CHAPTER 3

A Policy Toolkit for Healthcare Providers and Activists

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Overview

What is the role of healthcare professionals in the political process? Given the range of issues, where does the political process begin and end? Healthcare policy is centered around the notion that all healthcare providers require a fundamental understanding of the healthcare system that is not limited to the knowledge required to practice their discipline. No longer can healthcare professionals be prepared solely for clinical practice. They must ready themselves to deal with the economic, political, and policy dimensions of health care because the services they provide are the outcome of these dynamics.

Objectives

- Define the role of healthcare professionals in policy advocacy and politics.
- Describe processes for becoming a policy advocate within one's own organization, profession, and community.
- Recognize the difference between expertise and internal and external advocacy in relation to stakeholders.
- Apply the concepts of health policy to case study vignettes.
- Develop one's own toolkit for becoming a health policy advocate.

Professional nurses and other allied health practitioners must have a seat at the policy table, but they must also understand the perspectives of their colleagues; therefore, we have used contributors from outside of nursing, including allied health professionals, activists, politicians, economists, and policy analysts who understand the forces of health care in America. The rationale behind an interdisciplinary approach is that no one person has the right solution to the challenges confronting health care in America. These challenges include high costs, limited access, medical errors, variable quality, administrative inefficiencies, and a lack of coordination.

It is not surprising that the healthcare system is under serious stress and that a host of actors both within and beyond the system have myriad solutions to the problem. This text offers current and future healthcare practitioners who are committed to reducing health disparities and achieving healthcare equality insight into how clinical practice is derived from regulations and laws that are based on public policy and politics. This chapter suggests that politics is both necessary and critical to making changes, whether we are discussing system-level reforms (e.g., national health insurance reform) or a local hospital improving health data access (e.g., electronic medical records).

This chapter provides healthcare practitioners a toolkit, or a working model, of how to "do" policy advocacy within and beyond our organizational lines. The toolkit is based on the ability to answers these questions: What is the health professional's role in policy advocacy and politics? What are the major distinctions in affecting policy through the two primary areas addressed in this text? This chapter examines two broad components of policy change: the influence and power of stakeholders or constituencies, and the power of expertise. Although these arenas overlap, here we examine them separately to portray their specific roles more accurately.

What, then, is the healthcare practitioner's role in the political process? Where does that process take place? In this chapter we examine the dynamics of the process. Many traditional views define the political process as external only, primarily defined at the policy-making levels of government or boards and commissions; therefore, the argument follows that professionals below senior-level decision makers are primarily reactive; that is, they respond to proposals from up the line and must calculate how to implement changes that others have imposed on them.

In public administration this has traditionally been defined as a politics/administration dichotomy; that is, political decisions are made by higher ups, and the administrator finds a way to carry out those decisions. That dichotomy, however, is not reflective of reality because in actual decision making and in the practicalities of day-to-day management, policy shaping and implementation within a given organization are the result of interactions at all levels of the organization. The administrators are trying to influence policy outcomes, like those in the policy arena. It is time that practitioners do the same.

There is another reason why practitioners must develop a political/policy toolkit. Politics and policy making are not a function only of the external environment of the organization. In fact, the most sophisticated and nuanced elements of such a policy/political role can also be found in the internal environment of the organization. Again, practitioners can play a role in influencing these outcomes.

Imagine the following scenario: Your senior executive pulls you aside one day and says, "Do

you know that proposal you've wanted to push forward about how we reallocate the staff here in the organization? Well, why don't you put together the budget, a time line, and what we need to do to move this forward in the next budget cycle?" You have been anxious to do so for some time, and you stay in the office every evening detailing the proposal (with fancy pie charts, a time line, personnel requirements, etc.), and you turn it in to your executive.

A week goes by, and then two then three. You are getting anxious; to start some of the time line issues you would need to get rolling soon, but you've heard nothing. You mention it to the executive and she nods, looks solemn, and asks you back into the office. She sits on the edge of the desk (not behind the desk, not a good sign) and pulls out your proposal. You can see it has lots of red marks throughout. The executive shakes her head and says, "Well it really is a great idea; it really is the way to go in the future, but I ran it up the line, and well, you know, politics got in the way. It's just not going to fly!" She hands back your proposal. You return to your office and open the file cabinet of other projects that didn't get off the ground, and you think, politics!

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Why didn't it fly? What could have happened? Senior managers did not like the proposal? It competed with other proposed changes that could fly. What kept yours from flying? Perhaps it was because you had not accounted for the politics of your own organization. Politics exist at the organizational level, not just at the policy-making level, and you did not take into account those considerations. Thus, our approach in this chapter suggests that the politics of the environment are both external and internal.

We suggest that the key to gaining more effective use of the policy environment, both inside and outside the organization, is to understand more effectively the power that one has to effect change. Unlike many analyses of power that are often based on the individual, our approach is to examine the organizational power that exists for the practitioner/advocate. We examine that power through two broad lenses: the power of stakeholder relationships and the power of expertise.

Figure 3-1 is a simple heuristic about power. This pyramid has been widely used in political science and policy fields for years. Power can be seen in the levels of the pyramid, with the narrowest (and thus the weakest) type of power at the top of the pyramid. It becomes broader with more effective types of power. The power to make others do things is obvious, from the actual use of force (including weapons) through the more common use of force in an organization, which is the power of the organization to enforce rules, standards, and practices. Influence is more nuanced, but its role is also obvious. Does the organization have the capacity to convince others that they should support or acquiesce to the organization's decision? There are many reasons an organization may be able to influence a decision. Possibly the organization has shown the capacity to be successful; maybe the organization has demonstrated knowledge or connections to accomplish the

