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Effective Strategies for Achieving Scope of Practice Reform in Pennsylvania

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Abstract

Background—Current regulatory impediments prohibit advanced practice registered nurses from practicing to their full capacity.

Purpose—To examine the process of successful removal of scope of practice barriers in Pennsylvania under the Rx4PA legislation introduced in 2007.

Method—We used qualitative research techniques, including purposeful sampling of participants. Twelve stakeholder informed interviews were conducted between October 2013 and May 2014. Participants were closely involved with the development of the Rx4PA legislation. Thematic content analysis was performed to analyze our interviews.

Discussion—Interviews identified overarching themes, including the importance of leveraging years of grass roots advocacy, identifying political allies, and recognizing mutually beneficial compromises.

Conclusions—The combination of timing, careful political maneuvering, and compromise were key to scope of practice reform in Pennsylvania and may be useful strategies for other states seeking similar practice changes.

Keywords

legislation (state); nurse practitioner; political participation; regulation of nursing practice

Slowly, stone by stone, we are taking the barriers down and turning them into paving stones

Interview Participant

Advanced practice registered nurses (APRNs) are among the fastest growing group of health professionals and increasingly provide care across a range of primary care and specialty settings (Auerbach, 2012). Despite extensive research suggesting their role in improving patient outcomes (Horrocks, Anderson, & Salisbury, 2002; Newhouse et al., 2011),

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restrictive regulatory environments often prohibit them from practicing to their full capacity (Institute of Medicine, 2011). Studies suggest that legislation and regulatory barriers are among the most persistent impediments to APRN role expansion (Delamaire & Lafotune, 2010). Points of contention between professional nursing and physician organizations include disagreements over provider payments, physician supervision requirements, and the ability of nurse practitioners (NPs) to independently manage primary care patients (Yin, 2010).

In 21 states and the District of Columbia, NPs have full practice authority (American Association of Nurse Practitioners [AANP], 2016). In the remaining states, some form of physician supervision is required in order for them to fully practice or prescribe (AANP, 2016). States without full practice authority often require collaborative agreements with an outside health discipline in order for NPs to provide care (Barton, 2016). Other states restrict NP scope of practice (SOP) in additional ways. In 23 states, NPs are unable to sign death certificates, and in nearly a dozen states, NPs are prohibited from signing worker's compensation forms or ordering physical therapy (Barton, 2016).

Restrictive SOP is not without consequence. There are higher primary care demands in states that have more restrictive SOP policies (Kuo, Loresto, Rounds, & Goodwin, 2013). In addition to potentiating access barriers, a recent report by the Federal Trade Commission (2014) suggests that overly restrictive SOP laws may represent anticompetitive conduct, lead to increased cost, constrain innovation, and lower care quality.

Over a dozen states across the nation are attempting to revise SOP legislation (AANP, 2016). In September 2013, a measure to remove SOP barriers was taken off California's legislative agenda following strong opposition from the California Medical Association (California Healthline, 2013). Similarly, after legislation for full practice authority received unanimous support from Nebraska's state senate, the bill was subsequently vetoed by the Governor after discussion with his chief medical officer (Nurse.com, 2014). In contrast, several states, including, New York, Minnesota, and Connecticut, recently passed legislation reducing restrictive SOP laws (Connecticut Advanced Practice Registered Nurse Society, 2014; Minnesota Board of Nursing, 2014; Nurse Practitioner Association New York, 2014).

Given the variable level of success in reducing SOP barriers, examining the process and identification of key points involved in legislative reform is imperative (Schober, Gerrish, & McDonnell, 2016). To date, there have been few systematic examinations of the legislative process involved in reforming state-level APRN SOP regulations (Gutchell, Idzik, & Lazear, 2014; Hansen-Turton, Ritter, & Valdez, 2009; Madler, Kalanek, & Rising, 2014; Schober et al., 2016). Understanding this process, however, is of importance as the nation faces a primary care shortage and access to the underserved persists (Institute of Medicine, 2011).

