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APRN Legislative Change in Pennsylvania: DNP Project Proposal

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Abstract

Current nursing legislation in Pennsylvania places unnecessary barriers on Advanced Practice Registered Nurses (APRNs), thus impacting residents in the state by limiting overall access to health care, and placing financial barriers on healthcare services. To address this serious legislative issue, the aim of this project was to examine current legislation, assess current evidenced-based APRN literature and produce talking points specifically for a group of ARPNs referred to as Clinical Nurse Specialists (CNSs). A literature review table was developed to address evidence about the practice of APRNs and CNSs. The Knowledge to Action framework in conjunction with the Conceptual Model for Nursing and Health Policy were used to direct the proposed CNS legislative change process. A legislative needs assessment in the form of an online survey was developed and sent to all 253 Pennsylvania legislators to assist in forming the talking points to support CNS legislative change in Pennsylvania. The surveys from 8 respondents were analyzed and responses were tabulated using Microsoft Excel spreadsheet. The responses from the legislators were used to revise talking points to be more specific about the issues legislators indicated were important to them in the survey. Talking points were then distributed via e-mail, traditional mail and posted on the Pennsylvania State Nurses Association's website.

Section 1: CNS Legislative Change in Pennsylvania

Introduction

Access to affordable, safe, and effective healthcare is a major concern of the nation. The Affordable Care Act (ACA) outlines the issues and possible solutions. The current legislation in Pennsylvania related to advanced nursing practice sets barriers on the scope of practice for Advanced Practice Registered Nurses (APRN), thus impacting society on many levels. Furthermore, the Institute of Medicine echoed these healthcare needs by strongly recommending that the limitations to APRNs scope of practice be removed, as these barriers inhibit nurses from responding to the impending healthcare needs of the nation [1]. A bold statement made by the [1] asserts that nurses should be full partners with physicians and other healthcare providers in efforts to redesign the healthcare of the nation. This full partnership should include leading advisory boards on healthcare reform, and being active in the policymaking arena [1].

Problem Statement

The current legislation in Pennsylvania related to advanced practice nursing sets barriers on the scope of practice for Advanced Practice Registered Nurses (APRN), thus impacting residents in Pennsylvania by limiting overall access to health care, and placing financial barriers on healthcare services [2]. Access to affordable, safe, and effective healthcare is a major concern within the state. The Affordable Care Act and the IOM outlined these issues and posed solutions for improving access to health care; however, Pennsylvania legislators have intentionally overlooked these recommendations for various reasons and, in doing so, they have closed their eyes to sound evidence-based research. Many states have begun to remove practice barriers to APRNs completely, or in part, by allowing APRNs to prescribe, treat, and diagnose [3]. Pennsylvania is not one of those states and has been strongly opposed to the removal of practice barriers for APRNs. As legislators look toward the future of healthcare in Pennsylvania, it is essential to translate the evidence-based research concerning APRNs into practice within the state.

Purpose Statement

The purpose of this project was to review the current state of Pennsylvania's healthcare access and assess recommended legislative changes to Pennsylvania's nursing practice laws that restrict APRNs from practicing to the fullest extent of their education and clinical preparation. With this project, strategies were developed to educate legislators about APRN practice. One method that was used to educate legislators was brief, critical topics, often referred to as talking points, related to APRN practice in Pennsylvania that are written and explained in such a way that multiple disciplines and professions can understand and comprehend the importance of the issue [4]. A legislative needs assessment survey was developed to assess specific concerns legislators had about APRN practice. The results of this survey assisted with the refinement of educational literature provided to legislators across the state in the form of talking points.

Evidence-Based Research Relevance to Practice and Impacts of Social Change: Pennsylvania APRN Legislation

The current legislation in Pennsylvania regarding advanced practice nursing places unnecessary barriers on APRNs. Evidenced-based research conducted about these barriers to APRN practice delineates the current detriments to health care in Pennsylvania. A compelling report presented by the [2] provided evidence that the state is severely limiting access to health care, which includes both mental and physical care. Forty-eight of the 67 counties in Pennsylvania are considered to be rural, and populations residing within rural communities tend to have poorer health outcomes than those residing in urban areas [2,5]. These areas face healthcare provider shortages and heavily rely on Medicare and Medicaid [2]. Twenty-two percent of Pennsylvania's population lives in a federally designated Primary Health Provider Shortage Area (HPSA) or in a federally designated Medically Underserved Area (MUA) [2,6]. Furthermore, residents in rural communities travel to urban settings for health care, thus taking away local money, sometimes totaling upwards of $50 million in some counties that could be reinvested in the rural communities [2]. Rural communities within the state not only face healthcare access issues, but also economic difficulties due to the lack of providers.

APRNs are in a position to provide high quality, cost-effective health care services to multiple populations [2,7]. The Affordable Care Act guidelines establish policies that will create an influx of consumers into the Pennsylvania healthcare system. This means that the 1.3 million residents who are uninsured and the 683,000 residents who have private insurance will be provided with healthcare coverage, and there will be an increased demand for primary healthcare providers to meet this need [8] Healthcare providers, who are truly lacking in the state despite what physicians may say, will be in demand, and the APRN can efficiently and safely fill this role [2,6,9-11]. Table 1 presents a current overview of supporting evidence about the practice of APRNs. As Florida has projected, removing practice barriers for APRNs will save the state $339 million annually. Florida's older adult population (65 and over) is 16.83% of the total population, and Pennsylvania's older adult population is nearly the same at 15.23%. This is significant to the provision of health care, as older adults tend to consume more healthcare dollars than younger adult populations ($11,000 compared to $3,300 annually) and utilize more healthcare provider time [11]. Clearly, the impact of APRN legislation in Pennsylvania can have numerous beneficial impacts on the healthcare system, communities, and individuals.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
The Nursing Workforce Challenge: Public Policy for a Dynamic and Complex Market [12].	Expert opinion	V	Assessment of federal survey data, and key informant interviews.	Provides evidence that APRNs contribute to producing high quality care, contribute to care teams for expanded access to primary care, coordinate across modalities of care, and provide continuity of care. Also provides evidence that shortage of primary care physicians increases the demand for more nurses to serve as primary care providers.
Moving Forward with Role Recognition for Clinical Nurse Specialists [13].	Expert opinion	V	Authors discussed the role of the CNS and what needs to be done to remove practice barriers to comply with the NCSBN's Consensus Model	CNSs consider human factors, collaborate with other experts in the field, and make modifications to plans that promote measurable improvement in outcomes for patient populations. Changing legislation for the CNS is most difficult, due to rigid state laws and opposition from state medical groups.

Tapping the Potential of the Health Care Workforce: Scope-Of-Practice and Payment Policies for Advanced Practice Nurses and Physician Assistants [14]..	Expert opinion	V	Author is a consultant from the National Health Policy Forum	APRNs practicing in specialty areas can increase access, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases.
The Practice Boundaries of Advanced Practice Nurses: an Economic and Legal Analysis [9].	Cross-sectional study	III	Authors conduct a cross-sectional and time series analysis of the factors that lead to restrictions on APRNs imposed by states.	The authors found substantial differences across the states both in the extent of an APRNs authority to prescribe and in the range of drugs which they are allowed to prescribe. The authors also found a positive correlation across states between the supply of APRNs (i.e., the ratio of practitioners to population) and the State's corresponding practice environment score, which measured limitations to APRN practice.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
A Vision of the Future for Clinical Nurse Specialists [15].	Expert opinion from National Association of Clinical Nurse Specialists	V	Utilized multiple professional organization documents (American Nurses Association Nursing: Scope and Standards of Practice and Scope and Standards of Advanced Practice Nursing, IOM recommendation, and Institute for Healthcare Improvement) to define CNS role.	CNSs provided clinical expertise within a specialty that enabled CNSs to provide expert advanced care in 3 spheres (patient, nurse, system) of influence that positively affected delivery of care in their area of specialty.
Health Care Reform and The Federal Transformation Initiatives: Capitalizing on The Potential of Advanced Practice Psychiatric Nurses [16].	Comprehensive review of literature	III	Multiple data sources (National Sample Survey of Registered Nurses, American Nurses Credentialing Center, American Association of Colleges of Nursing, 2007 APNA and the ISPN survey of APPNs, and 2006 U.S. Census data) were utilized to describe the APPN demographic and work characteristics, employment patterns, geographic distribution, and educational trends.	15,973 APPNs actively engaged in a nursing position (clinically active) in the United States. 61.3% of the APRNs with a graduate degree in mental health nursing are certified with the ANCC. There are 432 advanced practice psychiatric nurses in Pennsylvania based on the ANCC 2008 survey. State regulatory barriers limit scope of practice in many states; only 13 states allow independent practice.
The Effect of State Laws on The Supply of Advanced Practice Nurses [17].	Cross-sectional study	III	Data on state regulations were examined to construct variables that divide states into categories of high and low prescription authority, and high and low levels of professional independence. Data sets had observations for 50 states and Washington, D.C. for the period from 1989 through 1995.	Enrollments in APRN programs are 30% higher in States where APNs have a high level of independence. There is also a positive correlation between states that have a greater professional autonomy and entry into advanced practice nursing. Enrollments in APRN programs increase by 13% in states granting APRNs greater prescription authority. Study indicates that legislation removing practice barriers increased the number of primary care providers through APRNs.

Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants [8].	Expert Opinion with extensive review of high quality studies.	IV	26 Primary care practices in a managed care organization examined analysis of 21 options for controlling health care spending in Massachusetts that included expanded use of NPs and PAs to deliver primary care.	A study of 26 primary care practices in a large managed care organization showed that practices that used NPs and PAs more extensively in providing care had lower labor costs per visit estimated that utilizing APRNs would lead to savings of $4.2 billion to $8.4 billion (0.6% -1.3%) over the period 2010-2020 in the state.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Nurse Versus Physician-Led Care for the Management of Asthma [18].	Systematic Review	I	Randomized controlled trials comparing nurse-led care versus physician-led care in asthma for the same aspect of asthma care were included. Five studies on 588 adults and children were included concerning nurse-led care versus physician-led care. One study included 154 patients with uncontrolled asthma, while the other four studies including 434 patients with controlled or partly controlled asthma. Types for nurses working independently from a physician included: specialized asthma nurse, a nurse practitioner, or a specifically trained nursing professional.	There was no significant difference between nurse-led care for patients with asthma compared to physician-led care.
The Role of The Clinical Nurse Specialist in Promoting Evidence-Based Practice and Effecting Positive Patient Outcomes [19].	Observational survey	IV	Approximately 50 CNSs at one urban acute care institution were given a survey.	Common practice areas that were addressed by CNSs were expert leader, clinician, and educator.
Substitution of Doctors by Nurses in Primary Care [20].	Systematic Review	I	4,253 articles were screened which included RCTs. 25 articles, relating to 16 studies, met inclusion criteria. Nurse practitioners, clinical nurse specialists and advanced practice nurses were types of nurse providers included in the review. The review was limited to primary health care services that provided first contact and ongoing care for patients with a variety of health care problems.	Patient health outcomes were similar for nurses and doctors; however, patient satisfaction was higher with nurse-led care. APRNs produce as high quality care as primary care physicians and produce high quality health outcomes for patients. Cost comparison between physicians and nurse providers could not be determined.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Substantive Areas of Clinical Nurse Specialist Practice: A Comprehensive Review of the Literature [21].	Comprehensive review of literature	III	The aim of the research was to identify practice areas of clinical nurse specialist. Criteria for inclusion in the sample were determined a priori. Data extraction from abstracts was conducted via thematic content analysis. The final sample contained 753 anecdotal articles, 277 research articles, 62 dissertation/thesis abstracts, and 181 abstracts from presentations.	3 common areas of CNS clinical practice were identified: management of care of complex and vulnerable populations, education and support of interdisciplinary staff, and facilitation of change and innovations within healthcare systems.
Clinical Nurse Specialist Practice Patterns [22].	Cross-sectional survey	III	A survey of 1,523 California Board of Registered Nursing Certified CNSs was conducted. Response rate was 62.1% (947). Descriptive and inferential statistics were used to analyze the data and identify patterns in CNS practice.	Rankings of the 5 CNS role components demonstrated statistically significant differences between the roles. Clinical practice was ranked first, followed by education, consultation, leadership, and research. The majority of time in the roles were mainly spent in clinical practice (38.3%) and education (25.7%). 91% of the respondents reported they were most active in the area of consultation. Only 3 of 25 activities done by NP and CNS were unique to the CNS (running support groups, providing psychotherapy, and teaching staff)
Sustaining Excellence: Clinical Nurse Specialist Practice and Magnet Designation [23].	Expert Opinion	V	Using the National Association of Clinical Nurse Specialists model of spheres of influence, focus of articles was on the CNS's contribution to improved clinical outcomes, nurse satisfaction, and patient satisfaction.	Described the role of the CNS in achieving and sustaining Magnet designation in an urban, academic quaternary care center. Presented CNS as flexible within the role to prioritize and respond to needs of patients, staff, or organizations. CNS was essential in implementing innovations and sustaining improved patient outcomes. The CNS role supported the process by which care was delineated, changes were made, and improvements were noted.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review [10].	Systematic Review	I	69 articles based on RTC or observational studies were included that had been published between 1990 and 2008. 37 articles were related to NPs, 11 were related to CNSs and 21 were related to CNMs. 20 were RCTs and 49 were observational studies. Articles included had to have at least 3 supporting studies.	37 studies examined patient outcomes of care by NPs compared with care managed exclusively by physicians. Patient satisfaction, functional status measured as ADL/IADL, rates of ED and urgent care visits, rates of hospitalization and re-hospitalization, mortality rates in chronically ill geriatrics, high risk infants and adults with acute and chronic illness were all equivalent in NP and MD comparison groups. NP comparison groups ranked higher than MD groups in controlling serum lipid levels and blood pressure control. 11 CNS studies included outcomes related to patient satisfaction, hospital length of stay, hospital costs, and complications. Satisfaction among patients on units with a CNS was similar to comparison groups. Cost and length of stay was comparable or better in CNS groups compared to non-CNS care. Complications were lower or comparable when a CNS was involved in care.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Patient Safety and Quality: An Evidence-Based Handbook for Nurses [11].	Comprehensive review of literature	III	CRNAs: 404,194 anesthesia cases across 22 States were examined to assess CRNA surgical safety.	No statistically significant difference between hospitals staffed by CRNAs (without anesthesiologists) versus hospitals in which anesthesiologists provided or directed the anesthesia care.
			CNSs: A RTC examined 194 prenatal infant and 173 maternal home care outcomes provided by a CNS.	The group cared for by CNSs experienced fewer fetal/infant deaths, fewer preterm infants, fewer prenatal hospitalizations, and fewer re-hospitalizations compared to the control group. Cost saving for the group care for by the CNS was estimated to save the hospital 2.5 million dollars.
			RTC of 276 elderly medical and surgical patients and 125 caregivers to demonstrate the effects of a comprehensive discharge planning protocol implemented by a geriatric CNS.	From initial discharge from the hospital until 6 weeks after discharge, the group who had care provided by a CNS had fewer readmissions, fewer total days of re-hospitalization, lower readmission charges, and lower charges for all health care services compared to the other group who did not have CNS services.
			CRNPs: In a RTC 1,316 patients seeking primary care after an emergency or urgent care visit were randomly assigned to either a NP or a physician. In this study the NP had the same independence as the physician.	Interviews with patients and health services utilization data was used and demonstrated that the health status of the NP patients and the physician patients were comparable at initial visits, 6 months, and 12 months. After 2 years, a follow up study demonstrated that patient outcomes were still comparable between NP patients and physician patients.

			A sample of 501 physicians and 298 NPs responded to a hypothetical scenario regarding a patient with epigastric pain.	The physician group was more likely to prescribe a medication without seeking a relevant history. The NP group was more likely to ask in-depth health history questions and obtain a complete health history.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Pulse of Pennsylvania's Physician and Physician Assistant Workforce: A Report on the 2008 Survey of Physicians and Physicians Assistants [24].	High-quality survey with >80% response rate	III	In 2010, physicians and physician assistants licensed under the State Board of Medicine were surveyed during the license renewal period that ran from September to December. Data analysis was completed on valid surveys returned for both physicians and physician assistants. Surveys without a valid license number, duplicate responses and surveys with inactive or expired license numbers were removed.	Results of the 2010 Pennsylvania Physician Workforce Survey demonstrated the lack of rural primary care providers. 30% of rural primary care physicians were planning on retiring by 2015. Of the 9,479 physicians practicing in the state in 2010 only 793 practiced in rural settings.
Status check V: Pennsylvania Rural Health Care [2].	Expert Opinion from State recognized organization, with review of state health data	IV	National and state data are compiled by experts from the PA Rural health Association to assess the health care needs of rural Pennsylvanians	Residents of an area of under service are more likely to be rural, of minority status, poorly educated, living in poverty and have limited access to transportation. 22% of the population resides in a federally designated underserved area. Rural Pennsylvania has approximately one primary care physician for every 663 residents. Pennsylvania is the third largest employer of APRN's. These providers are more likely to work in rural and underserved areas.

Author/Title	Type of Article	Level of Evidence	Sample	Findings
Ranking State NP Regulation: Practice Environment and Consumer Healthcare Choice [25].	Retrospective Study	III	Panel of four doctor ally prepared NP researchers conducted a secondary analysis of the regulatory environment data contained in The Pearson Report 2007, which reflected state and DC regulations as of December 1, 2006. Content analysis of the data identified 12 measures of each state's or district's practice environment that impacted patients' access to care, and safety.	Identified effects of the current arbitrary approach to regulation of NP practice. Analysis of state regulation presented the need for legislators to understand that restrictions on consumer choice are not based on patient-safety concerns or on evidence. Pennsylvania received a "C" ranking and it was noted that Pennsylvania greatly restricted patient choice by the practice barriers placed on NPs.

. Effect of a Clinical Case Manager/Clinical Nurse Specialist on Patients Hospitalized with Congestive Heart Failure.	Retrospective Chart Review	II	A retrospective chart review on 491 hospitalized congestive heart failure patients conducted over a 12 month period examined the length of stay when care management was provided by a CNS.	88 clients' care was managed by a CNS and 403 clients' care was managed in the usual manner without the services of a CNS. The group managed by the CNS had significantly shorter lengths of stay in the hospital (8% decrease) (4.6 days with CNS care and 6.29 days without CNS care) and lower hospital charges (10% decrease) ($8,512 with CNS care and $11, 213 without CNS care) than the group who did not have CNS services.

Table 1: Literature Review Table: APRN Evidence-Based Practice

Project Outcomes

This doctoral project related to APRN legislative change in Pennsylvania focused on the following outcomes:

Produce talking points related to CNS legislation

Produce a survey to assess legislators' educational needs related to APRN practice and analyze the results.

Use results to refine talking points based on survey analysis

Distribute talking points to legislators

Present findings to stakeholder groups

1.1. Definition of Terms

- In this paper, APRN refers to an advanced practice registered nurse, as defined by the National Council of State Boards of Nursing (NCSBN). The NCSBN defined an APRN as a clinical nurse specialist, a certified registered nurse anesthetist, a certified nurse midwife, or a certified registered nurse practitioner [26]. The [26] further defined what an APRN is by focusing on educational qualifications and stated, an APRN "is a registered nurse who has completed an accredited graduate-level or doctoral educational program preparing him/her for practice and who has also passed a national certification exam (p.4)". Moreover, the [26] noted that an APRN is educationally prepared to assume responsibility and accountability for health promotion and maintenance, as well as assessment, diagnosis, and management of patient problems that include pharmacological and non-pharmacological interventions, and that APRNs should practice to the fullest extent of their education and clinical preparation.
- Talking points are contained in policy briefs that are presented to legislators and their support staff [4]. Talking points refer to critical topics that support the expansion of the APRN scope of practice in Pennsylvania and are based upon current, evidence-based research taken from literature reviews [4] Talking points are to be presented in an organized, written manner, typically a one -or two -page document to legislators to explain the major concepts of legislative change [4]. APRNs and other supporters of legislative change can also obtain talking points from the PSNA website to present to their district representatives in a face-to-face meeting. Talking points will be utilized to educate the legislators and the general public about the most important issues related to the removal of practice barriers for APRNs within the state. Furthermore, the talking points are written and explained in such a way that multiple disciplines and professions can understand and comprehend the importance of the issue [4].
- A position statement is an explanation of an organization's stance and/or opinions developed by an internal deliberation process by the organization's governing body [27].
- APRN: refers to an advanced practice registered nurse, as defined by the National Council of State Boards of Nursing (NCSBN). The NCSBN defined an APRN as a clinical nurse specialist, a certified registered nurse anesthetist, a certified nurse midwife, or a certified registered nurse practitioner [26]. The [26] further defined what an APRN is by focusing on educational qualifications and stated, an APRN "is a registered nurse who has completed an accredited graduate-level or doctoral educational program preparing him/her for practice and who has also passed a national certification exam (p.4)". Moreover, the [26] noted that an APRN is educationally prepared to assume responsibility and accountability for health promotion and maintenance, as well as assessment, diagnosis, and management of patient problems that include pharmacological and non-pharmacological interventions, and that APRNs should practice to the fullest extent of their education and clinical preparation.
- Certified Registered Nurse Practitioner (CRNP): As defined by the [26] CRNPs are members of the health delivery system, practicing autonomously in areas as diverse as family

practice, pediatrics, internal medicine, geriatrics, and women's health care, prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CRNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CRNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CRNPs and acute care CRNPs, which have separate national consensus-based competencies and separate certification processes (p.10).

- Clinical Nurse Specialist (CNS): As defined by the [26]. The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities (p.9).
- Certified Nurse Midwife (CNM): As defined by the [26]. CNM provide a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics (p.8).
- Certified Registered Nurse Anesthetist (CRNA): As defined by the [26]. The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons (p.8).
- Advanced practice registered nurse: As defined by the [26]. The title Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner. The title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population (p.9).

Assumptions and Limitations

Due to the lengthy process of legislative change, a major limitation of this DNP project was time. Many factors were dependent upon APRN legislative change within Pennsylvania, including the specific majority party in the House of Representatives and if APRN legislation can be put onto the agenda. Finding sponsors for the proposed bills was also a limitation and directly affected the outcomes of change for APRNs. Due to time constraints, this project focused on immediate actions that impact legislative change, such as policymaker evidenced-based research education and the education of the public about the healthcare benefits of APRNs. It is assumed that these initial steps taken to put change into place will be followed through by the PSNA and will eventually be put onto the House of Representatives Professional Licensure Committee agenda. Time and access to legislators was also a limitation, as providing evidence-based practice education directly to the policymakers required face-to-face time with them or their aides.