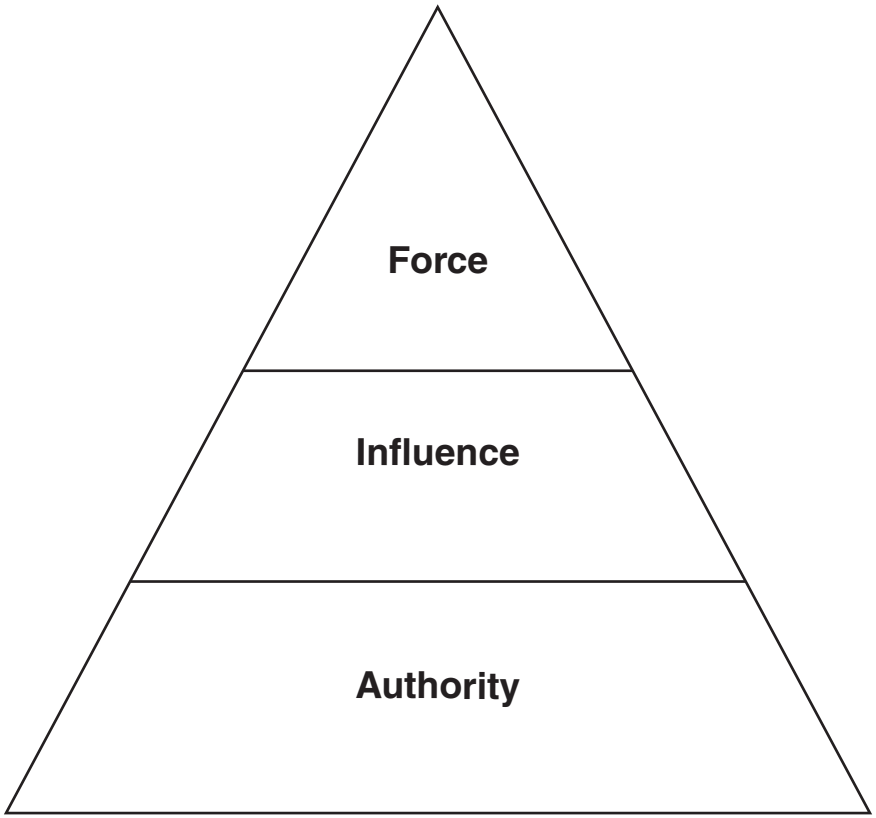

Figure 3-1 The Power Pyramid.

required tasks. Nevertheless, the organization must convince others that its decisions are good. Finally, the broadest and most critical part of the pyramid is authority. At the core of a lot of political theory is authority—the acceptance of the organization to decide and the acceptance by others of its decisions without serious question. Expertise is one form of authority. It is clear that in some situations the expertise of the organization, its professionals, or the policy implementation of that expertise is simply accepted—but that is not always true!

One example of how all three elements of the power triangle work is when you are driving your car late at night and you stop at a red light with nobody around. There you sit because a light bulb with a red cover is on. Now, that is power! Do you recognize why you stopped? Did you have to be convinced? (Maybe you think for a second that lights regulate traffic, but it is the middle of the night and there are no cars around.) You do not run the light right away because you first look around to see if there is a police car around. Now all three elements are in play. You stopped at the light in the first place because it turned red, and you stop at red lights.

Thus, how do we understand our power in organizations? There are multiple

elements—from the regulatory environment, the level of federalism, the growth of the state, and so forth. Here we summarize two broad elements that undergird the organization's power: stakeholders and expertise. We are going to distinguish between internal and external power (power within the organization and beyond) (see Figure 3-2).

Stakeholder Power

For many in the healthcare arena, stakeholder power is the most obvious political tool. A simple "who do you know, who is on our side" model of developing policy change is obvious. Too often, however, our approach is to simply add up the influential players on our side and the other side. The stakeholder list becomes a roster of names rather than the nature of power relationships. If it is just a matter of numbers, any policy that is supported by a greater number of individuals or organizations should prevail. Under those conditions, we would suggest that a national health system that is effective for the poor would be the easiest to pass, but we know that organizations representing low-income groups have less influence than those representing high-income groups. It therefore cannot be just numbers!

Stakeholder analysis is tied to the network of stakeholders and which sets of stakeholders are closer to your organization and which are more

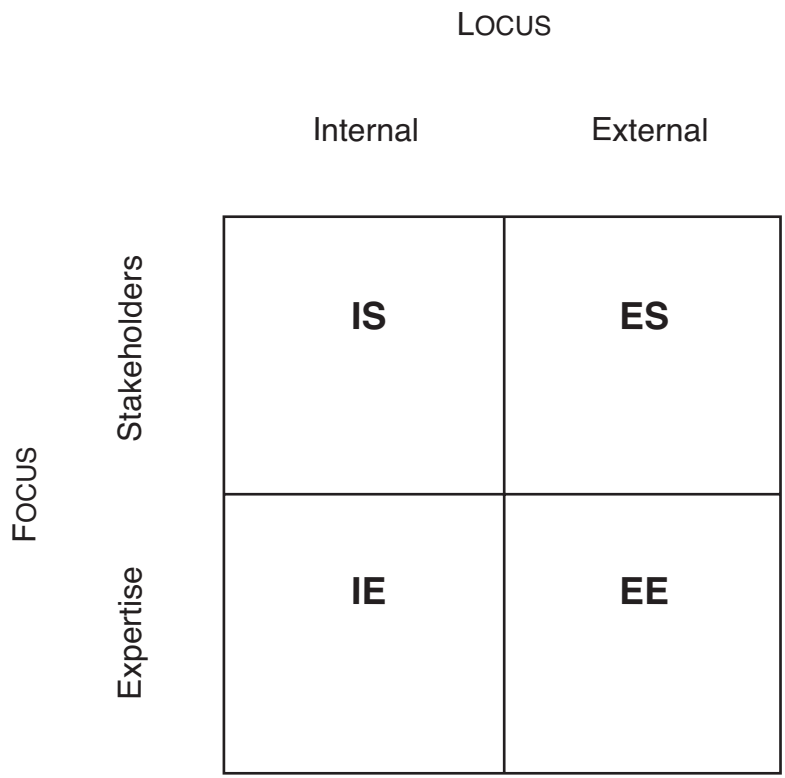

FIGURE 3-2 Focus and Locus of Organizational Power.

distant. This close/distant issue is often defined in terms of natural and face-to-face relationships—ideally, which groups deal with your agency or policy arena on a routine, constant basis and which groups deal with your organization on a more limited basis. Thus, the classic stakeholder map often has concentric circles of groups and organizations that are closer and further away from the organization based on the level of interdependence and organizational closeness (Fottler, Blair, Whitehead, Laus, & Savage, 1989). If you represent a veterans' hospital, for example, members of veterans' organizations, such as the American Legion or Veterans of Foreign Wars, are more central to your organization, but if you are working at a children's hospital, that organizational tie is irrelevant. Thus, understanding how central other stakeholders are to the organization may be the first part of a stakeholder analysis (Figure 3-3).