In an effort to unpack the often hidden process of SOP policy formation, we undertook a qualitative study of key stakeholders involved in SOP legislative reform in Pennsylvania under the Edward G. Rendell administration. In 2004, Democrat, Governor Rendell introduced his vision to reform health care in the state. The proposed legislation, referred to as the *Prescription for Pennsylvania* (Rx4PA), sought to increase access to health care,

control spiraling state health-care costs, and improve quality (Governor's Office of Health Care Reform [GOHCR], 2007). Rendell tied these objectives (at least in part) to expansions in SOP for APRNs. In July 2007, key provisions of the Rx4PA legislation passed through Act 48 and with it APRNs were allowed to perform an expanded range of services including ordering durable medical equipment, signing disability forms as well as other prescriptive authorities and patient care services (Hansen-Turton et al., 2009).

Exploring the policy formation surrounding Rx4PA allowed us to examine the development of SOP legislation with full consideration of relevant influences such as the political climate and the opinions and values of key decision makers (Lemer, Cheung, Viner, & Wolfe, 2014). Our research was guided by Kingdon's (2002) Multiple Streams Framework, a policy model which helps to identify how policy evolves. According to Kingdon's model, policy agendas are set in motion by the identification of a clear problem, which is then addressed by concerned interest groups or policy advocates (Odom-Forren & Hahn, 2006). Kingdon's model posits a metaphoric merging of three *streams* which converge to become part of the policy agenda. Kingdon's three streams include the *problem stream*, which refers to the conditions or challenges that indicate a concern or issue, while the *policy stream* denotes the involvement of stakeholders who are involved with highlighting the concern. Finally, the *politics stream* comprises the national mood and focuses on the political climate surrounding a particular issue (Kingdon, 2002). The convergence of the three streams offers a *window of opportunity* from which an issue gains prominence as a political priority.

Our exploration of the policy formation surrounding SOP reform in Pennsylvania reveals the problems, policies, and politics involved in crafting the Rx4PA legislation (Figure 1) and included interviews of key informants ($n=12$) involved in the legislative process during the Rendell administration. The following questions guided our research:

1. What state-level concerns compelled Governor Rendell, nursing advocates, and legislators to address APRN SOP restrictions?
2. How did nurses, a professional group with mercurial involvement in the political process, negotiate effectively to help shape SOP reform?
3. What political strategies did proponents and opponents use during the SOP reform negotiations?
4. We begin with a brief overview of Rx4PA. We then provide the results of our qualitative interviews, which were conducted between October 2013 and May 2014. We end with a synthesis of the themes that emerged from our interviews.

Background

Rx4PA: A State at the Crossroads of Reform

On January 21, 2003, Edward Rendell began his first term as Democratic Governor of Pennsylvania following a campaign focused on economic revitalization, improved education, and health-care reform ("The Official Site of Edward G. Rendell", 2016). In 2006, shortly into his second term, Rendell introduced Rx4PA, a sweeping health reform bill that represented a set of strategies focused on controlling cost, increasing access, and addressing

health-care system inefficiencies (GOHCR, 2007; Hansen-Turton et al., 2009). It also aimed to expand insurance coverage to the 800,000 Pennsylvanians without health-care insurance (Burger, 2007). Pennsylvanians were 11% more likely than all other Americans to use the emergency room (Chollet, 2006) and one of every 10 Pennsylvanians above age 18 reported lacking a primary health-care provider (Pennsylvania Department of Health, 2006). Access to health was particularly dire in rural communities, where only 31.5% of PA physicians and 15.2% of the state's registered nurses practice, despite 21% of the state's population living in these settings (GOHCR, 2007).

On March 22, 2007, 11 democratic cosponsors introduced Rx4PA as a large omnibus bill in the PA House of Representatives (H.R. 700, 2007). At the time of its introduction, the PA House of Representatives was democratically controlled, while the Senate held a Republican majority. Because Rendell's proposal to expand insurance coverage was linked to a new 3% Fair Share tax on businesses, it drew an immediate fire-storm of controversy from lawmakers and legislators (Burger, 2007). Many House Republicans were opposed to new taxes (Associated Press, 2008). Other legislators regarded Rx4PA favorably and drew endorsements from a broad coalition of Pennsylvanians including, unions (AFSCME District 47, SEIU), concerned citizens (Pennsylvanians United for Affordable Health Care), and professional health-care leaders (PA Osteopathic Medical Association, The Orthopedic Society; Dale, 2007, 2008).