Another limitation of this project was the legislative needs assessment. The purpose of this assessment was to obtain information about the current knowledge legislators had about APRNs and APRN practice. The assessment, in survey form, was not based on any previous surveys, as there were none found in current literature. The survey was developed in conjunction with the PSNA. The director of government affairs and the chief executive officer were vital in its creation; however, the validity of the survey was an issue because it has not been previously piloted. This issue of anonymity with the survey was addressed by having legislators go to an online survey where their identity was kept confidential. Although legislators received an e-mail that directed them to the website, their answers to the survey questions was tabulated by the website and their identity wasn't recorded. According to the Survey Monkey's privacy policy and settings,

IP addresses of legislative respondents was not collected or stored in the survey's system or given out to the survey creator [28]. The survey system does not sell or distribute responses collected from surveys to anyone other than the survey creator [28]. Lastly, related to the assessment, a potential limitation was obtaining accurate data about legislators. It was possible that the legislative aides could complete the online survey, thus giving false information about the actual legislators' understanding of the education, role, and scope of practice of APRNs. To assess accurately who was actually filling out the survey, a question was included that asks who the responder is: an aide or a legislator. There was also another selection that allows the responder to mark "other," which prompts the responder to type in a text box. No matter what was selected about the responder, nowhere does the survey ask for an actual name or any other identifying information that could link a legislator's identity to the survey.

Summary

Planning for legislative change is an involved process that encompasses research, stakeholders, providing education and, most importantly, time. It was the intention of this project to set in place initiatives that promote legislative change for APRNs within the state of Pennsylvania. This project involved intensive collaboration with the PSNA and other invested stakeholders to remove barriers to APRN practice in order to provide for the health care needs of the consumers in the state. The foundation for legislative change was rooted in years of documented evidence-based research about the quality of APRN practice. Most importantly, the call for the removal of practice barriers is echoed by numerous nationally recognized health care organizations.

Section 2: APRN Practice

Review of Scholarly Evidence: Barriers to APRN Practice

Background of APRN Issues in Pennsylvania

It is important to note that the term "APRN" is not recognized in Pennsylvania. Currently, the only APRN groups allowed to prescribe in the state are the certified nurse midwives and the nurse practitioners. Due to this fact, most evidence about prescriptive safety in Pennsylvania is based on these two groups. Three APRN groups, the nurse practitioners, the clinical nurse specialists, and the nurse anesthetists are engaged in policy change initiatives. The certified nurse midwives have requested to be left out of the process, as they reported satisfaction with their scope of practice and their representation under the Pennsylvania Board of Medicine. This project focused on the clinical nurse specialist, as the PSNA was the group who represented these APRNs. The nurse practitioners and the nurse anesthetists had their own representation in the legislative process; however, each group was committed to being supportive of each other in the process.

Review of Scholarly Evidence

Generalized findings related to APRNs

Research conducted by numerous agencies found that limitations to the scope of practice of APRNs are a detriment to the healthcare system as well as to the patient [9,12,14,16,26,29]. Table 1 below is a literature review table that presents various levels of research articles related to generalized APRN practice, as well as CNS practice. Table 1 presents findings about APRN practices such as cost-effectiveness, safety of care, positive patient outcomes and high patient satisfaction.

Pennsylvania is the third largest employer of APRNs in the country but greatly underutilizes these nurses [2,6]. Evidence shows that 48 of the 67 counties in Pennsylvania are considered to be rural, and populations residing within rural communities tend to have poorer health outcomes than those residing in urban areas [2] These areas face healthcare provider shortages and heavily rely on Medicare and Medicaid. Twenty-two percent of Pennsylvania's population lives in a federally designated Primary Health Provider Shortage Area (HPSA) or in a federally designated Medically Underserved Area (MUA) [2,6]. Furthermore, residents in rural communities travel to urban settings for health care, thus taking away local money that can be reinvested in the rural communities, sometimes totaling upwards of approximately 50 million dollars in some counties [2]. The [8], the Pennsylvania [2], and the [24] noted that non-physician providers are more likely to practice in rural settings than physicians. The [2] and the [24] collaborated to examine the rates of physicians practicing in rural areas of the state. The two organizations discovered that in 2008, the state had approximately one physician for every 663 rural residents, compared to one physician for every 382 residents in urban areas [2,24]. This data showed that out of the 12,173 primary care physicians in Pennsylvania only 21% practiced in rural areas [2]. Furthermore, the [8] complied research about Nurse Practitioners (NP) and found that there were approximately 83,000 NPs in practice in 2009, making up about 27% of primary care providers nationally. The [8] also noted that nurse practitioners "make up a greater share of the primary care workforce in less densely populated, less urban, and lower income areas, as well as health professional shortage areas (p.3). Lastly, in a survey conducted by the PA Department of Health (2012), Table 2 below represents the number of APRNs working in rural versus urban populations; demonstrating that approximately 19.3% of APRNs practice in rural settings. Based on [6] national research about geographical distribution of APRNs in rural settings, this raises the question of practice restrictions limiting APRN practice in rural areas of Pennsylvania, thus limiting overall access to health care.

Type of Advanced Practice Certification	Urban Counties	Rural Counties	Total
Certified Nurse Midwife	228	53	281
Clinical Nurse Specialist	315	60	375
Certified Registered Nurse Anesthetist	1,813	483	2,296
Certified Registered Nurse Practitioner	1,709	381	2,090
Total	4,065	977	5,042

Table 2: Geographical Distribution of APRNs in Pennsylvania.

Note: From Health Resources and Services Administration. "Health Professional Shortage Areas" (2010). Reprinted with permission.

Based on the American Medical Association's GeoMapping Initiative, the [30] firmly adheres to the belief that scope of practice issues for non-physician providers should not be expanded because physician and non-physician providers "tend to practice in the same large urban areas (p. 3)." The American Medical Association continues to adhere to this belief, even after statistics from healthcare-related agencies speak differently; in fact, this is one major area of opposition from the physician community [2,6,8,24,31].

A wealth of research indicates that physicians tend to work more in urban settings [6,31]. [31] conducted a study of rural hospital CEO's who reported physician shortages from states across the nation, Pennsylvania included. Interestingly, 100 percent of the rural hospital CEO's in Pennsylvania reported physician shortages, compared to a 57 percent national average (MacDowell et al., 2010). The Health Resources Services Administration (HRSA) presented national statistics reflecting areas where healthcare providers tend to work. The data provided by [6] echoed what the other research indicated, that physicians are more likely to work in urban settings. In "remote rural/frontier" areas, the geographical distribution of primary care nurse practitioners is 9.1 %, compared to 4.2 % of primary care family physicians [6]. Unfortunately, the chart only lists nurse practitioners, not all APRNs, most likely because APRNs are not universally recognized by all states at this time.

The Pennsylvania Rural Health Association [2] brought these statistics to a state-level, indicating that nearly two thirds of the state's primary care physicians practice in the five most urban counties in the state: Allegheny, Bucks, Delaware, Montgomery, and Philadelphia; thus adding to the rural health provider disparities, which the [30] denies [2,24]. The refusal to remove practice limitations contributed to 14 counties in Pennsylvania being deemed severely deficient in health services [2]. APRNs are more likely to practice in these rural communities; and, are possibly the best prepared healthcare professionals to care for the diverse needs of the population [2,5,6].

There are numerous reasons why Pennsylvania legislators have been opposed to the removal of practice barriers. Opponents argue that the removal of scope of practice barriers will increase competition to physicians; furthermore, opponents argue that the care provided by APRNs is unsafe. Opponents also state that APRNs lack the needed education to provide healthcare without the supervision of a physician. However, these issues are not based on any evidence-based research. Current evidence-based practice research has demonstrated that APRNs provide safe and effective care. Numerous organizations choose to hire APRNs because research indicates that APRNs will improve patient safety and quality, increase patient throughput, increase physician productivity and provide an increase in continuity of patient care [12,17,20]. A systematic review investigating the safety and quality of care provided by APRNs conducted over an 18-year period provided evidence indicating that APRNs deliver effective, high-quality patient care, have an extensive role in improving the quality of patient care, and can increase access to health care [10]. Lastly, evidence indicates that there is not a relationship between collaborative agreements between physicians and APRNs and the safety of care provided by the APRN [18]. As Table 1 demonstrates, APRN independent practice is safe because of the competency of the APRN, not the supervision from a physician [11,25]. Current literature discredits the argument that APRNs are unsafe in providing care, and also presents to Pennsylvania the need to bring the current legislation up-to-date with best practice evidence in health care.

While many people in the medical community claim that APRNs are not adequately trained to provide safe care, the comparison of education seems to indicate that MDs and APRNs have similarities in many aspects of their coursework and preparation. The advanced practice committee of South Carolina's Board of Nursing presented a comparison of APRN and physician education in their White Paper on Advanced Practice Registered Nurses, and found many similarities [32]. APRNs complete a four-year degree prior to entering into master's work, and physicians complete a three or four- year degree before entering into medical school. Medical students graduate from a four-year medical program and receive a medical degree; whereas, APRNs complete three years of APRN education and graduate with a master's degree in a specialty area; upon passing a national exam, certification in that area is granted [32]. Foundational courses for APRNs include advanced pathophysiology, advanced health assessment, advanced physical assessment, advanced pharmacotherapeutics, and advanced diagnostics [32]. Physician's foundational courses work is in anatomy, physiology, histology, advanced diagnostics, and advanced assessment [32]. During graduate education, APRNs complete 1000 hours of clinical in which they directly manage patient care, and physicians compete a senior year clinical

practicum that involves shadowing and observation of preceptors who may be Nurse Practitioners, CRNAs, CNMs, and physicians [32]. Physicians then complete a residence program in their specialty area involving at least three years with 1850 practicum hours per year. APRNs who have a doctoral degree must complete three to five years of education focused in a specialty and complete at least a 1000hour practicum [32]. This comparison does not mean that APRNs are claiming to be physicians, nor that APRNs want to be compensated as a physician would; it is not even implying that APRNs want to have the title of M.D. or want to be compared to physicians. It is just simply demonstrating that APRNs receive an extensive education and clinical training that allows them to safely provide care to multiple client populations. APRNs are not physicians, rather they are a uniquely skilled group of providers offering holistic, safe, and cost effective healthcare to diverse populations.

CNS Evidence-Based Practice

According to the [26], the CNS has a unique APRN role that integrates care across the continuum and through three spheres of influence: patient, nurse, and system. Based on graduate-level educational training, CNSs possess the skills necessary for independent practice. The CNS is educated to provide multiple levels of both direct and indirect advanced nursing interventions, creating strong, positive, clinical outcomes [15,21-23,26] (Table 1). Graduate-level education provides CNSs with advanced training that includes "knowledge of physiological responses and disease management skills, foreshadowing and symptom recognition awareness, and techniques for reducing unplanned transitions and complication rates" [22,23] noted that there are many similarities between the role of the nurse practitioner and the CNS, in fact, a study indicated that out of 25 APRN activities, only three were specific to the CNS role (running support groups, providing psychotherapy, and teaching staff). This finding is congruent with other reports that indicated that CNSs are educated on coaching, goal setting, and adult learning principles that can be applied in a variety of settings and forums to enhance patient outcomes [21-23]. [21] conducted an extensive literature review with the intent of answering what roles a CNS performs. They found consistent themes that demonstrated that CNS practice is directed towards managing the care of complex and/or vulnerable populations and families. Furthermore, the researchers found in their literature review that three main characteristics of CNS's roles emerged: CNSs manage care of complex/vulnerable populations and families through expert direct care delivery, coordination of care, and collaboration with other health care professionals [21]. The CNS expert practitioner incorporated current, evidence-based specialty care into clinical practice, and produced treatments and care of illness, symptoms, and responses to illness using advanced concepts related to the nursing process [21]. CNSs have the unique training and ability to impact population care across the continuum in three specific spheres of influence and enhance patient outcomes by providing advanced nursing interventions. The CNS role is flexible and allows these APRNs to expand nursing practice to more diverse populations than would a nurse practitioner or nurse anesthetist [23].