To understand stakeholder power for an organization, one must define it in terms of organized stakeholders. When working with various healthcare organizations, we often hear

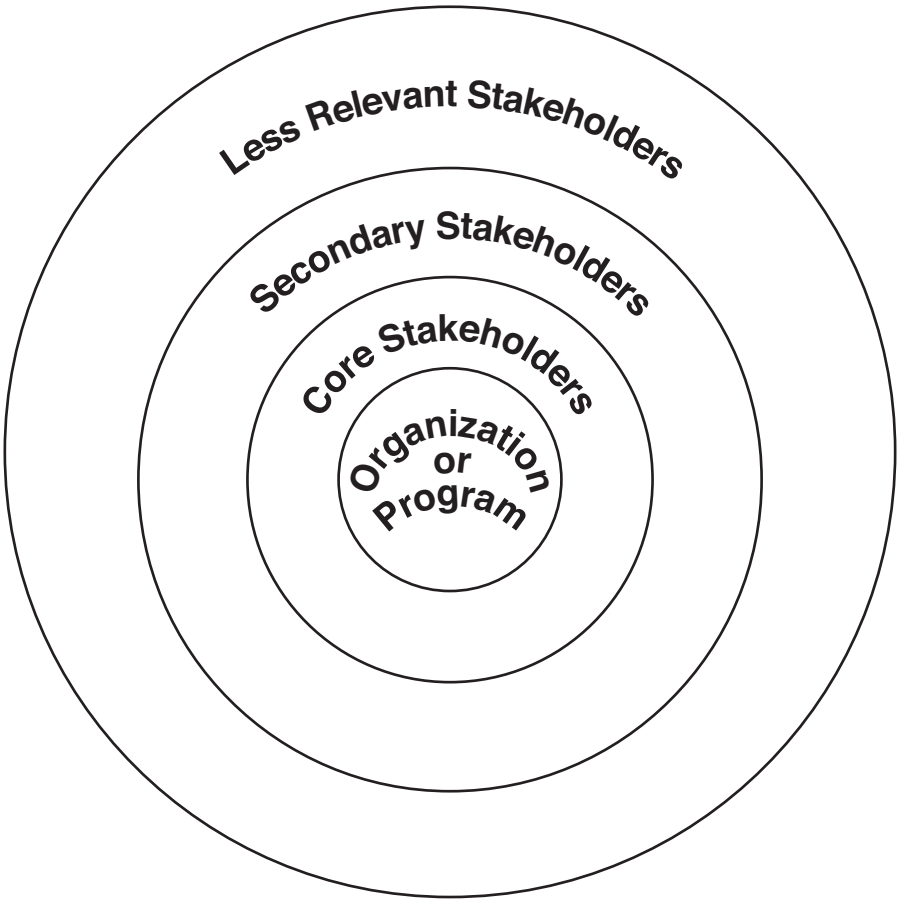

Figure 3-3 Simplified Stakeholder Map.

stakeholders described in individual terms (e.g., patients or customers), but the key is to recognize the importance of having stakeholders who are organized and have well-defined structures. For example, *veterans* is a vague definition for a set of stakeholders, but the American Legion or Veterans of Foreign Wars are two critical organized groups that represent veterans.

What if there is no organized set of stakeholders? The first question might be, why is that true? Perhaps the stakeholders in the external environment that your organization deals with are too amorphous to be defined. In James Q. Wilson's (1989) terminology, you may represent a majoritarian organization that has no discernible set of constituents or stakeholders other than the public. If that is the case, stakeholder power will be more limited for your organization. At the other end of Wilson's stakeholder organizational model are client agencies whose power is defined heavily through a strong relationship with a single client group. In those cases, the organizations must seek to avoid being captured by that single clientele group (Wilson, 1989).

However, we have found that many organizations have developed stakeholder groups over time (often for nonpolitical reasons), which generates some level of influence. One of our favorite examples comes from outside the healthcare arena—police departments. If one thinks about natural constituents or stakeholders, a police department's most obvious stakeholders are those who commit crimes—we are not sure how to build a stakeholder group there! Over time, police departments have developed a host of support organizations, including neighborhood watch groups. The reason they are created is not to influence political decisions about police departments, but strong neighborhood watch groups (organized across a city) can become a critical secondary stakeholder group for a police department. Who organized those neighborhood watches? Generally, police departments took the lead and the neighborhood watch groups typically support what is being proposed by the police department.

The example of a children's hospital is appropriate here. One might argue that on a day-to-day basis, the constituents of such a hospital are the patients. They are children, but maybe we would include the parents. What about parent groups? Generally, they have limited interest in being stakeholders of the hospital; in fact, they want their children to get well and leave the hospital. What about children suffering from a chronic illness or a long-term disease such as cancer? Most hospitals have developed parent and childrens groups that get together periodically to support each other (and to provide additional information to the hospital and to other patients and their families about coping with the illness). If the hospital's outreach department has helped organize the group so that it establishes officers and meeting dates, the group is organized! Is it the same as a veterans' organization? Clearly not, but it would be wise to include such a group in any efforts to advocate for policy changes (inside and beyond the hospital).

Finally, we suggest that most professional groups have delineated additional ways to develop clear stakeholder relationships because they have a stake in what happens within the day-to-day operations of an organization. In nursing, for example, the American Nurses Association (2013) has created an advocacy network and has detailed how to expand the relationships with both nurses and other stakeholder groups in the field. Additionally, the National League for Nursing (2013) offers a Public Policy Advocacy Toolkit to guide

nurses, nursing students, and nursing faculty through the levels of governmental actions. To understand the advocacy role, one must see the importance of the professions' own expertise, to which we now turn.

