid, long-standing relationships with a broad range of bipartisan policy makers, funders, civic leaders, business leaders, and legislative advocates, the nurses of Pennsylvania were able to gain broad support for nursing reforms as part of a bold and comprehensive health care reform agenda.

Notes

1. This sampling of issues addressed by the Prescription for Pennsylvania is meant to provide the reader with an understanding of the breadth of topics covered by the reform plan. It is not intended to be an all-inclusive list. A discussion of the full range of topics addressed by the reform plan is beyond the scope of this article, which focuses only on the nursing-related components of the Prescription for Pennsylvania.


3. The Pennsylvania Independent Regulatory Review Commission is an independent state agency that reviews all regulations promulgated by state agencies on the basis of statutory authority, legislative intent, public interest, economic or fiscal impact, and clarity.

References


Tine Hansen-Turton, BA, MGA, JD, is the Executive Director of the National Nursing Centers Consortium, which represents nurse-managed health centers across the country. She is also Vice President for health care access and policy at Public Health Management Corporation, a large public health institute. In addition, she provides executive management services to the Convenient Care Association, a trade association representing retail-based health clinics staffed by nurse practitioners. She writes and publishes for many peer-review professional healthcare and legal journals and is a regular presenter at state and national health care conferences. She is co-author of Community and Nurse-Managed Health Centers: Getting them Started and Keeping them Going, an American Journal of Nursing Book of the Year Award winner, and Conversations with Leaders: Frank Talk from Nurses (and Others) on the Front Lines of Leadership, published by Sigma Theta Tau International.

Ann Ritter, BA, JD, works with community-based health centers to pursue policy changes that will expand their ability to serve vulnerable populations. As Director of Health Center Development and Policy at the National Nursing Centers Consortium, she researches policy issues and monitors regulatory and legislative developments at state and federal levels. Her articles on the unique policy issues facing nurse practitioners have appeared in The Health Lawyer, Policy, Politics and Nursing Practice, and Nursing Economics.

Brian Valdez, BA, JD, serves as the Health Policy Manager for the National Nursing Centers Consortium. In this role, he helps design policy initiatives intended to increase the financial stability of nurse-managed health centers and remove barriers to nurse practitioner scope of practice. His activities include drafting legislation, helping to organize legislative briefings on emerging policy issues, writing legislative testimony, and preparing organizational policy statements.