Research has been conducted about the safety and quality of care that CNSs provide to patients and patient populations. Specific literature related to the CNS from [11] indicated that in a single hospital system, hospital units who employed a clinical nurse specialist had better patient outcomes, which included receiving more nursing interventions and having shorter hospital stays. Furthermore, [13] noted that the role of the CNS and the nurse practitioner greatly overlap in the aspect of populations served, care settings and core competencies. Research has demonstrated that CNSs are more likely to be engaged in the direct management of patients with specific diseases or conditions, and under the CNS's management of care, patients are more likely to have positive outcomes [10,11,13,19,33,34] Other areas documenting improved patient outcomes related to CNS care include management of clients with diabetes, asthma, wounds, and childhood obesity [13]. [19] noted that CNSs "influence unit-based and organizational practice through direct care in both acute inpatient settings and outpatient areas" (p. 269). Evidence-based practice indicates that CNSs should be utilized in assisting in course correction, when anticipated patient outcomes are not achieved, as CNSs are able to facilitate working towards the prescribed plan of care with both patients and families [10,11,13,19,33,34]. When managing specific patient populations, research has demonstrated that CNSs take into consideration multiple human factors, engage in inter and intra- disciplinary collaboration and accurately modify care plans to provide measurable improvements in patient outcomes [10,11,13,19,33,34] presented evidence indicating that CNSs are highly competent with implementing evidence-based practice that relates to change, mentoring staff through stages of development, and working within systems; furthermore, CNSs demonstrate proficiency in devising creative options to improve clinical practice within their place of employment.

CNSs have the ability to specialize in specific patient populations. Populations in rural areas of the state lack accessible mental health services for numerous reasons including financial issues, geographical issues and lack of mental health providers [2,24,35]. The residents living in rural portions of the state are not able to readily obtain mental health treatment or preventative services, creating widespread health disparities. Co-occurring mental health services and mental health services for older adult populations were the top priorities identified state-wide by counties [36]. Lack of access to mental health care and lack of mental healthcare professionals is clearly a growing concern in Pennsylvania. Psychiatric CNSs, a type of CNS who specializes in the mental health of individuals, families, and communities,

have the unique ability to provide access to safe, cost-effective, high quality mental health care and substance use services [7,16]. There is an extreme need for an expansion in mental health services, and the psychiatric CNS is far too often not recognized as a mental health professional who can meet this need [37]. However, much research has documented that the psychiatric CNS is a licensed provider who has the capability to provide the full array of mental health services, including psychotherapy and medication management in a way that increases access to services, provides cost-effective treatments, and produces high-quality care, especially in rural populations [7,16].

Summary

The current APRN legislation in Pennsylvania is fostering an environment that creates major healthcare access issues, as are already noted in rural communities within the state. [38] stated that two types of errors can happen in a system, active and latent errors, the latter of which could possibly be occurring in Pennsylvania. A latent error happens when factors such as poor system design, poor decision making, and inadequate management come together, beyond the system's operator's control, to cause an adverse event [38]. More dangerous than active errors, latent errors typically go unnoticed in a system and fester until a major, complex problem surfaces. Is Pennsylvania's lack of healthcare access in rural areas a result of latent errors within the healthcare system, fostered by outdated legislation based on the 1985 Nurse Practice Act? It is very possible that this issue will escalate as the ACA provides current uninsured residents with healthcare access. By 2019, it is estimated by the Congressional Budget Office that 32 million individuals will be incorporated into the healthcare system, as research has consistently shown that insured individuals utilize the healthcare system more often than the uninsured [8,39]. In Pennsylvania, this means that the 1.3 million residents who are uninsured and the 683,000 residents who have private insurance will be provided with healthcare coverage; however, there will be a new demand for primary healthcare providers to meet this need [8]. Changes in legislation related to APRNs must occur in order to prevent major, system-wide problems within the healthcare system in Pennsylvania. The CNS, a specific type of APRN, possesses the education and ability to provide safe, cost effective, high quality care to diverse patients, populations, and systems, yet in Pennsylvania; CNSs struggle to provide for client needs due to restrictive practice laws.

Literature Review Table

Table 1 provides a literature review of twenty APRN and CNS related articles summarizing various levels of research related to generalized APRN practice, as well as specific CNS practice. Table 1 presents findings about APRN practices such as cost-effectiveness, safety of care, positive patient outcomes and high patient satisfaction. The table also outlines that safe practice and positive patient outcomes associated with CNS practice. The wealth of literature supports the independent practice of all APRN groups, especially the CNS. Level I indicates that the research is based on systematic review or meta-analysis of all relevant randomized controlled trials. Level V is a weak base of research, usually from the opinions of experts, authorities or expert committees.

Conceptual Framework

Knowledge of Action

Pennsylvania's policymakers should be urged to engage in active evidence-based healthcare policy. Knowledge translation into healthcare policy has a systems thinking mentality, meaning that one views health care as an independent organization with subsystems and assesses how the system interacts as a whole [38]. Systems thinking is prevalent throughout different fields; it is not unique to health care. The design for APRN legislative change in Pennsylvania was based on the Knowledge to Action framework (KTA) as described by [40] as well as the Conceptual Model of Nursing and Health Policy. The KTA, which can be utilized with numerous stakeholder groups, including policymakers, is dynamic and complex. Many phases in the model may occur simultaneously, such as uniting stakeholders, disseminating knowledge and conducting needs assessments [40]. The Model of Nursing and Health Policy furthers the utilization of the KTA by assessing and evaluating outcomes of proposed legislation. [41] model addresses the following:

What social problems are solved?

To what extent stakeholders are impacted

If the target population is impacted

Costs and benefits of the proposal [41]

Figure 1 depicts the fluidity of the KTA model as it applies to APRN legislative change in Pennsylvania and incorporates the Conceptual Model of Nursing and Health Policy to evaluate outcomes within the KTA.

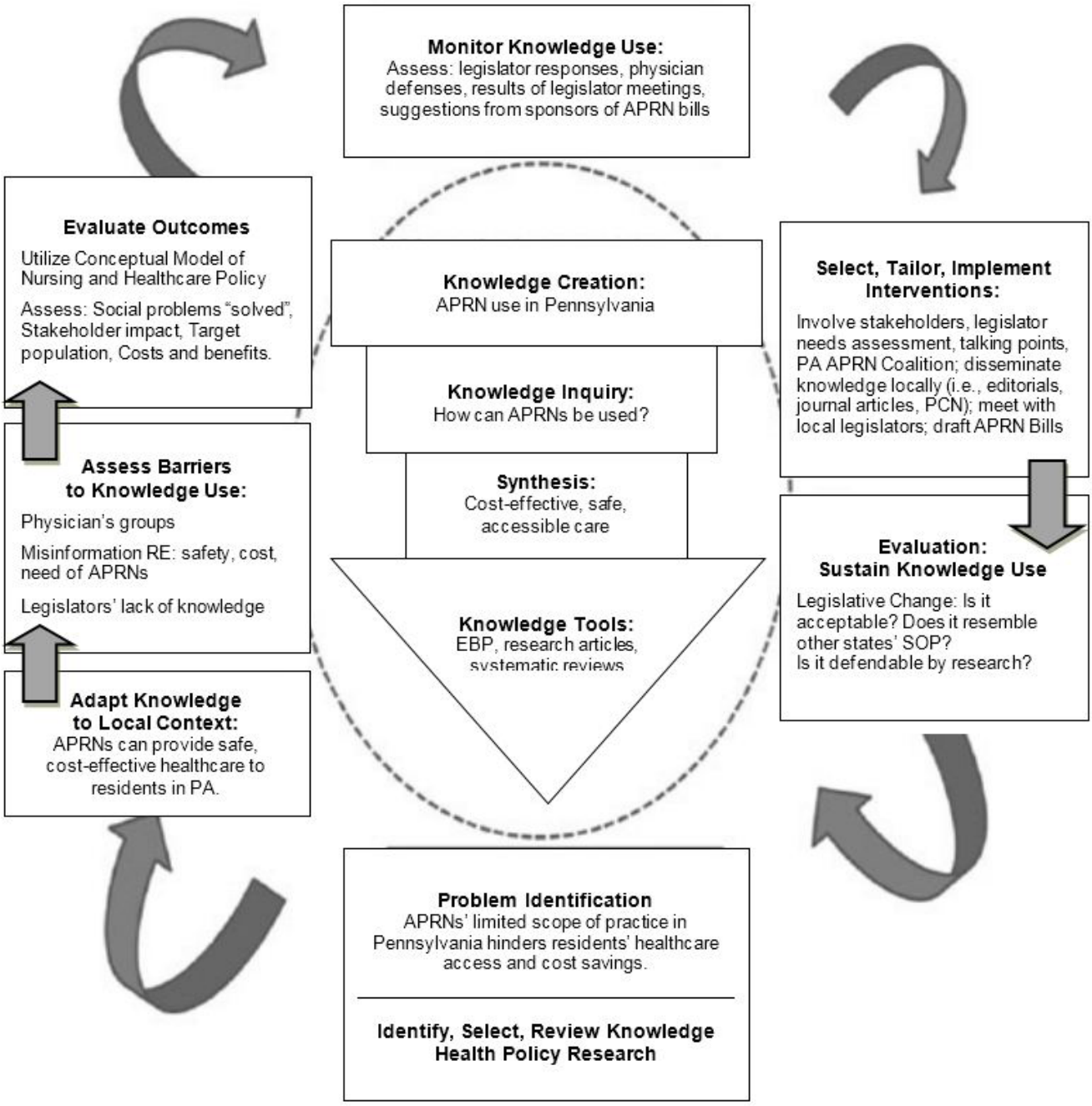


Figure 1: Chart depicting the KTA Framework as described by [40] applied to the Pennsylvania APRN legislative change process with evaluation based on Conceptual Model of Nursing and Healthcare Policy.

By utilizing the Knowledge to Action framework in conjunction with the Conceptual Model of Nursing and Health Policy, legislative change for the APRN in Pennsylvania was assessed. Figure 1 exemplifies this process as a systems model. The KTA framework is best utilized as a systems model when key stakeholders are collaborators in the model and are willing to invest time and resources in the process [42]. A systems model also assesses key stakeholder involvement and identifies the stakeholders who shape the dynamics of the system; as change in one part of the system can create unexpected changes in another part of the system [42]. The core of the model focuses on knowledge creation, inquiry, synthesis, and tools. For this DNP legislative change project, the question is asked about how APRNs can be utilized in Pennsylvania to provide increased access to safe and cost-effective health services. Inquiry and synthesis allows knowledge to be obtained and assessed through reviewing current literature about APRN practice. It also takes into account how APRNs are being utilized elsewhere in the country and the benefits thereof. The KTA's core also identifies tools used in acquiring knowledge, such as systematic reviews, scholarly peer-reviewed articles, and database searches that examine evidence-based practices [42].

In the KTA, after knowledge has been created and investigated, at the core, there begins a process of problem identification: Pennsylvania is limiting access to safe and cost-effective healthcare services by placing restrictions on the APRN. Next, the problem is adapted and placed in local context: APRNs, more specifically the CNS, can provide these services in Pennsylvania if barriers to practice are removed, as research suggests. Issues related to the removal of barriers to practice for the APRN, including opposing stakeholder views, are identified and examined. Some of the barriers to be examined include physician interest group's opposition, legislators' lack of accurate knowledge about APRN practice, and the unfortunate lack of accurate information about the safety of independent APRN practice.