Expertise

What is expert power in an organization? Some define it in terms of knowledge acquisition and professionalism. Thus, an expert organization would have a large proportion of highly educated professionals, defined by advanced education, licensure, professional norms and ethical standards, and a lifetime of continuing education. The healthcare arena has a clear advantage here. The various professions within any existing healthcare arena are often complex, and they have specialized education, training, and licensure at virtually every level of professional delivery of services. Such professionalized organizations often begin with a noticeable advantage over other organizations in which there is little or no professionalized work force because of their expertise that lends added weight to their advocacy positions.

Thus, any definition of organizational expertise must begin with the nature of the expertise of the organization and whether it is well developed and professionalized and of the highest educational standards; however, one must be careful about defining this power simply as a set of acquired educational or professional standards. In the end, it is a bit like a traffic light—all the diplomas, certificates, and licensures do not necessarily mean the expertise is perceived as powerful. Similar to the number of stakeholders not being as important as the proximity of stakeholders to the decision makers, not all experts carry equal weight when it comes to organizational decisions.

What is the key to this expertise? It is the perception of others that the expertise is legitimate. Many healthcare professionals blunder here because they believe a variety of graduate and professional degrees automatically leads to support of their expertise. To put it in simple terms, many occupations (especially in the healthcare arena) are licensed, certified, and with advanced education, but they do not have equal expertise power. Why? Maybe because the public or the broader political and policy environment does not differentiate the various specializations, or the expertise of the profession is recognized strongly only by the profession itself. The public tends to understand expertise hierarchically. The expertise of physicians carries more weight than other professionals within the healthcare system.

The best example today is the widespread public agreement about the need for more nurses. How does that translate generally? The public does not differentiate well between LPN, RN, diploma, AD, BSN, MSN, NP, CRNA, CNS, or advanced practice nurses. But it does see the difference between a general practitioner in medicine and a specialist in oncology. What is the difference? We suggest that the public is convinced (generally through well-defined efforts by the medical establishment) that there are differences in behavior in the various medical specializations and that some of them have more expertise power because the public perceives them as more expert. Why is that not as true in nursing? We think part of the explanation is that the nursing profession has been reluctant to publically emphasize the differences among the various areas of nursing professionalism. We suggest that this limits the political capacity of the various specializations to garner separate political support.

Buresh and Gordon (2000) proclaim that nurses are not recognized as a profession because they do not educate patients and their families, friends, and communities about nursing work. If the voice and viability of nursing were commensurate with the size and importance of nursing in health care, nurses would receive the three Rs: respect, recognition, and reward. These authors expound that if the work of nurses is unknown or misunderstood, then nurses cannot be appreciated or supported and cannot exert appropriate influence in health care. They go on to say that the general public needs to know what nurses do today and why their work is essential.

> Those in a position to influence legislation, policy making and funding must know that health care environments rich in nurses promote high levels of health whereas understaffed settings put patients at risk. They need to be aware of the incipient tragedies awaiting patients when nurses are not available to prevent falls, complications, errors in treatment and care or to rescue patients in need. (Buresh & Gordon, 2000, p. 18)

An example of how nurses fail to communicate their expertise can be found in the simple example of dress. Professionals are often recognized by their attire or uniform. The behavior and dress of nurses today tend to downplay professionalism by blurring the identity of nurses and making the place of nursing in health care more ambiguous. In healthcare settings, it is often not easy for patients or families to pick out who is a nurse and who is not. Buresh & Gordon (2000) proclaim that without a protocol to provide clarity, it is up to individual nurses to convey who they are through their appearance, behavior, and language. It has become a common practice for nurses in hospital settings to not tell or show their last name on name tags. Physicians would certainly not do this. When members of the largest healthcare profession (nurses) opt out of the standard professional greeting, they risk communicating that they do not regard themselves as professionals (Buresh & Gordon, 2000).

Can you imagine hospitals saying today, as they did 20–30 years ago, that they cannot afford to staff with registered or BSN-prepared nurses? What has pushed that bar? The Institute of Medicine's report on the future of nursing recommends that we "increase the proportion of nurses with a baccalaureate degree to 80 percent and double the number of nurses with a doctorate by 2020" (Institute of Medicine, 2013, p.1).

Thus, exerting expert power in an organizational setting must also include addressing some important issues, not the least of which is the belief that the expertise of the particular set of professionals has a valid place in the policy environment. When policy is being made internally, such as in a hospital, about how practices are implemented, changed, evolved, or reorganized, is the profession you represent at the table in the discussion? If not, why?

We all understand how professions develop expertise over time. They have specialized degrees, certifications, accreditations, licensures, state associations, and so forth. For the nursing profession there is no higher recognition than a Magnet designation for a healthcare organization. The American Nurses Credentialing Center's Magnet Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice. The organization says, "Consumers rely on Magnet

designation as the ultimate credential for high quality nursing" (American Nurses Credentialing Center, 2013, p. 1).

It is agreed that it is important for excellent nursing care to be recognized and rewarded, but why don't all healthcare organizations have Magnet status? Many hospitals have tried and failed, others elect not to go for Magnet status. What does that tell us about this professional issue? It is still desirable but not everyone is doing it; therefore, it is controversial. Many healthcare institutions cannot afford the Magnet journey. For others, they cannot meet the level of nursing education and expertise that is required due to size, location, and so forth.

Thus, as we develop the toolkit for expert power, we must ask a critical question: Who believes this expertise of a profession is valued and should be represented in the decision-making process both within and beyond the organization?

Toolkit Case Studies

The case studies included in this toolkit chapter are designed to aid the reader in understanding the politics of organizational power. They are divided based on four categories: external stakeholder, internal stakeholder, external expertise, and internal expertise. Each of these real-life case studies illustrate how health professionals have applied the tools as highlighted within this chapter. The case study authors have included references, when applicable. To guide your comprehension and application of the toolkit, the authors have included several thought-provoking questions at the end of each case study. Readers are encouraged to critically analyze the political methods and power used in each case study, exploring the stakeholders and type of expertise involved. The questions following each case study are helpful for group discussion and individual analysis. This chapter concludes with one additional case study that has not had any political result to date, and readers are asked to analyze that case in terms of how one might build the necessary political stakeholder and expert power.

