



Health Policy

Political Framing: A Strategy for Issue Analysis

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A B S T R A C T

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Political framing is a tool for issue analysis. Reframing the discussion of nurse practitioner scope of practice through purposeful actions includes building a stakeholder coalition and sharing a united voice. This article provides an example for others who are seeking legislative solutions to address barriers to nurse practitioner practice.

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Full practice authority (FPA) is defined by the American Association of Nurse Practitioners (AANP) as “State practice and licensure laws provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications and controlled substances—under the exclusive licensure authority of the state board of nursing.”¹ Currently, AANP designates 22 states plus the District of Columbia as FPA states. The remaining states are designated as reduced or restricted scope of practice states.¹ Legislative efforts are ongoing in these states to remove barriers to allow nurse practitioners (NPs) to practice to the full extent of their education and training. Historically, successful FPA legislative efforts include planning, preparing politically savvy nurse leaders, regular communication with policy teams, grassroots mobilization of stakeholders, and building relationships with legislators.²

In this report we provide an example of how the process of political framing can be used to reframe the issues of practice and licensure. We first define the historical context of licensure laws in a restricted state and then use political framing to analyze the issue. Political framing includes issue identification, consideration of the political frames of the parties involved, and reframing the issue.

Issue Identification: Virginia’s Restricted Scope of Practice for NPs

Virginia NPs practice in a restrictive environment in which a collaborative agreement is mandated and licensing is under the jurisdiction of the joint boards of nursing and medicine. A thorough examination of the issue underlying any policy matter is essential to foster success in shaping policy-driven solutions. The issue should be examined from the following perspectives: historical, legislative context, and resources and economics.³

Virginia’s Scope of Practice

Historical Context

The issue of restricted scope of practice has deep historical roots. The evolution of the NP role is rife with both interprofessional and intraprofessional conflict. In 1917, the landmark legal case, *Frank v. South*, set the precedent of nursing being subordinate to medicine; Kentucky courts ruled that anesthesia provided by nurse anesthetists was completely under the supervision of physicians.⁴ This ruling set the stage for conflict between the disciplines of nursing and medicine.

Intraprofessional conflict also existed. Prominent nurses, such as Martha Rogers, were concerned that the discipline of advanced practice nursing was drawing nurses away from nursing science and into the science of medicine.⁴ Interprofessional and intraprofessional conflict over the role of the advanced practice nurse promulgate the concern of NPs seeking to be physician substitutes. The failure to recognize each discipline’s uniqueness despite overlap in skill set created rhetoric that is difficult to overcome. The historical underpinnings of the patriarchal role of medicine shape the discussion of NP licensure around the country.

Legislative Context

Over the last 5 decades, Virginia has made incremental policy changes aimed at the removal of barriers for advanced practice registered nurse (APRN) practice. In 1975, the first regulations governing the certification of NPs were enacted by Virginia’s newly formed Joint Boards of Nursing and Medicine. Later that same year, the first professional organization for NPs was created, The Nurse Practitioner Professional Practice Group.⁵ This group morphed into the Virginia Council of Nurse Practitioners (VCNP) in 1984; VCNP remains the professional advocacy group in Virginia today.

In 1988, Virginia legislated that NPs applying for license in the state were required to submit verification of passing a national certification examination. Prescriptive authority for Schedule VI drugs was enacted in 1991; 9 years later prescriptive authority was expanded to Schedules III-VI and further expanded in 2006 to include Schedule II drugs. The gradual approach to broadening prescriptive authority to include all schedules required persistence and strategic planning on the part of nursing advocates.

Before a legislative change in 2012, the prescriptive authority statute required that the “supervising” physician “regularly” practice in the same setting as the NP. In addition, medical record review was required for prescribing. Legislation in 2012, replaced the terms “supervision” and “regularly practice” with “physician-led team practice.” This change was met with controversy. AANP supported the Institute of Medicine’s definition of team-based care and emphasized that all members of the team should practice to the full extent of their training, with leadership of the team being “patient directed” and that the legal permission of NPs to practice their profession not be predicated on a physician-linked regulatory structure.⁶

The American Medical Association’s (AMA) stance was that “the best model has physicians in the lead, with care provided by all professionals performing up to their level of training, at the discretion of the physician leader.”⁷ The AMA argued that mandated physician-led teams promoted safety as opposed to allowing physician substitution.⁷ This change in the language of the bill reflected a regression to the historical alignment of members of the medical profession as supervisors of the practice of nursing professionals.