After barriers were investigated, tailored interventions were chosen. For this DNP project, interventions that have been selected focused on the assessment of legislative knowledge about APRN practice by conducting an educational needs assessment, and the involvement of stakeholders to collaborate and form talking points to use in legislative and general public education. Evidence, in the form of brief, generalized talking points, was disseminated for educational purposes. Key stakeholders in support of the change were encouraged to meet with district representatives and discuss these talking points. Monitoring knowledge use involved investigating how the public as well as legislators responded to the dissemination of research. Legislative responses to face-to-face meetings should be addressed by correspondence between nurses and the PSNA, as well as opposition to the presented research. The PSNA encouraged nurse constituents to meet with legislators to address the proposed CNS legislation and report back to the PSNA about the outcomes of the meetings. It was assumed that much of the opposition stemmed from physician organizations. Suggestions from champions or sponsors of the proposed APRN expansion of scope of practice legislation were also taken into consideration at this phase of the KTA model.

The next phase of the KTA addresses the evaluation of outcomes. It was in this phase that the Conceptual Model of Nursing and Health Policy (CMNHP) provided an accurate evaluation process. The CMNHP is further explained in Section III of this paper. The CMNHP, within the KTA, evaluated how proposed legislation aimed to "solve" issues of access to safe and cost-effective health care provided by APRNs within Pennsylvania. Furthermore, the model assessed the impact of policy on stakeholders and on the target population, healthcare consumers within the state. The CMNHP evaluated the prospective costs and benefits of the proposed legislation. Lastly, in the KTA process, sustained knowledge use was addressed. This phase focused on asking if the proposed legislative change is acceptable. In assessing this, Pennsylvania can compare the APRN proposed change to other states' utilization of APRNs. The KTA asked if the proposed change in Pennsylvania resembles other states' legislation. It also assessed if the scope of practice change in Pennsylvania is similar to that found in other states. Most importantly in this phase, the KTA assesses if the legislative policy change is defendable by research, which, in the case of the expansion of APRN scope of practice in Pennsylvania, was most definitely defendable by a plethora of research.

Summary

Three of the four APRN groups in Pennsylvania are uniting to propose practice changes that are founded in evidence-based research, as demonstrated by Table 1. Translating the research into practice was the concept behind the selected models chosen. The KTA is a dynamic, systems-based approach to policy change built on knowledge creation and translation. In this DNP legislative change project, included within the KTA is the CMNHP, which aids in the evaluation of outcomes and addresses healthcare policy impact on a broad social scale. Utilizing these models will assist in the legislative change process. This model is addressed more in depth in Section III, under APRN Policy: Evaluation and Planning. The goal of this project was to produce talking points and provide education to legislators about the health care resources that CNSs can provide to Pennsylvania. Engaging stakeholders in this process was another major component of this project. APRNs within the state are a dramatically underutilized group of providers who have been limited in their practice by restrictive legislation.

Section 3: Approach

Project Design: APRN Legislative Change in Pennsylvania

As legislative change for APRN practice in Pennsylvania is dependent upon numerous variables, legislative change initiatives were developed based on the current literature and guidance from the Pennsylvania State Nurses' Association (PSNA), as well as other professional nursing stakeholder organizations. Short-term success of the project was determined based upon completing a drafted Clinical Nurse Specialist (CNS) legislative proposal, and finding a prime sponsor for the proposal, as well as co-sponsors. Furthermore, the process of seeking out sponsors for the bill was dependent upon providing knowledge to legislators about CNS practice. Other outcomes involved having the proposal presented to the Professional Licensure Committee and having the proposal put onto the committee's agenda for a vote. It is possible that these objectives will not be met during this project due to the uncertainty of the legislative process and the timing of legislation; however, steps to ensure the successful completion of these outcomes were implemented during this project. These outcomes were specific for the CNS because the PSNA has been chosen to represent this APRN group. Other APRN professional organizations have been selected to represent the interests of the nurse practitioners and the nurse anesthetists. To complete the project, the following steps were taken:

- Apply the Knowledge-to-Action Framework in conjunction with the Conceptual Model for Nursing and Health Policy to design a specific program to address legislative change.
- Conduct a legislative needs assessment survey to assess where education about APRN practice should be targeted.
- Disseminate evidence-based information to legislators via talking points based on results from survey.

Stakeholder Involvement

Major stakeholders in APRN legislative change are directly affected by the current scope of practice laws, thus making it essential to have their participation in the change process. Healthcare consumers, healthcare organizations, and individual APRNs are impacted by current restrictive scope of practice laws. It is with these groups in mind that legislators became the target population to produce and enforce legislative change on a state-wide level. Policymakers are influenced by individuals, communities, and professional organizations; these stakeholders must unite to inform policymakers about current evidence based practice that impacts healthcare access [43].

Major stakeholders to be involved in the legislative change process should include the Pennsylvania APRN Coalition, the Hospital Administration of Pennsylvania (HAP), and the Pennsylvania State Nurses' Association (PSNA). Other stakeholders should be identified who are supportive of the expanded scope of practice change, such as the Pennsylvania Rural Health Association, AARP, and other healthcare consumer groups. The first step in creating legislative change was to bring the PA APRN Coalition and HAP together. This happened in September and it was decided that APRN legislation would be drafted. Separate bills will be formed for each APRN group and a legislative sponsor, or champion, for the package of bills were named. During this process, the APRN Coalition continued to meet on a monthly basis to stay informed and engaged in the process. HAP has stated their support, but cannot openly provide lobbyist for the efforts. Talking points were being drafted for each group in support of their proposed legislative changes. This paper focused on the Clinical Nurse Specialist's (CNS) agenda, as PSNA was the representative organization of the CNS group. The talking points reflected current knowledge deficits and needs of legislators, based on a survey that was sent out to legislators in the spring. These talking points were tailored to meet the educational needs of legislators and assisted in providing them with current evidence-based research related to APRN practice.

Program Design

The design for APRN legislative change in Pennsylvania was based on the Knowledge to Action framework (KTA) as described by [40]. The KTA, which can be utilized with numerous stakeholder groups, including policymakers, is dynamic and complex. Many phases in the model may occur simultaneously [40]. Figure 1 depicts the fluidity of the KTA model as it applies to APRN legislative change in Pennsylvania. I have also incorporated into the KTA model the Conceptual Model of Nursing and Health Policy as an evaluative model of healthcare policy.

Evaluation is critical in determining the overall success of a policy. The evaluation of health policy can revolve around two aspects: what is the process in the development of a policy and is the content of the policy in line with current evidence-based practice [44]? Nursing and health policy are intrinsically linked to one another, and therefore, they should be uniquely evaluated in light of one another. The Conceptual Model of Nursing and Health Policy (CMNHP) has philosophical underpinnings focusing on the nursing professions' interest and participation in the field of health policy [41]. The model encompasses five levels of increasingly broad frames of reference for evaluating nursing and health policy, and also links nursing outcomes with health policy outcomes [41]. The levels range from nursing and policy impact on an individual and family to the impact of nursing and policy on all of humankind. Of the five levels, the scope of practice for Advanced Practice Registered Nurses (APRN) legislative change proposal in Pennsylvania falls onto level four. The fourth level represents the

outcomes of health policy on healthcare systems of geographical communities, states, and nations, and it focuses outcomes on the equity of healthcare access, effectiveness of delivery of health care, and the equity of costs and burdens of delivery [41].

Monitoring and evaluation are critical elements in legislative change. The first step in change is developing a policy and evaluating if the policy addressed the outlined objectives [44]. The CMNHP outlines policy and program evaluation criteria that focus on the level the policy addresses, social problems that the policy solves, stakeholder impact, costs and benefits, and the effects of the policy on the target population when the policy is implemented [41]. [41] referred to policy and program evaluation as policy research, which was the application of a policy in specific populations and situations to discover its outcomes. Furthermore, [45] noted that the overall purpose of policy evaluation was to provide policymakers and the public with a sound basis for discussing and judging conflicting proposals and outcomes. After evaluating the APRN proposed legislative change for Pennsylvania using the CMNHP, a clearer picture can be formed of the short-term and long-term outcomes of the bill.

Conducting a Legislative Needs Assessment Survey

A needs assessment focusing on the educational needs of policymakers was conducted, as legislative change truly lies in their hands. Assessing the legislators' current knowledge and requests about further education needs guided the formation of talking points and better direct the dissemination of research findings. The assessment also asked questions to gain information about where legislators obtain their knowledge about health-related issues. The survey also assessed the constituent population, asking if the constituents are more rural or urban. This question guided the information contained in the talking points, as APRNs can be vital in providing services to rural populations. Translating knowledge to action requires policymakers to be educated and knowledgeable, which means providing them with evidenced-based research that specifically meets their diverse information needs. One must also consider and respect policymakers' time and provide them with information that is concise and pertinent to the issue at hand [40]. To be respectful of time, an anonymous survey contained eight questions that assessed legislators' perspectives (see Appendix A).

Sssessing access to the population is essential in designing a needs assessment. Although individuals have limited access to policymakers, collaborating with a professional a nursing organization like PSNA can increase the likelihood of responses. A link to the online survey was e-mailed to the legislators in Pennsylvania, in collaboration with the PSNA that has current Pennsylvania legislators' e-mail addresses. Surveys are by far the least expensive way to collect data, but should be reliable in measuring the data that is collected, and, if possible, used previously with established reliability. No surveys specific to legislators' educational needs have been identified. Through an e-mail information letter, legislators were provided with a link to an online survey (Survey Monkey), where their identity was kept confidential. Although legislators received an e-mail that directed them to the website, their answers to the survey questions were tabulated by the website and their identity weren't recorded. Survey questions, developed in conjunction with the PSNA, focused on assessing if the legislator was familiar with the role of an APRN and the benefits of APRNs, as well as what further information the legislator would requested about APRNs and where the legislator obtains information about health-related issues. The survey utilized general questions about all APRNs, as the language of the all the bills addressed the term APRN. Because the CNS is an APRN, data from the surveys could be applicable to the CNS as well. Data collected from the online survey assisted in developing talking points, which then were distributed to nurses and presented to local legislators in either face-to-face meetings or over the phone.

In order to conduct the survey, IRB approval was obtained. Upon IRB approval, the anonymous survey was sent out via e-mail to PA legislators from the e-mail account of the director of government affairs at the PSNA. The online survey remained open for three weeks and collected data online as each legislator completed the survey. Furthermore, the online survey website, Survey Monkey, automatically collected the data. The data collected was mainly qualitative in nature, which assessed perceived educational needs. The survey results were analyzed by this researcher and the researcher's preceptors from the PSNA. Qualitative and quantitative data analysis was conducted, and the data was presented and stored in a Microsoft Excel spread sheet format. This process aided in the formation and revision of CNS legislative talking points.

Knowledge Dissemination

As mentioned previously, talking points are a critical element in providing legislators with information about the issue at hand. Based on respondent data from the survey, talking points were revised to target specific regions within the state. For example, a legislator may indicate a need for more information about how APRNs can assist in providing increased healthcare access to rural populations. Talking points can be revised and distributed to legislators who represent constituents in rural parts of the state. Once talking points are developed, they can be distributed to stakeholder groups, such as the Pennsylvania chapter of the American Psychiatric Nurses' Association (APNA). Local representation from constituents in specific legislators' districts was essential in grassroots initiatives [25]. The PSNA posted the CNS talking points in their member-only section for their members to access and present to local legislators to provide education about the bill. The PSNA and other professional nursing organizations

encouraged their members to meet with their representatives and discuss the APRN bill. Again, to demonstrate a united front, the use of talking points aided in a cohesive voice among the APRNs.