Despite pockets of support, Rx4PA's introduction as a large omnibus bill failed to move out of the Senate Finance and Banking or Insurance Committees (Phillips Associates, 2007). Subsequently, HB 700 was divided into a number of single-issue bills, three of which were related to APRN SOP reform (H.R. 1253, 2007; H.R. 1254, 2007; H.R. 1255, 2007). By eliminating barriers to APRNs that remained in existing laws and regulations, Rx4PA aimed to improve access to health care, while simultaneously addressing the shortage of primary care providers in the state (GOHCR, 2007). Rendell put his plan to reform SOP into motion after forming the GOHCR, led by Rosemarie Grecco and Ann Torregrossa. Although neither were health-care professionals, both Grecco and Torregrossa had extensive backgrounds in law, policy, and banking (Hansen-Turton et al., 2009).

In addition to the expertise provided by Grecco and Torregrossa, aspects of the legislation pertaining to APRNs were reportedly aided by a white paper, developed by the Alliance of Advanced Practice Nurses (2005), a group of professional nursing organizations in PA. According to representatives of the Alliance interviewed in our study and officials from the GOHCR, the white paper provided an overview of the educational background, practice settings of APRNs, and barriers to care that existed because of outdated laws and regulations (Alliance of Advanced Practice Nurses, 2005; Hansen-Turton et al., 2009) and was used to frame the SOP provisions laid out in Rx4PA.

In their final versions, HB 1253 proposed to eliminate the 4:1 physician-to-NP supervision ratio and change the prescribing of Schedule II controlled medications from 7 to 30 days. HB 1253 also extended the ability of NPs to prescribe Schedule III drugs (medications with moderate to low potential for physical and psychological dependence) and Schedule IV drugs (medications with lower potential for abuse, i.e., Robitussin) from 30 to 90 days.

Additionally, HB 1253 changed regulations to allow NPs to order physical, respiratory, and occupational therapy, initiate dietitian referrals, prescribe durable medical equipment, and issue oral orders in long-term care (H.R. 1253, 2007). For the first time in Pennsylvania law, HB 1254 outlined Certified Nurse Specialists licensure and education requirements and defined their SOP. Finally, HB 1255 granted prescriptive authority to certified nurse midwives. Pennsylvania was one of the last states to bestow this ability (H.R. 1254, 2007; H.R. 1255, 2007; Hansen-Turton et al., 2009). Although the scope bills faced early resistance from organizations, including the Pennsylvania Medical Association (Dale, 2008), after months of negotiation, Rendell and his allies dissuaded their concerns and Rendell signed HB 1253–1255 into law on July 20, 2007 (University of Pennsylvania Almanac, 2007).

Methods

Design

We used qualitative methodology, specifically semistructured interviews (Sandelowski, 2000) to examine the process involved in achieving SOP expansion. The qualitative descriptive design allowed us to capture common and divergent perceptions related to the integration of SOP expansion into the Rx4PA legislation. In addition to our interviews, we gained further background information about the legislation and the surrounding time period, through a review of primary source documents including: editorials, white papers, newsletters, memos, organizational reports, newspaper articles, and fact sheets, related to SOP legislation in the decade preceding and during the period when Rx4PA legislation was introduced.