External Expert Power

The first two cases are doubtless well known to readers, but what may not be well known is the history of policy development in these areas. As you examine these two case studies, remember that their purpose is to show the role of expertise in affecting policy.

Case Study

External Stakeholder Power: Margaret Sanger as Nurse and Public Health Advocate

Ellen Chesler

"No gods, no masters," the rallying cry of the Industrial Workers of the World, was her personal and political manifesto. Emma Goldman and Bill Haywood, Mabel Dodge, and John Reed were among her earliest mentors and comrades. Allied with labor organizers and bohemians, Margaret Sanger first emerged on the American scene in those halcyon days at the turn of the 20th century when the country seemed wide open with possibility, before world war, revolution, and repression provided a more sober reality.

She organized pickets and protests and pageants in the hope of achieving wholesale economic and social justice. What began as a callow faith in revolution quickly gave way to a

more concrete agenda for reform. Working as a visiting nurse on New York's Lower East Side, she watched a young patient die from the complications of a then-common illegal abortion and vowed to abandon palliative work and devote herself to a single-minded pursuit of reproductive autonomy for women.

Sanger proudly claimed personal freedom for women. She also insisted that the price women pay for equality should not be the sacrifice of personal fulfillment. Following in the footsteps of a generation of suffragists and social welfare activists who had forgone marriage to gain professional stature and public influence, she became the standard bearer of a less ascetic breed, intent on balancing work and family obligations.

The hardest challenge in writing this history for modern audiences, for whom these claims have become routine, is to explain how absolutely destabilizing they seemed in Sanger's time. Even with so much lingering animus toward women's rights today, it is hard to remember that reproduction was once considered a woman's principal purpose and motherhood was her primary role—women were assumed to have no need for identities or rights independent of those they enjoyed by virtue of their relationships to men. This principle was central to the long-enduring opposition women have faced in seeking rights to work, to inheritance and property, to suffrage, and especially to control of their own bodies.

Sanger needed broader arguments. By practicing birth control, women would not just serve themselves, she countered. They would also lower birthrates, alter the balance of supply and demand for labor, alleviate poverty, and thereby achieve the aspirations of workers without the social upheaval of class warfare. It would not be the dictates of Karl Marx, but the refusal of women to bear children indiscriminately, that would alter the course of history, a proposition ever resonant today as state socialism becomes an artifact of history, while family planning, although still contested, endures with palpable consequences worldwide.

In 1917 Sanger went to jail for distributing contraceptive pessaries to immigrant women from a makeshift clinic in a tenement storefront in the Brownsville section of Brooklyn. Sanger's contribution was to demand services for the poor that were available to the middle class. Her heresy, if you will, was in bringing the issue of sexual and reproductive freedom out in the open and claiming it as a woman's right. She staged her arrest deliberately to challenge New York's already anachronistic obscenity laws—the legacy of the notorious Anthony Comstock, whose evangelical fervor had captured Victorian politics in a manner eerily reminiscent of our time—and it led to the adoption, by the federal government and the states, of broad criminal sanctions on sexual speech and commerce, including all materials related to contraception and abortion.

Direct action tactics served Sanger well, but legal appeal of her conviction also established a medical exception to New York's Comstock Law. Doctors—although not nurses, as she originally intended—were granted the right to prescribe contraception for health purposes, and under that constraint she built the modern family planning movement with independent, freestanding facilities as the model for distribution of services, a development that occurred largely in spite of leaders of the medical profession who remained shy of the subject for many years and did not formally endorse birth control until 1937, well after its scientific and social efficacy was demonstrated.

By then, Sanger and Hannah Stone, the medical director of her New York clinic, had also achieved another legal breakthrough.

They prevailed in a 1936 federal appellate court decision in New York that licensed physicians to import contraceptive materials and use the federal mail for transport. The ruling effectively realized years of failed efforts to achieve legislative reform in Congress, although it did formally override prohibitions that remained in several states until the historic ruling in *Griswold v. Connecticut* with its claim of a constitutional doctrine of privacy, later extended so controversially to abortion in *Roe v. Wade*.

Sanger had long since jettisoned political ideology for a more reasoned confidence in the ability of education and science to shape human conduct and in the possibility of reform through bold public health initiatives.

With hard work and determination, she was able to mobilize men of influence in business, labor, academia, and the emerging professions. No less critical to her success was her decision to invest in the collective potential of women, many of whom had been oriented to activism by the suffrage movement and were eager for a new cause after finally winning the vote in 1920. She also lobbied the churches, convincing the clerical establishments of the progressive Protestant and Jewish denominations of the virtue of lifting sexuality and reproduction from the shroud of myth and mystery to which traditional faiths had long consigned them. She even won a concession from the hierarchy of the American Catholic Church, which overruled the Vatican and endorsed natural family planning, or the so-called rhythm method, as a way of countering the secular birth control movement and reasserting religious authority over values and behavior.

With an uncanny feel for the power of well-communicated ideas in a democracy, Sanger moved beyond women's rights to put forth powerful public health and social welfare claims for birth control. She proved herself a savvy public relations strategist and an adept grassroots organizer. Through the 1920s and 1930s she wrote best-selling books, published a widely read journal, and she crisscrossed the country and circled the globe to give lectures and hold conferences that attracted great interest and drove even more publicity. She built a thriving voluntary movement to conduct national- and state-level legislative lobbying and advocacy and to work in communities on the ground, sustaining affiliate organizations that organized and operated pioneering women's health clinics. Offering a range of medical and mental health services in reasonably sympathetic environments, many of these facilities became laboratories for her idealism.

Yet the birth control movement stalled during the long years of the Great Depression and World War II, stymied by the increasing cost and complexity of reaching those most in need and overwhelmed by the barrage of opposition it engendered. The issue remained mired in moral and religious controversy, even as its leadership determinedly embraced centrist politics and a sanitized message. When hard times encouraged attention to collective needs over individual rights and when the New Deal legitimized public responsibility for economic and social welfare, Sanger cannily replaced the *birth control* moniker with the more socially resonant *family planning*. She invented both terms and popularized them after consulting allies and friends. These strategies of accommodation, however, did nothing to stop officials of the National Catholic Welfare Conference and other opponents from making the most scandalous accusations that birth control was killing babies, waging war on poor families, even causing the Great Depression itself by slowing population growth and lowering consumer demand, a proposition that some economists of the day endorsed.