Summary

Innovative solutions to healthcare reform are at the forefront of our nation's concerns. Pennsylvania is beginning to feel the pressure to provide safe, cost-effective care, yet is currently unwilling to undergo legislative change to implement improved health care. Current legislation is not responsive to the scope of practice barriers to APRNs and is a detriment to patients' access to health care, especially in the rural communities of the state [2,6]. Translating evidence-based research related to the utilization of APRNs into policy can potentially improve access to healthcare, as well as provide safe and cost-efficient care. Providing legislators with first hand reports of how nursing policy issues impact constituents, as well as presenting accurate research-based information can be vital in engaging policymakers in evidence-based healthcare. Furthermore, it is essential for nurses within Pennsylvania to become involved in the legislative process to impact policy change. The Conceptual Model of Nursing and Health Policy guided the nursing profession in this complex and time-consuming process and assist in evaluating proposed legislation. Careful planning involved uniting stakeholders and providing legislators with education about APRNs based on the results of a legislative needs assessment. It is with these steps in mind that this DNP project has been constructed and shall attempt to amend the Pennsylvania Nurse Practice Act of 1951 and update APRN legislation utilizing the concepts of the Knowledge to Action Framework.

Section 4: Findings, Discussion and Implications

Findings

A brief eight question legislative needs assessment survey was developed to assess specific concerns legislators had about APRN practice in Pennsylvania. The respondents were able to complete the survey anonymously, online. The results of this survey assisted with the refinement of educational literature provided to legislators across the state in the form of talking points.

Surveys were sent to all 253 Pennsylvania legislators. The response rate was 3% (8 respondents). Reasons for this low response rate will be further discussed in the limitation section of this paper. Table 3 depicts the survey responses. Sixty-two and a half percent of those surveyed reported that either they had a background in healthcare, or that they had a family member who had a background in healthcare. Thirty-seven and a half percent reported no background in healthcare, and no family members with a background in healthcare. In response to the question "to whom do you rely on a majority of the time for accurate information about health policy and healthcare issues," 12.5% stated they rely on a physician, 12.5% indicated they rely on a nurse, 25% reported they rely on a physician professional organization, 12.5% rely on a professional nurse organization and 37.5% reported they rely on a CEO or hospital administrator. The responses to the question "Based on your knowledge, who is considered an Advanced Practice Registered Nurse (APRN)?" legislators answered CRNP (37.5%), CRNA (12.5%), CNS (12.5%) and CNM (25%) and 62.5% reported not knowing who was considered an APRN. This survey question allowed the respondents to choose more than one answer. Only 12.5% of those surveyed identified all four of the APRN groups as "being considered an APRN."

One respondent only identified a CRNP as being and APRN and one respondent identified a CNM and a CRNP as an APRN. 57.1% of respondents reported that they were unaware of the benefits of APRNs. 25% responded that a benefit of APRNs was the provision of high quality health services, 25% reported that a benefit was the provision of safe healthcare services, 25% reported the provision of cost-effective healthcare services was a benefit, 25% reported a benefit was the provision of accessible healthcare services in rural parts of the country and 12.5% reported that a benefit of an APRN was an increase of positive patient outcomes in acute care settings. 87.5% of the respondents indicated that they were unaware of the national recommendations related to APRNs. One person skipped this question. Respondents selected the topics about APRNs that they were interested in learning more about from the PSNA. 87.5% indicated they wanted to know more about the role of ARPNs. 50% wanted to know more about the educational qualifications of APRNs. 25% wanted to know about the safety of care provided by APRNs. 37.5% wanted to know about the cost-saving potential of APRNs. 37.5% wanted to know more about how APRNs could increase healthcare access. 37.5% wanted to know more about barriers to APRN practice in Pennsylvania. 25% indicated that they wanted to know more about national efforts regarding APRN practice, and 37.5% stated they wanted to know more about the settings where APRNs practice. The survey asked respondents to select the best description of their constituent population, urban, suburban, or rural. 25% of respondents described their constituent population as urban, 50% as suburban and 25% as rural. Lastly, responses to the question "who is taking this survey" indicated that 83.3% were actual legislators, 25% were the legislator's chief of staff, and 16.7% were health policy aides.

Do you or a family member have a background in healthcare?							
Yes	No						
62.5% (n=5)	37.5% (n=3)						
Physician	Nurse	Physician Professional Organization	Nurse Professional Organization	CEO/ Hospital Administrator			
12.5% (n=1)	12.5% (n=1)	25% (n=2)	12.5% (n=1)	37.5% (n=3)			
CRNP	CRNA	CNS	CNM	I don't know			
37.5% (n=3)	12.5% (n=1)	12.5% (n=1)	25% (n=2)	62.5% (n=5)			
In your opinion, what are the benefits of APRNs?							
Provision of Healthcare Services							
High quality	Safe	Cost effective	Accessible in rural parts of the country	Increase of positive patient outcomes in acute care settings			
25% (n=2)	25% (n=2)	25% (n=2)	25% (n=2)	12.5% (n=1)			
I am aware of National recommendations about the use of APRNs.							
Yes	No	Skipped question					
0% (n=0)	87.5% (n=7)	12.5% (n=1)					
The role of the APRN	Educational qualifications	The safety of care provided	Cost-saving potential	How APRNs can increase access to healthcare	Barriers to practice in	National efforts of APRN practice	Settings in which APRNs practice
87.5% (n=7)	50% (n=4)	25% (n=2)	37.5% (n=3)	37.5% (n=3)	37.5% (n=3)	25% (n=2)	25% (n=2)
What type of region best describes your constituent population?							
Urban	Suburban	Rural					
25% (n=2)	50% (n=4)	25% (n=2)					
Who is filling out this survey?							
Legislator	Health policy Aide	Other*					
83.3% (n=5)	12.5% (n=1)	25% (n=2)					
*"Chief of staff" was filled in on both of the surveys.							

Table 3: Survey Results Discussion

Discussion

Although the response rate to the survey was low (3%), valuable information was still gained. The most significant topic that was learned from the responses was the lack of knowledge legislators had about who is considered an APRN and about the national recommendations about ARPNs, such as the ones from the IOM. Half of the respondents also indicated that they were unaware of the benefits of APRNs. This is a significant finding because it most likely means that legislators also do not know about the trends in other states related to the use of APRNs. Most of these changes in other states have been due to the national

recommendations. Another finding that was significant, and that impacted the revision of taking points was the APRN topics that legislators wanted to know more about from the PSNA. The legislators indicated the topic they most wanted to know more about regarding APRNs was the role of APRNs, and they were least interested in learning more about the safety care provided by APRNs and the national efforts related to APRNs. 37.5% of respondents stated they rely on either a physician or a physician professional organization for accurate information about health policy and healthcare issues. It is interesting to know that safety of care that APRNs provide was not a more popular topic of interest to legislators, as this is the argument many physician groups use in opposition to independent APRN practice.

Only one respondent was able to correctly identify the all four groups of APRNs and this respondent also reported having a background in healthcare or having a family member who had a background in healthcare. Knowledge about APRNs needs to be dispersed not only to legislators but also to the general public. Five of the respondents indicated they or someone in their family had a background in healthcare, yet there was still a generalized lack of knowledge about APRNs, their role, benefits of services and national recommendations for their increased role in health care delivery.

Implications

Valuable information was gathered from this survey. The responses from the legislators aided in the revision of talking points. Appendix B contains the talking points. Notable changes included a section added to the talking points that include the benefits of CNSs. An important issue to mention is that the bill that is being proposed specifically deals with the CNSs, so all education contained in the talking points deals with that specific APRN role. The talking points were revised to include a specific definition of APRN as well as CNS, as this was a topic for which a majority of the legislators indicated wanting more information. The talking points clearly state "A CNS is one of the four advanced practice registered nurse groups who have a minimum of a master's degree in advanced practice nursing. The four APRN roles are: Clinical Nurse Specialist (CNS), Certified Registered Nurse Practitioner (CRNP), Certified Registered Nurse Anesthetist (CRNA) And Certified Nurse Midwife (CNM)." To explain the role and education of APRNs, specifically, CNSs, the talking points were revised to state that a CNS: "has passed a national certification exam, and is educationally prepared to assume responsibility and accountability for health promotion and maintenance, as well as assessment, diagnosis, and management of patient problems that include pharmacological and non-pharmacological interventions. A CNS provides patient education that emphasizes wellness, health promotion and disease prevention, which makes APRN access critical in health care models that promote wellness behaviors."

In order to increase the response rate, future surveys should be sent out during a time when legislators are not solely focused on the state budget. Response rates could potentially be increased by sending out surveys at the beginning of the terms in the fall. Furthermore, terms within in the survey should be explicitly defined. The term "background in healthcare," should be further defined in future research in order to better understand what respondents were identifying as a "background." This term was not defined in the survey and could have been interpreted as to include being a physician to having a family member who is in a health career field. In summary, responses from the survey provided valuable information; however, response rates were low, and could be increased with better timing of the survey administration. Clearly defining terms could also provide the researcher with more exact information.

Strengths & Limitations

There were several limitations with this project. The initial limitation was the timeframe in which the APRN survey was sent. Unfortunately, the survey was sent during a time when legislators were reviewing the state budget. It was this issue that was believed to cause the limited response rate of the surveys. Analysis of survey responses were limited in the information obtained due to the low response rate. In turn, this limited the accuracy of how talking points were revised. Although, all of the surveys indicated that more information was needed about the role of APRNs, it is not known how many other legislators felt this way. It was because of this response that the talking points were revised to include more about the role of APRNs. Another limitation with this project was the survey itself. Because there was not a prior survey assessing legislator's knowledge about APRNs the survey was created by this researcher and reviewed by experts from the PSNA; however, the survey was never tested for both internal and external validity.

Moreover, some of the terms contained in the survey could be further defined, such as "background in healthcare." In further surveys these questions could be further clarified by asking specifically about what the legislator's background is in healthcare, or what the legislator's family member's background in healthcare is. Other terms that were not clearly defined were urban, suburban or rural. Their meanings were left up to the interpretation of the respondent. In future research these terms need to be defined to assess more accurately the constituent population. There were several strengths of this project. The survey was created to be respectful of legislator's time and was limited to only eight questions. As mentioned above, the survey was also reviewed by a panel of experts from PSNA. Furthermore, although minimal response rates were hindering, the responses did indicate a need for further information specifically about the role of APRNs. Another strength of this project was the literature review attesting to the major benefits of APRNs, as well as a discussion attesting

to the national organizations' efforts to support expanded APRN practice. This review of literature was put into a chart format and provided to legislators at their request. The talking points indicated the literature in support of APRN practice and stated that the research could be provided upon request.

Analysis of Self as Policy Advocate

Health policy advocacy can be a complicated and complex field for a novice. I became interested in policy advocacy because of one of my doctoral classes that I took at Walden. This was my first experience actually reading legislative documents. Although it took me hours to pull out the intricacies of policies that I was reading, I soon realized that the policies I was researching for the class directly impacted my practice as an advanced practice nurse and as a registered nurse. It was because of the class that I chose to focus my DNP project on policy advocacy. Through the process of finding a practicum site I learned that not all professional nursing organizations are created equal. It was my state nurses' organization, the Pennsylvania State Nurses' Association (PSNA) that could actually take an intern and lobby for my professional interests. This began a year (plus) eye-opening experience in the world of health care policy. Through this experience, I was able to cultivate my skills in reading and comprehending policies, develop summaries of policies, and discuss critical issues about policies with legislators and stakeholders. I was also able to better understand the process of how legislation is created. Pennsylvania has a very complex legislative system, and from creating legislation to getting the legislation passed can literally take years. As I reflect on my abilities and professional development over the last year, I can clearly observe a greater breadth and depth of knowledge in policy advocacy.