Sample

A team of three PhD prepared nurse researchers conducted the semistructured interviews (J. M. B. C., D. A. S., and K. W. N.). Interviews were conducted in person (at home or place of employment), by phone, or using Skype electronic communication service. Purposive sampling was used to identify initial participants for the study, with modified snowball sampling to identify additional key stakeholders. A total of seven requests for participation were initially extended in August 2013. During the course of interviews, an additional eight names were provided by participants. A second wave of invitations were e-mailed in October 2013 to these eight individuals, which yielded an additional five participants. In total, we conducted 12 interviews between October 2013 and May 2014. Our use of a flexible, purposive sampling frame with snowball sampling provided participants with an opportunity to participate in the research process by suggesting additional stakeholders. This feature of the research allowed us to gauge a diverse spectrum of participants in the research process and enhance authenticity and rigor in our study design (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Our inclusion criteria required that participants have firsthand knowledge of or were directly involved in the development of Rx4PA.

Each study participant signed a written consent form before the interview. Interview participants represented a broad spectrum of stakeholders representing the Alliance of Advanced Practice Nurses, PCNPs, Professional Licensure Committee of the House of

Representatives, Pennsylvania State Nurses Association, GOHCR, National Nursing Center Consortium, Hospital and Health System Association of Pennsylvania, and Pennsylvania Medical Society (Table 1). Institutional review board approval was obtained from the Office of Research Protections at the University of Pennsylvania.

Data Collection

Two moderators conducted the interviews, one facilitated discussion while the other recorded verbal and non-verbal communication via digital recorder and field notes. The semistructured interview guide consisted of 15 questions moving from general to more specific followed by a series of probes or questions meant to refocus or guide the respondent (Table 2). We began by asking participants about their role in the design and formation of the Rx4PA legislation. After the initial question, participants were asked to carefully reflect on their experiences of coalition building, collaboration, and negotiation process related to SOP change. In addition, participants were asked to discuss techniques used in the policy process that yielded the most benefit. Each interview lasted between 90 and 180 minutes, and all audio recordings were professionally transcribed.

Data Analysis

Thematic content analysis was used to interpret interview results (Hsieh & Shannon, 2005), and inductive approaches were used for coding (Bradley, Curry, & Devers, 2007). Transcripts were first, independently reviewed by two research team members (J. M. B. C. and K. W. N.). A subset of interviews were used to group similar concepts, identify meaningful units, and develop codes. After the remaining interview transcripts were analyzed, we validated findings by independently coding and categorizing the units of meaning. To augment rigor and increase trustworthiness, the full research team discussed coding discrepancies until consensus was reached.

Results

Study participants included 10 women and two men. All 12 interviewees had college degrees and beyond. They came from the central and southeastern regions of Pennsylvania (Philadelphia, Harrisburg, and Reading). Participants expressed a range of views related to the process of enacting of SOP reform. Five salient themes emerged from the interviews.

Theme 1: Laying the Groundwork

While the provisions of Rx4PA related to SOP reform were enacted in 2007, several interview participants emphasized the importance of the many previous years of grassroots advocacy. For APRNs in Pennsylvania, fighting for full practice was not a new endeavor. Interviewees, including a leader in the retail-based clinic industry in Pennsylvania and several members of the PCNP, attributed the eventual passage of Rx4PA to a “Strong ground game and foundation ... [and] decades preceding of calculated nursing political maneuvering.” Another said, “[T]he strategy started all the way back to 1997. So this is a deliberate effort.” Another said, “RX was a culmination of pretty much years of a deliberate attempt.”

Through these statements, our key informants emphasized the importance of grassroots advocacy established prior to legislative efforts and referred to the long history of political activism on the part of APRNs and other key stakeholders in Pennsylvania. Rx4PA was far from the first effort on the part of APRNs to advocate for full practice legislation. APRNs had long been providing patient care, and, in the years leading up to Rx4PA, they were increasingly politically active through their state advocacy organization, PCNP.

In 1977, the rules and regulations for NPs were approved by the State Boards of Nursing (SBON) and Medicine (SBOM), which allowed APRNs to provide patient care (Alliance of Advanced Practice Nurses, 1999; Towers, 1999). Nevertheless, due to a difference in interpretation of the 1977 legislation between the State Boards of Nursing and Medicine, years of protracted battles ensued related to the interpretation of NPs' ability to prescribe without a physician cosignature. In 2000, the Boards of Nursing and Medicine voted to approve the regulations to grant NPs prescriptive authority. This was a hard fought victory; at the time, Pennsylvania was one of only three states (with Michigan and Georgia) where NPs were unable to sign their own prescriptions (Jenkins, 2002). The iterative battles over practice expansions and the eventual passage of Rx4PA were summed up by a lobbyist from the PCNP who stated, "history led up to this point." It was well understood, at least by nursing informants involved in the political process, that enactment of Rx4PA was the culmination of a long political process.