Having enjoyed Eleanor Roosevelt's enthusiastic support and personal friendship in New York, Sanger went to Washington in the 1930s hoping that Congress would overturn the Comstock law and legalize contraceptive practice as a first step to her long-term goal of transferring responsibility and accountability for services from small, privately funded clinics to public health programs with appropriate resources and scale; however, she failed to anticipate that the success of the Roosevelts would depend on a delicate balance of the votes of conservative urban Catholics in the north and rural, fundamentalist Protestants in the south. There would be no invitations to tea at the White House and no government support, at least until Franklin Roosevelt was safely ensconced in a third term.

Like other well-intended social reformers of her day, Sanger also endorsed eugenics, the then ubiquitous and popular movement that addressed the manner in which biological factors affect human health, intelligence, and opportunity. She took away from Darwinism the essentially optimistic lesson that man's common descent in the animal kingdom makes us all capable of improvement, if only we apply the right tools. Believing that ability and talent should replace birthright and social status as the standard of mobility in a democratic society, she endorsed intelligence testing, an enduring legacy of the era, and she did not repudiate the infamous Supreme Court decision of 1929 in *Buck v. Bell* that mandated compulsory sterilization on grounds of feeblemindedness. She also supported the payment of bonuses to women who volunteered for sterilization because they wanted no more children.

These compromised views placed her squarely in the intellectual mainstream of her time and in the good company of many progressives who shared these beliefs. Still, her failure to consider the validity of standard assessments of aptitude or the fundamental rights questions inherent in these procedures has left her vulnerable, in hindsight, to attacks of insensitivity and bigotry. The family planning movement at home and abroad has long been burdened by the charges that it fostered prejudice, even as it delivered welcome services and relief from unwanted childbirth to women in need.

Embittered by these controversies and disenchanted with the country's increasing pronatalism after World War II, Sanger turned her attentions abroad. In 1952 she founded the International Planned Parenthood Federation, with headquarters in London, as an umbrella for the national family planning associations that remain today in almost every country.

By the time of her death in 1966, the cause for which she defiantly broke the law had achieved international stature. Although still a magnet for controversy, she was widely eulogized as one of the great emancipators of her time. She lived to see the U.S. Supreme Court provide constitutional protection for the use of contraceptives in *Griswold v. Connecticut*. She watched Lyndon Johnson incorporate family planning into America's social welfare and foreign policy programs, fulfilling her singular vision of how to advance opportunity and prosperity, not to speak of human happiness, at home and abroad. A team of doctors and scientists she had long encouraged marketed the oral anovulant birth control pill, and a resurgent feminist movement gave new resonance to her original claim that women have a fundamental right to control their own bodies.

In the years since, however, further controversy has surrounded the practices of what developed as often alarmist global population control efforts that adopted rigid demographic

targets and imposed harsh, unwelcome, and culturally insensitive technologies on women. Population policy makers and service providers have been fairly criticized for abusing rights by ignoring or downplaying the risks of providing costly technologies where health services are inadequate to cope with potential complications and where failure rates have been high, even though these products are medically benign when properly administered.

In 1994 the United Nations International Conference on Population and Development in Cairo created a framework for state responsibility to ensure programs allowing women to make free and informed decisions about family planning, but also obligating access to comprehensive, reproductive health services of high quality, including birth control. Population and development professionals, however, also committed to a doctrine that weds policies and practices to improvements in women's status—to education, economic opportunity, and basic civil rights for women subject to culturally sanctioned discrimination and violence—just as Margaret Sanger first envisioned.

Hundreds of millions of women and men around the world today freely practice some method of contraception, with increasing reliance on condoms in light of the epidemic spread of HIV/AIDS and other sexually transmitted infections. This represents a sixfold increase since rates of population growth peaked in the 1960s.

Still, half the world's population today—nearly 3 billion people—are under the age of 25 years. Problems associated with widespread poverty, food insecurity, and environmental degradation are widespread. There remains considerable unmet need for family planning, and there is tragically insufficient funding for research on new methods and for new programming to meet ever-increasing demand. Funding for both population and development programs has slowed dramatically, as other needs compete for funds and as concern now spreads about an aging and shrinking population in many countries where birthrates have sharply declined. The cycles of history repeat themselves.

Case Study Questions

- At what points did the science of birth control precede any change in policy/practice in this area? Why do you think that was the case?
- Why was the expertise of effective birth control not widely shared, and why did it take the medical establishment so long to endorse policy change in this area? Clearly, the women's movement was part of the opening of change in this area, but how did it contribute to the creation of knowledge?
- What happened to the policy of birth control after the American Medical Association supported it in the 1930s?
- Why did it take another 30 years for birth control to be widely available to women in America?
- Have there been changes in recent years in the broader environment that are analogous to the early adoption of birth control programs (e.g., RU-486, or the so-called morning after pill)?
- Have these changes increased or limited access to birth control? Think through the acceptance of the expertise in this area and the ways in which it has contributed (or limited) the change in policy in this environment and the ways in which it has not been taken into account.
- Can you illustrate how expertise is still about perception, both within professional fields and in the broader public?

Case Study

External Stakeholder Power: Successful Efforts to Pass Advanced Practice Nurse Legislation

Claudia J. Beverly

The Arkansas State Legislature meets every other year to conduct the business of the state. In the year preceding the legislative session, the Policy Committee of the Arkansas Nurses Association (ArNA) examines the healthcare needs of the state and designs a strategic health policy plan for nursing that will be introduced in the upcoming session. The work is always initiated with a clear understanding of the needs of the state's citizens. In this rural state, 69 of the 75 counties are medically underserved. The poverty level is one of the worst in the country. The health statistics of Arkansans are in the bottom four states, and several counties do not have a single primary care provider. Given the many healthcare challenges facing the state, nursing is in a key position to address these needs, and society expects them to do so.