VCNP, however, promoted the new language as an incremental change consistent with the state’s political will and historical context.⁸ During the 2018 legislative session, for example, the Virginia legislature adopted changes that authorized NPs with 5 or more years of practice under the existing state’s requirements to practice without a collaborative agreement. The joint board oversight between Nursing and Medicine and other elements of the law remained intact.

Socioeconomic Factors

Resources and the economics associated with any issue are important considerations and often drive discussions surrounding proposed solutions. The 2014 Federal Trade Commission (FTC) report,⁹ “Competition and the Regulation of Advanced Practice Nurses,” endorsed the removal of barriers to FPA for NPs. The FTC cited that restricting NP practice impedes on the consumer’s access to high-quality health care, thereby reducing a free marketplace.⁹ The savings is the result of several mechanisms including the elimination of costly collaborative agreements, the financial incentivization of physicians to enter agreements, the reduction in malpractice claims, and the reduced rate of reimbursement for NP-led care.¹⁰ Of particular interest in Virginia, NPs historically provide care to underserved populations and would offset the increasing primary care provider shortage in the state.¹¹

Access to care is a highly debated political issue in Virginia. The issue gained even greater prominence when Governor Ralph Northam, a physician and strong proponent of Medicaid expansion, chose to focus his administration on health care equity. As noted previously, a thorough examination of the issue provides context and understanding of the broader political climate to frame discussion of practice and licensure issues. The state’s political climate and interest in improving access to quality affordable care can provide the focal point for moving forward. By using the shared interest in issues surrounding improving access to care and availability of quality affordable care, the effort to better align licensure

requirements with the national standard threads with the broader state policy conversations. After an issue analysis is completed, the next step is to create a policy solution that is guided by a theoretical model.

In the historical, legislative, and socioeconomic context, Virginia, like other states, demonstrates need to provide patients with full and direct access to NP care and modernize licensure laws, but the issue analysis reveals differing views of stakeholders. Further examination of these views and existing constructs can provide insight into frameworks that can be used to advance licensure reform.

Theoretical Framework

The issue analysis demonstrates opposing views held by organized medicine and nursing, including sectors within the nursing profession. These views can be aligned with existing political frames. Political frames are considered units of analysis in policy research and are described as “a package of ideas”¹² or “a central organizing idea.”¹³ Framing is used to create understanding and shared language around the forces that influence human decision making in the policy process. It precludes that policy is a social construct and is intimately tied to values and beliefs held by both individuals and society at large.

Frames have long been used to organize social constructs and make sense of societal norms. Their use generates considerable insight into the nature of policy debates and why discordance occurs when 2 opposing frames are presented. Framing is an active approach used by researchers and policymakers to understand and interpret ideas through cultural, societal, and psychological constructs.¹³ But frames are more than just collections of ideas. They are often used as “weapons of advocacy”¹⁴ to raise the emotional quotient of the policy issue. Recognizing the frame used is critical as frames drive what decision makers discern to be facts and how to balance competing facts to create compromised solutions.¹⁵

Framing the Issue: Medicine and Nursing Frames

The same themes are used by both medicine and nursing (quality and safety and interprofessional teams) when discussing autonomous licensure for NPs. Nursing’s frames generally state that removing barriers to practice for NPs will improve access to care by providing high-quality care, whereas medicine’s frame states that FPA for NPs will result in adverse patient outcomes. Regarding interprofessional teams, the nursing frame is that all health care providers are an integral part of the health care team and that leadership of that team is fluid, depending on the patient’s particular needs. This is in direct opposition to medicine’s frame, which holds that high-quality health care teams require physician leadership. To overcome these opposing frames, the issue needed to be reframed for stakeholders.

Creating the Solution: Reframing the Issue

The examination of the issue and identification of competing frames determines the legislative solution that is most likely to be successful for the stakeholders involved. The frame frequently used by organized physician opposition seeks to portray NP education as inferior to physician education, and therefore, unsafe.¹⁶ Talking points frequently make direct comparisons between NP education and physician training.¹⁷ The direct comparison of education can result in role confusion for stakeholders. The comparison is made to create the perception that the NP’s education lacks consistency and rigor; therefore, NPs provided unsafe care. Refuting these claims is essential to make progress with the legislative change.