Theme 2: Temporal Trends and External Influences Shape State Health-Care Reform

Participants also noted that factors external to state politics represented influential elements of the agenda setting and policy formation of Rx4PA. One participant noted that, at the same time that Rx4PA was being introduced, broader conversations were also underway over national- and state-level health reform initiatives. One interview participant recounted the temporal trends, including discussions about national health-care reform and its significant influence during discussions over APRN SOP reform: "Remember, what was brewing nationally was the discussion of whether there was ... even in those days, we were talking about, 'Are we going to get to some sort of national health care reform effort?'"

Perhaps even more salient were health reform initiatives occurring in other states, such as those proposed and enacted in Massachusetts under Governor Mitt Romney. When asked about external factors, several participants discussed the influence of state-level initiatives similar to the one proposed in Pennsylvania, stating: "I think they [GOHCR] certainly looked at what was happening in Massachusetts." Another said, "Massachusetts jumped the gun and said we will do insurance reform. So there's a parallel story here ... Rendell tried to virtually do the same thing as Mitt Romney."

One oft-cited flaw of the Massachusetts plan was lack of attention to ensuring an adequate supply of health-care providers to meet consumer demand following the passage of the health reform law (Kaiser Family Foundation, 2012; Massachusetts Medical Society, 2010). One participant pointed to the failure of the Massachusetts plan to address workforce supply as a tool to draw attention to the APRN workforce in PA.

I think we helped them realize that Massachusetts ended up being a disaster because there wasn't enough providers. So it became evident that unless you do something on the workforce side, you're not going to be ready. So that was used as sort of the story about unleashing the nurse practitioners to be ready for reform efforts.

Theme 3: “Carrots and Sticks:” Motivating Consensus Through a Dual-Pronged Approach

The fulcrum of nursing political activism and the national momentum surrounding health-care reform set the stage for Rendell's vision to expand APRN SOP. Nevertheless, internal politics and strategic maneuvering were also necessary to advance Rx4PA. Two key Rendell advisors described the early days of formal agenda setting and policy formulation that went into crafting the pieces of APRN SOP legislation this way:

We had a couple of practices such as we did not engage lobbyists ... [Second], we went directly to the legislators and to the regulators and tried to, started to build relationships ... [Third,] we did talk to associations, that were related to health care like the Nursing Home Association, all the different nursing associations, the Medical Society, and several others.

While the GOHCR began the process with relationship building, setting priorities on the road to negotiations was not straightforward. The GOHCR recognized that, in order to realize the desired changes, it must negotiate with stakeholders that were in opposition to APRN SOP expansion. Hence, strategic negotiations began between key Rendell officials and the Pennsylvania Medical Society, the state's leading medical professional and lobbying body. The GOHCR's first order of business was to draw the Pennsylvania Medical Society to the negotiation table was tackling something important to them: physician malpractice reform. One interviewee explained it this way:

The first assignment he [Rendell] gave us ..., was medical malpractice. And so we started to focus on medical malpractice premium changes and subsidies for physicians because, at the time, we were sort of leading the pack of other states in losing physicians, particularly specialists.

Despite their opposition to SOP reform, the Pennsylvania Medical Society was not completely opposed to Rx4PA and in fact supported several aspects of the health-care reform legislation, including increasing access to care and price transparency to understand cost. However, when it came to NP practice expansion, the medical society objected to changes in the collaborative agreement structure between medical doctors (MD) and NPs. One key informant expressed the views of the Pennsylvania Medical Society this way:

[W]e oppose independent practice for CRNPs; and we think there are limits to a physician's ability to collaborate with x-number of CRNPs ... you can envision a physician sitting in an office someplace overseeing 150 CRNPs spread out all over wherever. Now that's not very likely, but if you eliminated the ratios completely, something like that could be entirely possible.