In the early 1990s the ArNA, which represents all nurses in Arkansas, concluded that advanced practice nurses were best prepared to address the primary healthcare needs of Arkansans. At that time, however, there was no standardization or clear regulation for this level of nurse other than national certification and the registered nurse (RN) license that is basic for all levels of registered nurses.

The ArNA's first attempt to address the primary healthcare needs of the citizens was in 1993. Their attempt to pass legislation that would allow prescriptive authority by advanced practice nurses failed. After this failure, the ArNA, with the assistance of its lobbyist, began to develop legislation for introduction in the 1995 legislative session to provide a mechanism for advanced practice nurses to practice to the extent to which they are academically prepared. Additionally, a mechanism whereby society could be assured of safe practice by all providers needed to be in place.

The process began when a legislator from a rural area with the greatest need introduced a study bill. This bill provided an opportunity for the ArNA to educate legislators about advanced practice nursing and how this type of nurse could address the healthcare needs of Arkansans. The study bill was assigned to the Interim Public Health, Welfare, and Labor Committee of both the House of Representatives and the Senate. Several public hearings were held by the committee, and various groups and individuals both in support and in opposition were given the opportunity to voice their opinions.

During the hearings, there were opportunities to provide correct information supported by the literature. Clarification of the proposed legislation was also on the agenda. At one point concern was raised about the use of the term *collaboration with medicine*, as some persons preferred to use *supervision* or a definition that would limit the practice to one being supervised. The task force initiated a process to define the term *collaboration*. A review of the literature showed that collaboration had already been defined in the 1970s by both medicine and nursing. Armed with that information and definitions given by other sources, the task force reported their findings at the next hearing, and the definition jointly developed by medicine and nursing was incorporated into the proposed legislation.

Process for Success

The leadership of the ArNA understood the monumental task and the many challenges and barriers to addressing the healthcare needs of Arkansans. The association decided that

appointing a special task force to lead its efforts was the best strategy. This strategy provided a mechanism for focusing on the issue while ensuring that the health policy committee would continue to focus on broader policy issues.

The association selected a chair, included the chair in member selection by ArNA leadership, and established the first meeting. As the process evolved, two cochairs, a secretary, and a treasurer were named. The task force was representative of nursing broadly and included members of the Arkansas State Board of Nursing, advanced practice nurses with master's degrees (midwives, certified registered nurse anesthetists, nurse practitioners, and clinical nurse specialists), registered nurses, faculty from schools of nursing who prepared advanced practice nurses, and representatives from other nursing organizations. The task force met every other week during the first 6 months of the 2-year preparatory period then weekly for the remaining year and a half.

The first order of business was to develop a strategic plan that included establishing a vision, mission, goals and objectives, strategies, and time line. The vision was critical as a means of keeping task force members focused on the vast needs of Arkansans, particularly those in rural areas. The vision statement also served to keep the broader ArNA membership focused. A literature search on advanced practice nursing and health policy issues was conducted, and articles were distributed to all task force members. The assumption was that all of the members needed information to expand their current knowledge. Subcommittees were developed based on goals and objectives and the operational needs of the task force. Chairs were assigned for each subcommittee, and thus began the 2-year journey.

The American Nurses Association (ANA) played a vital role in the process. The legal department was available to assemble and provide information, offer guidance, and identify potential barriers and challenges. The support provided by the ANA was pivotal to our success.

The work of the task force focused on external and internal strategies. External strategies focused on stakeholders, which included the Arkansas Medical Society, the Arkansas Medical Board, and the Pharmacy Association. Understanding the views of our colleagues in other disciplines and identifying the opposition to our plans were critical to our success. Many meetings focused on educating those disciplines about the legislation we were seeking. Often this was a balancing act, providing the right information but not too much of our strategy while attempting to keep our enemy close. We valued the process of negotiation and participated in many opportunities to negotiate with colleagues.

Throughout this process, the ArNA did have a line in the sand, defined as the point at which there was no negotiation. Our line in the sand included regulations of advanced practice nurses by the Arkansas State Board of Nursing and reimbursement paid directly to the nurses. These two points were never resolved until a vote on the legislation occurred.

The good news is that the advanced practice nurse legislation passed successfully in 1995. The legislation was successful in that the criteria for an advanced practice nurse to be licensed in the State of Arkansas were written by nursing, advanced practice nurses were to be regulated by nursing, and the legislation acknowledged national certification and educational requirements. Prescriptive authority was granted, and selected scheduled drugs could be ordered by an advanced practice nurse. Reimbursement to advanced practice nurses was lost at the last minute. For advanced practice nurses in the field of geriatrics, Medicare passed reimbursement regulations in 1997. Medicaid reimburses geriatric nurse practitioners according to national guidelines. Reimbursement is critical to meeting

the needs of Arkansas citizens and is a topic that is still being discussed.

Many individuals participated in this successful campaign. A clear vision, legislation based on evidence and current literature, a comprehensive strategic plan, education of all parties (including those in opposition and those in support), and well-informed legislators were critical to success. Probably the most critical message in health policy legislation is to focus on the needs of the citizenry and what nursing needs to contribute.

Case Study Questions

- We suspect that most nursing professionals can expand on this case; however, the key question is, what was the nature of building a stakeholder network?
- Who were the critical first players in this movement, and why was their involvement critical?
- As the network expanded, which other professional groups were involved? Why were those groups, and not others, involved?
- Do you see why some professions were the logical next parts of the coalition for adopting change?
- Who was most likely to oppose advanced practice nursing? Obviously, you do not include likely opponents in the initial development of the network of stakeholders, but why?
- How did the coalition eventually succeed through this inclusive network?
- What would you have done differently in a different practice arena?
- What does this case study tell you about building stakeholders for advancing practice?
- What would you need to do to apply this policy to advancing roles in your healthcare setting?