Strategy for Reframing

Using Evidence

Nurses involved in legislative work must rely on outcomes evidence from completed research and models of regulation aimed at creating consistency in graduate nursing education to support the quality of care provided by advanced practice nurses. In 2008, the APRN community created the Consensus Model as the profession's standards for APRN practice and to ensure consistency in advanced practice nursing licensing, accreditation, certification, and education. The standards created by the Consensus Model ensure that NPs all meet minimum requirements as part of their education.¹⁸ Drawing on evidence from a breadth of sources, including the Robert Wood Johnson Foundation's "Future of Nursing Report,"¹⁰ the FTC advisories,⁹ and nursing outcomes research from the last 50 years, is critical.^{19,20} States may also need to draw from policy think tanks and state data to underscore the applicability of national data to the state. Reframing is possible by providing evidence to contradict falsities of inadequate training and unsafe care.

Another strategy nurses can use to counter the physician substitution claim is to purposefully reframe the role of the team in health care. Medicine's frame that physician-led care is "indisputable, given the extent of knowledge, training and experience" that only physicians can offer patients, is in contradiction to major work on team care.²¹ Nursing's messaging on team-based care can pull from works such as the Institute of Medicine's 2012 paper "Core Principles & Values of Effective Team-Based Health Care" to underscore concepts that high-functioning interprofessional teams where leadership of the team is fluid depending on the patient's needs are most appropriate.²² Discussing the overlap in underlying core education and skill sets between health care providers and the contributions each bring to patient care can also be valuable in coalition building.

Building a Coalition

In addition to educating legislators and stakeholders about the role of the NP, successful reframing requires using a variety of channels to inform stakeholders. These efforts, including grassroots communication, media campaigns, and direct engagement with legislators, take time and need to be in place before introducing legislation. Influential external stakeholders that can help reframe the issue include health and hospital systems, patient's advocacy organizations, and other health care provider associations. These stakeholders see these issues from their own frames and can bring fresh perspectives that policy makers may not have previously considered.

AARP, for example, an organization that represents millions of Americans seniors, believes that patients deserve more choice in their health care and that NP-delivered care can help its members live healthier lives with more affordable care options. This stakeholder frame has assisted policymakers to see the licensure issue through the frame of a large voter/patient group. Building this coalition of internal and external stakeholders is an important step in uniting the voice behind legislative efforts.

Using a United Voice

Intraprofessional collaboration among the various nursing organizations creates a robust campaign and casts a wide net to capture the support of stakeholders, constituents, and legislators. Nursing organizations using consistent messaging from a centralized source help create a clear message to legislators during the reframing process. Nursing advocates may find that working with a

public relations firm to create and disseminate content ensures consistency and facilitates engagement among all those working to achieve a shared legislative objective. Content to consider includes templates for letter writing campaigns, social media messaging, scripting for legislative phone calls, advocacy training videos, and coaches/mentors at scheduled nursing lobby days.

Coordinated efforts among the broad nursing community to host local legislative receptions and schedule ongoing nursing presence at the capitol are additional strategies for reframing the issue for policy makers. Increasing the visibility of nurses by writing letters to the editor, providing television and radio interviews, and using a centralized advocacy website for consumers are effective tools to reframe the issue for the public and garner patient/voter support for legislative efforts. Intraprofessional collaboration can foster a critical mass of support among constituents and work to capitalize on the referent power of nursing.

An Ongoing Process

Modifying policy is an essential component of the legislative process. Static and outdated licensure laws have led to the patchwork of patient access we see today, and the evolution of the profession will mean that continued changes will be needed in the future. Using principles of reframing will serve the NP community throughout these transitions. Work by Kingdon²³ and Longest²⁴ demonstrate specific forces used in creating legislative momentum and delineate the stages of the policy-making process. Longest proposed a "Model for Health Policy Making in the United States."²⁴ The model was originally intended to describe the federal system. However, the model can also be applied to the policy-making process used in state, county, and local governments. Because the process is cyclical, policy modification occurs when the consequences of existing policies feed back into the agenda setting and legislation development phases and starts the process over again.

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