Despite reservations of its members, the Pennsylvania Medical Society was drawn into the SOP discussions due to a desire to address a long-standing professional concern over

malpractice insurance. Formally known as the Medical Care Availability and Reduction of Error Fund (MCARE), Pennsylvania's state-mandated malpractice insurance was considered particularly onerous due to the high cost of premiums and payment structure. Hence, any overtures to address MCARE became a starting point for negotiations between the administration and the Pennsylvania Medical Society. When asked directly what made the Pennsylvania Medical Society open to discussing APRN SOP, a representative from the Society explained:

[T]here were overtures from the Rendell administration that they would be willing to work with us on using public sources of funding to help offset that increase in [MCARE] in return for some degree of cooperation on Prescription for Pennsylvania.

Another said:

These bills got done because there was a higher power [Rendell] bludgeoning the sides to get something done ... I mean he had carrots and sticks; and he was actively involved in all of this. And I think that's what made the scope bills probably happen at the end of the day.

While the executive branch and GOHCR staff used overt negotiating tactics to build consensus, it was clear that strategies shifted depending on the individual interviewed. For instance, some stakeholders took a neutral stance. One participant recounted their experience serving as a House of Representative Committee member charged with drafting the SOP bill, this participant reported operating from a position of neutrality while serving on the committee, never formally signing onto the single-issue scope bills. When asked about the process, this participant emphasized the importance of maintaining an unbiased stance:

I sort of set myself up as a neutral arbiter. And then I also did not sign on as a cosponsor of any of those pieces of legislation because, again, I didn't want to have myself being aligned one way or the other.

Theme 4: Backchannel Negotiations and Closed Door Conversations

Although some participants maintained positions of neutrality, other political insiders offered differing opinions about the negotiation process. When asked directly about the negotiation process, one interviewee answered, "Honestly, the way it worked was, it was, you know, back office discussions." By "back office discussions," this stakeholder referred to the frequent meetings held outside of official gatherings during the negotiation process. These informal discussions occurred by phone, late in the evenings, and involved a give and take between and within factions. This participant went on to clarify:

So there was a deal even before, and it was really- The joke is- I can't remember where the pub is, but it is a pub; and there's a room upstairs where a lot of negotiations happen, and that's what happened. What is done- I mean, everything in life is real- I mean, there's policy ...; and then there's the dirty politics.

This participant's statement highlights the often murky distinction between policy and politics. However, not everyone was as comfortable with the political maneuvering involved

in getting SOP passed. When asked about the negotiation process, a past president of the Pennsylvania State Nurses Association expressed notable discomfort:

Sometimes it can be a little disillusioning about how you can't get something passed unless you're willing to give. Or they're going to use your bill to stuff something else in it to get that passed, and, it was just a little disillusioning.

Theme 5: Necessary Concessions

In the end, the road to negotiation entailed concessions on the part of all players, including nurse and physician groups. When asked about these concessions, nursing interview participants noted:

[T]he biggest one [concession] I think was the fact that there's still not independence in Pennsylvania, which is why everybody's going back to see if we can get rid of the prescribing authority collaborative agreement because it is a barrier.

Another member of the nursing community added, "What happened with most of us almost right out of the gate was the most controversial things [i.e., CRNA bills] got taken off the table almost immediately."

Another said:

[A]s part of our agreement with the Medical Society, we had agreed ... that for the balance of that legislative session, which would have been 2008, and for 2009 and 2010, that we would not introduce any legislation that expanded our scope of practice.

When asked about concessions, it was also clear that *any* modifications to standing laws related to SOP were viewed by the Pennsylvania Medical Society as a concession. According to an informant from the professional medical organization: "The Medical Society was probably fairly comfortable with the status quo. And so I think all of the expansions that we agreed to were gives as far we were concerned."