I have evolved from sitting in on a board meeting of the PSNA to accepting the position as the Chair of the PSNA's Governmental Relations Committee. Accepting this opportunity was of great importance to me, as my opinions about politics and policy have greatly changed since the beginning of the Walden's DNP program. Even a seasoned member of the nursing community, I must admit that voting in local elections was not ever on the top of my priority list, prior to my project that is. Now, I am keenly aware of the importance of our local representatives and the dire need to communicate to them the interests their constituents. These representatives a become sponsors and co-sponsors of pieces of legislation. Being able to talk to them and present issues of importance from the world of nursing is vital in getting legislation passed. Another professional evolution that occurred in me was the understanding of the importance of my state nurses' association. This organization represents the interests of all the nurses in the state regardless if they are members or not. Unfortunately, only 1-2 % of all nurses in the state belong to PSNA. Promoting and educating student nurses and licensed nurses about the urgency to join this organization has become a passion of mine. As nurses, we represent a vast majority of health care professionals and outnumber most other health care professions; however, with only a small percentage of members, our collective voice is quieted.

Summary & Conclusions

APRNs, specifically, the CNS can have an invaluable and positive impact on the Pennsylvania healthcare system. Currently, barriers restrict the CNS from practicing to the fullest extent of education and clinical preparation. Through an online survey, legislators indicated that they are unaware of national recommendations regarding the CNS. Furthermore, legislative respondents to the survey are also unaware of what APRNs do. Although the sample is small, it is alarming that the role of the APRN was selected more than the safety of care APRNs provide. Typically, safety of care provided by APRNs is a major point of opposition brought to the legislators by medical associations. Although these accusations are untrue and unsupported in the literature, they have held up and completely stopped APRN legislation from passing in other states. This finding impacted the revisions of talking points, which is an educational tool utilized to provide legislators with quick and accurate information about a bill, in this case, the CNS bill. Legislators need to know the basics of what CNSs do and how they can positively impact the healthcare delivery in Pennsylvania. Talking points were revised based on the responses to the surveys and were distributed to legislators via face-to-face meetings, e-mail and traditional mail. Furthermore, the talking points were posted on the PSNA website. Legislators were also provided with a contact number for the Governmental Affairs Department of the PSNA so that they could contact the department with any questions of concerns about the bill or talking points. Providing legislators with an accurate, brief and understandable background about the CNS bill is vital to passing the legislation and getting the barriers to CNS practice removed in Pennsylvania.

Section 5: Final Summary

Overview of the Issue

Legislation in Pennsylvania related to advanced practice nursing sets barriers on the scope of practice for Advanced Practice Registered Nurses (APRN), which impacts residents of the Commonwealth by limiting overall access to health care, and placing financial barriers on healthcare services [2]. Access to affordable, safe, and effective healthcare is a major concern within the state. Although numerous national healthcare organizations support APRN legislative change, and approximately 20 states have passed pro-APRN legislation, Pennsylvania legislators have intentionally overlooked these recommendations for various reasons and, in doing so, they have closed their eyes to sound evidence-based research. Evidenced-based research conducted

about these barriers to APRN practice delineates the current detriments to health care in Pennsylvania. APRNs are in a position to provide high quality, cost-effective health care services to multiple populations, especially rural populations, which comprise approximately 72% of Pennsylvania's counties [2,7]. Another component to this issue is that the Affordable Care Act has established guidelines and policies that will create an influx of consumers into the Pennsylvania healthcare system. There will be an increased demand for primary healthcare providers to meet this increase [8]. APRNs can efficiently and safely meet this demand if legislation is changed [2,6,9,10,11].

Summary of Project Purpose

The purpose of this project was to recommend legislative changes to Pennsylvania's nursing practice laws that restrict APRNs from practicing to the fullest extent of their education and clinical preparation. Strategies were developed to educate legislators about APRN practice through talking points. Talking points refer to brief, critical topics, related to APRN practice in Pennsylvania that are written and explained in such a way that multiple disciplines and professions can understand and comprehend the importance of the issue [4]. Furthermore, a legislative needs assessment survey was developed to assess specific concerns legislators had about APRN practice. The results of this survey assisted with the refinement of talking points, which were used to educate Pennsylvania legislators about APRN practice. It was the intention of this project to set in place initiatives that promote legislative change for APRNs in Pennsylvania. This project involved collaboration with the PSNA and other invested stakeholders. Planning for legislative change is an involved process that encompasses research, stakeholders, providing education and, most importantly, time. The foundation for legislative change was rooted in years of documented evidence-based research about the quality of APRN practice.

Summary of Literature Review

APRNs in all four advanced practice roles provide safe and cost-effective care, according to the review of literature. Research conducted by numerous agencies found that limitations to the scope of practice of APRNs are a detriment to the healthcare system as well as to the patient [9,12,14,16,26,29]. In Pennsylvania APRNs are greatly underutilized, mainly because of restrictive practice laws. Pennsylvania is the third largest employer of APRNs in the country; however, APRNs are not able to practice to their fullest extent of clinical preparation and education [2,6]. This can lead to local money being diverted from rural economies to urban settings, where patients must travel in search of health care. The CNS has a unique APRN role that integrates care across the continuum and through three spheres of influence: patient, nurse, and system. Based on graduate-level educational training, CNSs possess the skills necessary for independent practice [26]. The CNS possesses the educated necessary to provide multiple levels of both direct and indirect advanced nursing interventions, creating strong, positive, clinical outcomes [15,21,22,23,26]. Table 2 summarizes the literature review for both APRNs and CNSs practice outcomes.

Overview of Design

The design for APRN legislative change in Pennsylvania was based on the Knowledge to Action framework (KTA) as described by [40] as well as the Conceptual Model of Nursing and Health Policy. Figure 1 depicts the fluidity of the KTA model as it applies to APRN legislative change in Pennsylvania and incorporates the Conceptual Model of Nursing and Health Policy to evaluate outcomes within the KTA. Translating the research into practice was the concept behind the selected models chosen. The KTA is a dynamic, systems-based approach to policy change built on knowledge creation and translation. In this project, the CMNHP aids in the evaluation of outcomes and addresses healthcare policy impact on a broad social scale. Utilizing these models assisted in the legislative change process.

Translating knowledge to action requires policymakers to be educated and knowledgeable; therefore, providing them with evidenced-based research that specifically meets their diverse information needs was an essential component of this project. A needs assessment focusing on the educational needs of policymakers was developed and conducted. This survey was anonymous and was provided in an online format to be respectful of time and budget. Survey questions, developed in conjunction with the PSNA, focused on assessing if the legislator was familiar with the role of an APRN and the benefits of APRNs, as well as what further information the legislator wanted to know about APRNs. IRB approval was obtained and the anonymous surveys were sent out via e-mail to all Pennsylvania legislators from the e-mail account of the director of government affairs at the PSNA. Data collected from the online survey assisted in developing talking points, which then were distributed to nurses and presented to local legislators in either face-to-face meetings or over the phone. Once talking points are developed, they were distributed to stakeholder groups, such as the Pennsylvania chapter of the American Psychiatric Nurses' Association (APNA). Local representation from constituents in specific legislators' districts was essential in grassroots initiatives.

Summary of Findings

There were eight respondents to the survey, two who were legislator's chief of staff, one who was a policy aide and 5 actual legislators. The most significant topic that was learned from the responses was the lack of knowledge legislators had about who is considered an APRN and about the national recommendations about ARPNs. Four of the respondents also indicated that they were unaware of the benefits of APRNs. The legislators indicated the topic they most wanted to know more about regarding APRNs was the role of APRNs, and they were least interested in learning more about the safety care provided by APRNs and the national

efforts related to APRNs and this respondent also reported having a background in healthcare or having a family member who had a background in healthcare. Knowledge about APRNs needs to be dispersed not only to legislators but also to the general public, as indicated by only one respondent being able to correctly identify the all four groups of APRNs, even though 5 of respondents indicated having a background in healthcare. Table 3 depicts a chart of the survey results. Appendix B contains the talking points, with notable revisions being the addition of an added to the talking points that include the benefits of CNSs. Furthermore, talking points were revised to include a specific definition of APRN as well as a definition of CNS, as this was a topic for which a majority of the legislators indicated wanting more information.

Summary of Implications

This project had both strengths and limitations which can greatly impact future research opportunities. The timeframe in which the APRN survey was sent was limiting. Unfortunately, the survey was sent during a time when legislators were reviewing the state budget, thus, it was this issue that was believed to cause the limited response rate of the surveys. In further surveys, questions could be further clarified by asking specifically about what the legislator's background is in healthcare, or what the legislator's family member's background in healthcare is. Other terms such as urban, suburban or rural should be clearly defined. The meanings of these geographic regions were left to the interpretation of the respondent. In future research these terms need to be defined to assess more accurately the constituent population. A strength of this project was the literature review attesting to the major benefits of APRNs, as well as a discussion attesting to the national organizations' efforts to support expanded APRN practice. This review of literature was put into a chart format and provided to legislators at their request.

Conclusion

All four APRN roles, specifically, the CNS can impact the health care delivery system in Pennsylvania if current practice legislation is amended. Currently, barriers restrict the CNS from practicing to the fullest extent of education and clinical preparation. There is a plethora of research that supports this legislative change; however, Pennsylvania legislation is lagging behind national efforts related to APRN practice. Through an online survey, legislators indicated that they are unaware of national recommendations regarding the CNS. Furthermore, respondents to the survey are also unaware of the role of APRNs and the benefits of CNSs. This is a major issue and hindrance for legislative change within the state. This project intended to provide legislators with specific knowledge about CNSs via talking points that were revised based on survey results. The education of legislators by nursing constituents is a vital step in the legislative change process. It was the intention of this project to initiate the initial steps of CNS legislative change in Pennsylvania.

1. Do you or a member of your family have a background in healthcare?

- ☐ YES
- ☐ NO

2. To whom do you rely on a majority of the time for accurate information about health policy and healthcare issues?

- ☐ Physician
- ☐ Nurse
- ☐ Physician professional organization (i.e. PA Medical Society)
- ☐ Nurse professional organization (i.e. PA State Nurses' Association)
- ☐ CEO/Hospital Administrators

3. What type of region best describes your constituent population?

- ☐ Urban
- ☐ Suburban
- ☐ Rural

4. Based on your knowledge, who is considered an Advanced Practice Registered Nurse (APRN)?

- ☐ A certified Registered Nurse Practitioner (CRNP)
- ☐ A Clinical Nurse Specialist (CNS)
- ☐ A Certified Nurse Midwife (CNM)
- ☐ A Certified Registered Nurse Anesthetist (CRNA)
- ☐ I don't know who is considered an APRN

5. Please select any/all topics you want to know more about related to Advanced Practice Registered Nurses (APRNs)

- ☐ The role of APRNs
- ☐ Educational qualifications
- ☐ The safety of care provided
- ☐ Cost-saving potential
- ☐ How APRNs can increase access to healthcare
- ☐ Barriers to practice in Pennsylvania
- ☐ National efforts of APRN practice
- ☐ Settings in which APRNs practice