Discussion

Our examination of the convergent factors leading up to the passage of Rx4PA revealed the multifaceted elements required for policy negotiation in Pennsylvania. Participant responses highlighted the diverse and at times contradictory beliefs held regarding the keys to achieving SOP reform. While a number of respondents credited years of grassroots advocacy on the part of nurses as a key determinant to the passage of SOP provisions, others contended that the promise of medical malpractice reform held greater sway with key physician groups. In the end, these influences and a range of exogenous factors such as spiraling costs and access concerns motivated diverse parties to welcome APRN scope expansion as a partial solution for Pennsylvania's mounting health-care challenges. These collective factors placed the APRN workforce on the legislative agenda and appear to verify elements of Kindgon's model which suggest that a policy agenda emerges through the confluence of an explicit problem, which motivates actors to suggest alternative solutions

(2003). The confluence of these events, coupled with an increasingly receptive political environment, provided a window of opportunity for legislation supportive of SOP reform.

Perhaps the most crucial factor, however, to passage of Rx4PA was the Governor himself. Participants in our study describe Rendell as a savvy politician, capable of wielding the necessary influence to negotiate with diverse groups. Rendell's ability to address medical malpractice reform, a pressing concern for one of his largest opposition groups demonstrated his ability to wield the authority conferred to him as Governor. From this position of power, Rendell encouraged compromise by appealing to the Pennsylvania Medical Society's internal motivations. Schneider and Ingram (1993) refer to the use of authority and incentive tools as necessary requirements for policy making (Porche, 2012). Our findings suggest that both tools were in play during the legislative negotiations and worked to motivate physicians to participate in the process.

Scholars have also noted that a key determinant in policy formation is timing events in such a way that a powerful political authority is simultaneously interested in advancing an issue or cause (Cerna, 2013; Sutton, 1999). For several decades prior to Rendell's election, professional nursing organizations such as the PA Coalition for NPs and the Alliance worked to craft a message regarding the ability of APRNs to provide safe and effective care. These years of advocacy by professional nurses coincided with Rendell's aim to address Pennsylvania's health-care crises, creating both the context and timing under which policy reform was able to take place. Meyer and Minkoff (2004) note in their work on social movements that the opportunity to effect policy change hinges on the ability to mobilize supporters to advance a particular claim. In the case of APRNs in Pennsylvania who had long fought for greater practice autonomy, Rendell's position in the executive branch occurred at a time when the state grappled with both a shortage of health-care providers and a need for increased primary care services, subsequently creating synergy between context, timing, and opportunity.

Our findings also highlight the importance of capacity building and unification among nursing stakeholders. During the period of our study, APRNs in Pennsylvania were represented by a number of organizations and historically lacked coordination and cooperation. However, during the legislative push to pass scope of reform legislation, diverse nurse leaders and nursing organizations worked together to support the hiring of a professional lobbyist, develop a white paper, define legislative goals, and leverage years of grass roots advocacy. These efforts allowed nursing leaders to speak with a clear voice and with a consistent message (Alliance of Advanced Practice Nurses, 2005).

The passage of revised SOP legislation through Rx4PA placed APRNs in Pennsylvania one step closer to reach full practice authority. It is important to note, however, that in the process of negotiation, concessions were made on both sides. For instance, even with the passage of Rx4PA, APRNs in Pennsylvania continue to practice with collaborative agreements, and following the passage of Rx4PA, APRN professional groups agreed not to seek further practice expansions for the 2008 through 2010 legislative sessions. Subsequently, our results highlight the complex process involved in negotiation for SOP

reform and demonstrate how the combination of good timing, careful political maneuvering, flexibility, and compromise serve as keys in the policy-making process (Haak, 2009).