6. I am aware of National recommendations about the use of APRNs.

- ☐ Yes
- ☐ No

7. In your opinion, what are the benefits of APRNs?

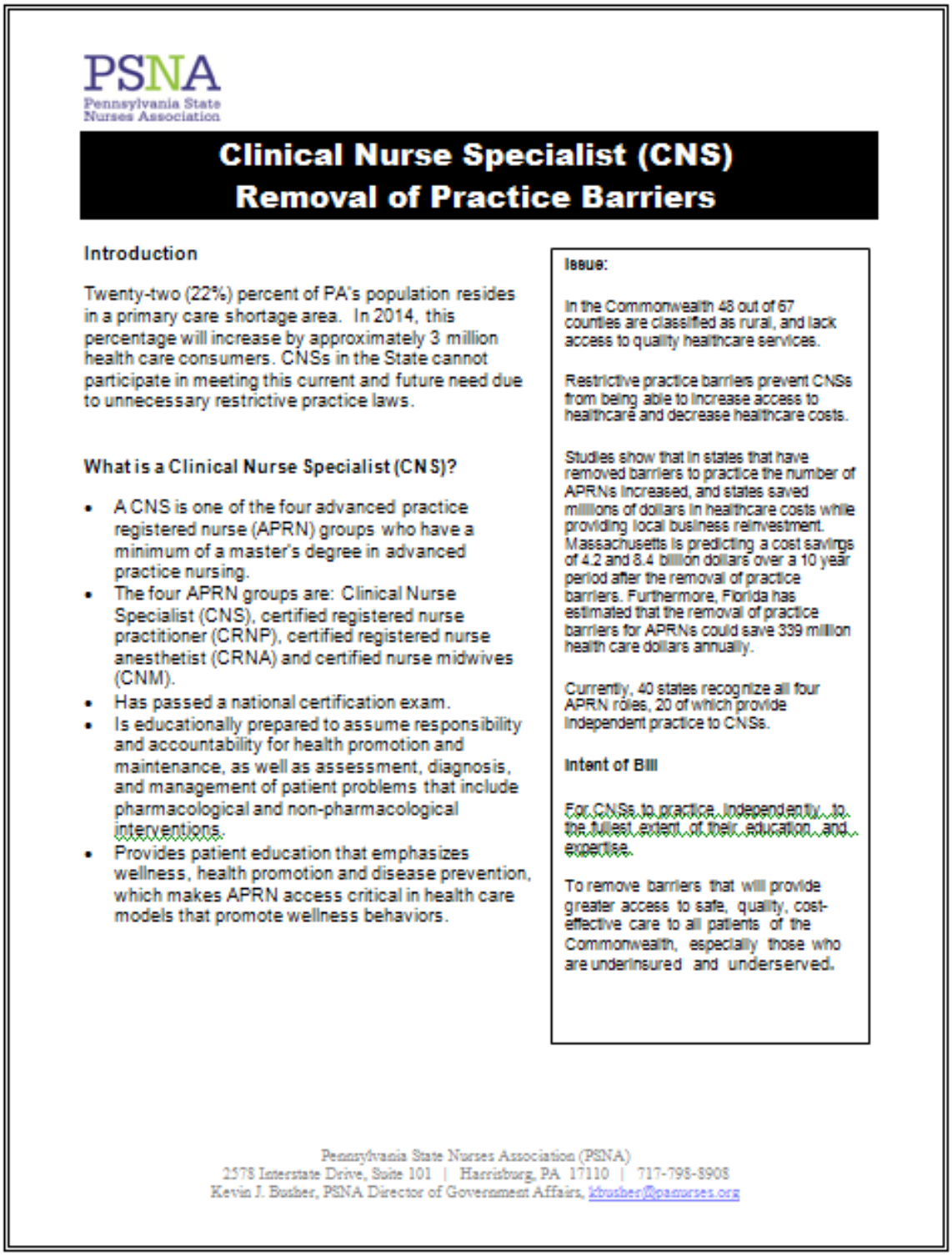
- ☐ Provision of high quality healthcare services
- ☐ Provision of safe healthcare services
- ☐ Provision of cost-effective healthcare services
- ☐ Provision of accessible healthcare services in rural areas of the country
- ☐ Increase of positive patient outcomes in acute care settings
- ☐ I am unaware of the benefits of APRNs

8. Who is filling out this survey?

- ☐ Legislator
- ☐ Health policy aide

Other (please specify) ☐

Appendix A: Legislative Needs Assessment



PSNA
Pennsylvania State Nurses Association

Clinical Nurse Specialist (CNS) Removal of Practice Barriers

Introduction

Twenty-two (22%) percent of PA's population resides in a primary care shortage area. In 2014, this percentage will increase by approximately 3 million health care consumers. CNSs in the State cannot participate in meeting this current and future need due to unnecessary restrictive practice laws.

What is a Clinical Nurse Specialist (CNS)?

- A CNS is one of the four advanced practice registered nurse (APRN) groups who have a minimum of a master's degree in advanced practice nursing.
- The four APRN groups are: Clinical Nurse Specialist (CNS), certified registered nurse practitioner (CRNP), certified registered nurse anesthetist (CRNA) and certified nurse midwives (CNM).
- Has passed a national certification exam.
- Is educationally prepared to assume responsibility and accountability for health promotion and maintenance, as well as assessment, diagnosis, and management of patient problems that include pharmacological and non-pharmacological interventions.
- Provides patient education that emphasizes wellness, health promotion and disease prevention, which makes APRN access critical in health care models that promote wellness behaviors.

Issue:

In the Commonwealth 48 out of 67 counties are classified as rural, and lack access to quality healthcare services.

Restrictive practice barriers prevent CNSs from being able to increase access to healthcare and decrease healthcare costs.

Studies show that in states that have removed barriers to practice the number of APRNs increased, and states saved millions of dollars in healthcare costs while providing local business reinvestment. Massachusetts is predicting a cost savings of 4.2 and 6.4 billion dollars over a 10 year period after the removal of practice barriers. Furthermore, Florida has estimated that the removal of practice barriers for APRNs could save 339 million health care dollars annually.

Currently, 40 states recognize all four APRN roles, 20 of which provide independent practice to CNSs.

Intent of Bill

For CNSs to practice independently, to the fullest extent of their education and expertise.

To remove barriers that will provide greater access to safe, quality, cost-effective care to all patients of the Commonwealth, especially those who are underinsured and underserved.

Pennsylvania State Nurses Association (PSNA)
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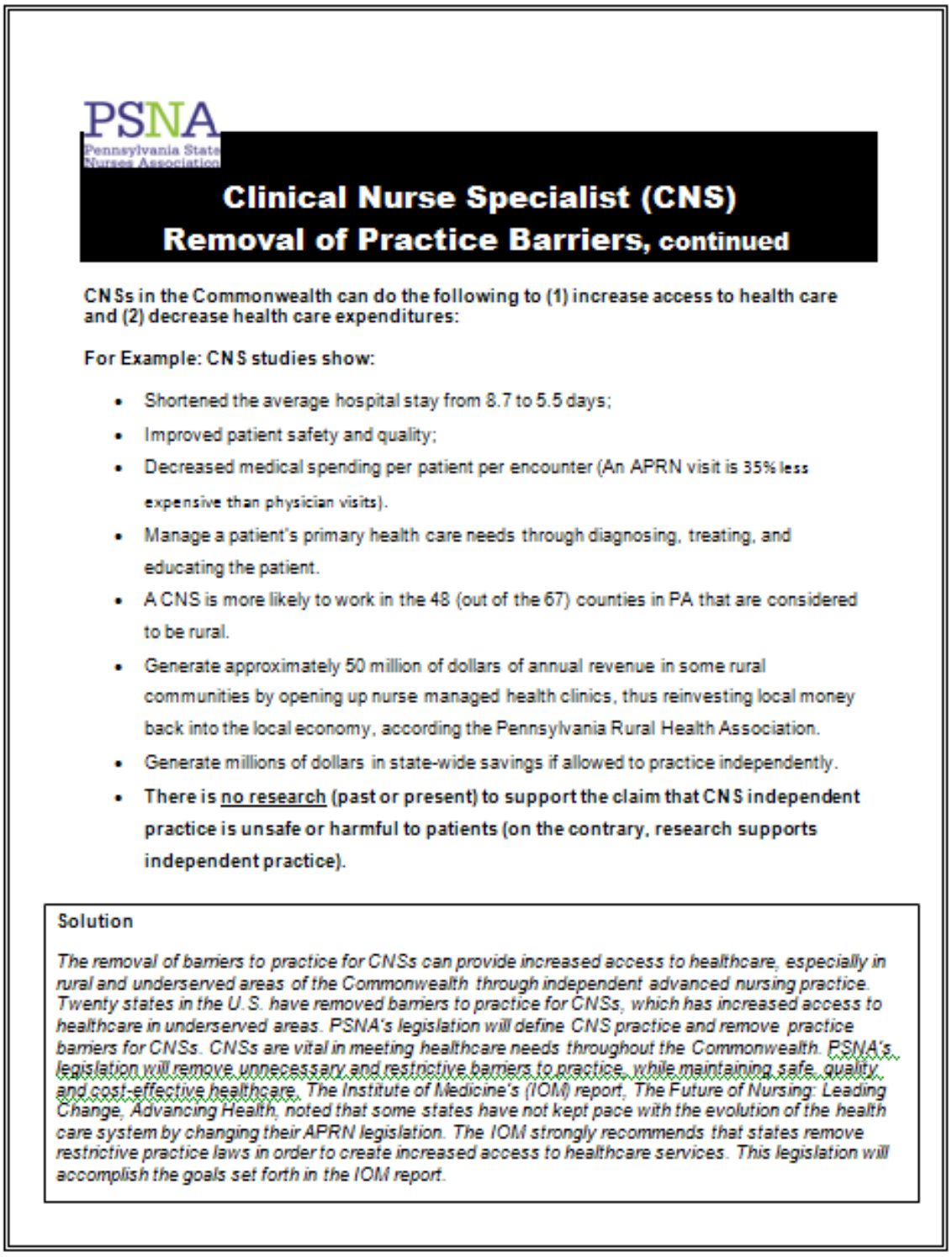

PSNA
Pennsylvania State Nurses Association

Clinical Nurse Specialist (CNS) Removal of Practice Barriers, continued

CNSs in the Commonwealth can do the following to (1) increase access to health care and (2) decrease health care expenditures:

For Example: CNS studies show:

- Shortened the average hospital stay from 8.7 to 5.5 days;
- Improved patient safety and quality;
- Decreased medical spending per patient per encounter (An APRN visit is 35% less expensive than physician visits).
- Manage a patient's primary health care needs through diagnosing, treating, and educating the patient.
- A CNS is more likely to work in the 48 (out of the 67) counties in PA that are considered to be rural.
- Generate approximately 50 million of dollars of annual revenue in some rural communities by opening up nurse managed health clinics, thus reinvesting local money back into the local economy, according the Pennsylvania Rural Health Association.
- Generate millions of dollars in state-wide savings if allowed to practice independently.
- **There is no research (past or present) to support the claim that CNS independent practice is unsafe or harmful to patients (on the contrary, research supports independent practice).**

Solution

The removal of barriers to practice for CNSs can provide increased access to healthcare, especially in rural and underserved areas of the Commonwealth through independent advanced nursing practice. Twenty states in the U.S. have removed barriers to practice for CNSs, which has increased access to healthcare in underserved areas. PSNA's legislation will define CNS practice and remove practice barriers for CNSs. CNSs are vital in meeting healthcare needs throughout the Commonwealth. PSNA's legislation will remove unnecessary and restrictive barriers to practice, while maintaining safe, quality and cost-effective healthcare. The Institute of Medicine's (IOM) report, The Future of Nursing: Leading Change, Advancing Health, noted that some states have not kept pace with the evolution of the health care system by changing their APRN legislation. The IOM strongly recommends that states remove restrictive practice laws in order to create increased access to healthcare services. This legislation will accomplish the goals set forth in the IOM report.

Appendix B: Contains the talking points.

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