Limitations

Given the qualitative nature of our study, we are unable to draw associations between the political strategies discussed and the ultimate passage of the legislation. Further, while we were able to capture a wide breadth of perspectives related to the important elements leading to SOP reform, there may be individuals whom we were unable to interview who held diverging opinions. For instance, while we were able to gain access to representatives from the GOHCR, we were unable to interview the Governor himself or officials in his executive office. We also note three of the four authors self-identify as advanced practice nurses and that this affiliation may have increased potential for bias or shaped their review of the legislative process. However, none of the researchers were involved in any way in crafting or developing the Rx4PA legislation and of the three authors, only one practices in PA in a clinical role unrelated to the Rx4PA legislation. This limited role as practitioners in Pennsylvania allowed the research team to maintain integrity and neutrality during the review of the legislative process. Finally, because our interviews were conducted in 2013 to 2014, nearly seven years after the passage of Rx4PA, there is a potential for recollection bias. We attempted to account for this possibility by analyzing data drawn from interviews with a concurrent review of primary source data, including memos, periodicals, and organizational records which allowed us to compare and contrast information provided by participants.

Conclusion

Our results identified a range of influences in policy development pertaining to APRN SOP. Although the policy-making process varies among states, valuable lessons can be drawn from effective SOP negotiations.

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Figure 1.
Adaptation of three streams model.

Table 1

List of Stakeholders.

Organization/company	Membership represented
Alliance of Advanced Practice Nurses (The Alliance)	Formed in 1995 by representatives from the Pennsylvania State Nurses Association, Pennsylvania Coalition of Nurse Practitioners, Pennsylvania Association of Nurse Anesthetists, and PA Chapter of the American of Nurse Midwives, The Psychiatric Advanced Practice Nurses of PA, PA Association of School Nurses, and Practitioners. At the time of Rx4PA legislation, represented 6,000 members.
Convenient Care Association (CCA)	Trade association representing approximately 65 clinics in Pennsylvania and over 95% of the over 1,900 retail clinics nationally.
Governor's Office of Health Care Reform (GOHCR)	Formed in 2003 by Governor Rendell, the OHCR developed and subsequently implemented Rx4PA.
Hospital and Health system Association of Pennsylvania (HAP)	The association comprised 240 hospitals and health system members, as well as other interested health-care stakeholders.
National Nursing Center Consortium (NNCC)	Represents 32 nurse-managed clinics in Pennsylvania and an estimated 150 clinics nationally.
Pennsylvania Coalition of Nurse Practitioners (PCNP)	Represents over 8,700 Certified Registered Nurse Practitioners in Pennsylvania.
Pennsylvania Medical Society	Represents 20,000 physicians and medical students in Pennsylvania.
Pennsylvania State Board of Nursing (BON)	Responsible for the licensure, certification, and regulation of nursing professionals in Pennsylvania. Represents all licensed nurses in Pennsylvania.
Pennsylvania State Nurses Association (PSNA)	Represents over 200,000 Registered Nurses in Pennsylvania.

Table 2

Sample Questions From the Semistructured Interview Guide.

1	What is your professional title now and what was it at the time of the Rx4PA legislation (2007)?
2	What was the general reaction from your organization with the introduction to Rx4PA? Was your organization in support of or opposed to SOP expansions introduced in the Rx4PA legislation?
3	What stance, if any, did your organization take on SOP expansions introduced in the Rx4PA legislation?
4	In hindsight, do you feel that the provisions outlined in Rx4PA legislation in relation to APRN scope of practice were successful? a. If yes, which provisions do you believe were the most successful and which had the most lasting impact? b. If no, why do you feel they were unsuccessful? What alternative strategies would you have supported?
5	What factors do you identify as leading to passage of the SOP expansions introduced in the Rx4PA legislation?
6	From your perspective, who were the key stakeholders in the development and passage of the SOP expansions introduced in the Rx4PA legislation? Who were the key opponents?
7	When considering those most opposed to the legislation, what were their concerns? How was their opposition expressed? (Media, letters to legislators, TV ads)?
8	We are interested in the negotiation process. Can you discuss that process? Who were other major negotiators involved in the process?
9	What has been the immediate and long term impact of the legislation?
10	Please identify major barriers/facilitators to the passage of Rx4PA.
11	Were there any components that you might have liked to see in the bill that were omitted?
12	What were the most contentious aspects of the bill?