Case Study

Internal Expertise Power: Expanding Newborn Screening in Arkansas

Ralph Vogel

Strides in technology have created great advances in how we can provide services to families and their children. A prime example is the expansion of newborn screening, which has dramatically increased the number and type of genetic conditions that can be detected immediately after birth. Historically, most states have screened for hemoglobinopathies (like sickle cell anemia), thyroid disorders, phenylketonuria, and galactosemia. These conditions, along with newborn hearing screening, were relatively easy to administer at a cost-effective rate. With advanced laboratory and computer technology, we can now add multiple genetic conditions that are identified during a single run. In 2004 the March of Dimes proposed expanding the genetic conditions for which newborns are screened to their List of 29, including several enzyme deficiencies and cystic fibrosis. The cost of the limited newborn screening had been approximately $15 per newborn, and it would increase to about $90 with the expanded list. Insurance companies would cover the cost of adding the additional conditions. The value of newborn screening is in identifying genetic conditions early and implementing treatment plans from birth. Over a life span, this greatly reduces the morbidity and mortality associated with later diagnosis. With some conditions, the care can be as simple as a dietary change that is implemented from birth. Early diagnosis also allows for genetic counseling with families about the risk that additional children will have the condition.

Many states adopted this recommendation quickly, although the process has been slower

in others. In Arkansas a committee, titled the Arkansas Genetics Health Advisory Committee (formerly Service), has existed for several years. Their mission is to monitor health care related to genetics in the state. This diverse committee includes several members of the Arkansas Department of Health (ADH) who are involved in the newborn screening program administration and laboratory testing, physicians from Arkansas Children's Hospital genetic clinic, and interested parties that either work in the area of genetics or are parents of children with genetic conditions.

The main purpose of the committee has been to coordinate care and to try to educate the public about genetic conditions and screening for newborns. The ADH receives samples from about 95% of the newborns in the state and does screening at their central location in Little Rock. When an infant is identified with a newborn genetic condition, the ADH notifies the community hospital and the assigned pediatrician, who counsels the family and develops a plan for care and follow-up.

Expanding the screening program to the existing March of Dimes List of 29 created several problems. The committee, however, felt strongly that it should take an advocacy role to address these concerns. The first problem was the cost of increased screening. Although most of the individual cost for each child could be absorbed by insurance or Medicaid reimbursement, as in other states, the initial financial support would need to be provided by the State. The ADH had no provision for increasing funding but estimated that the increased cost would be as follows:

- Two million dollars for equipment and supplies
- The addition of at least two more laboratory technicians to do the increased testing
- The addition of at least one more public health nurse to coordinate the increased number of identified genetic cases
- Training for new and current personnel on the new equipment
- Personnel time to develop and coordinate the expansion of the program
- Development of an education program to make parents and professionals aware of the changes

Overall the estimated cost for start-up was approximately $3 million, some of which could be recouped after billing for the tests was established.

The committee and ADH decided that we would outline a plan for expansion with estimated costs and submit it to the director of the ADH, Dr. Faye Bozeman. With his approval, we would then approach legislators and ask for the needed funding to be included in the upcoming budget. Because the Arkansas state legislature convened only every 2 years, it would be critical to move forward over the next 6 months. We prepared a letter to Dr. Bozeman that the committee approved on a Friday with the intention of mailing it on the following Monday. The next day, Saturday, Dr. Bozeman was killed in an accident on his farm; therefore, we were in a quandary about who should receive the letter and whose approval would be needed in the ADH. During the next 6 months there was an interim head who was thrust into the position and did not want to approve anything at this level of expense. We were on hold until a permanent director was named. After about 3 months, we decided to take another tack and develop a plan to seek legislative approval for funding and then approach the new ADH director after the person was named. We developed a list of legislators to contact and identified members of the committee who had worked with the legislators in the past and could approach them.

By this time we were 2 months from the legislature convening and knew that after it convened nothing new would be introduced;

therefore, we had to get support ahead of time. We approached some legislators and received tacit support, but none were willing to introduce a new bill or request funding without a permanent head of ADH. We had lost the opportunity for funding until the next legislative session in 2 years.

The committee decided to continue to seek support from the legislators and ADH with the idea of gaining funding in 2 years. Meanwhile, we began to look at other states and what newborn screenings they were currently doing to make sure that politicians were aware of national standards. We had identified that Arkansas was one of the last five states to not expand newborn screening, and all of the surrounding states in the region had incorporated all or a large part of the March of Dimes List of 29. Making legislators aware of this became one of our goals, and once they realized that the states surrounding Arkansas were already doing expanded screening of newborns, they were more receptive to our plan.

After we started to discuss funding with legislators during the legislative session, they seemed willing to support newborn screening. But we had a surprise: they said it did not require any special legislation or special funding; the ADH could expand newborn screening without their approval because this was already within their realm of responsibility. Funding could be obtained by submitting a budget request to cover the cost of expansion.

The interim head of ADH was willing to support this since the head of the newborn screening section was on our committee. By fall we had the budget expansion approved and support for newborn screening expansion. The decision was then made to target July 1, 2008, as the date to start the expanded program.

After we knew the finances and political support were confirmed, we developed a time line that involved equipment acquisition, training for ADH staff, an education program for the public, and a plan for making community hospitals and professional healthcare providers aware of the expansion. At this point the ADH contacted members of the media that it had worked with in the past and developed a plan for public information advertisements to be run on television and radio. These began running in early May, 2 months before the July 1 start date. Because the media members had worked with ADH in the past, it was much easier to develop the advertisements. Print media advertisements were also started, and the local chapter of the March of Dimes provided funding and brochures that were distributed to OB/GYN physicians in the state to make expectant mothers aware of the testing to be done on their newborns. One of the members of the committee also wrote an article that appeared in the March issue of the *Arkansas State Board of Nursing Update* magazine, which is distributed to 40,000 healthcare providers in the state.

In July the expanded screening began, and it has been continued with a relatively smooth transition, largely because of the preparation of the ADH staff in the laboratory and the outreach nurses. Because of the public awareness campaign, there has been little voiced concern from parents, and there seems to be an awareness of the value of the expanded screening.

Lessons learned from the process are as follows:

- Preparation is the key to a smooth transition.
- Know exactly what is required to proceed and who needs to approve new or expanded plans of action. If we had approached the legislature first to find out what they wanted, we could have saved time.
- Plan for the unexpected. We could not have anticipated Dr. Bozeman's death, but it did cause about a 6-month delay.
- Educate everyone who is going to be involved. This includes administrators, healthcare

providers, laboratory staff, parents, and professionals in the impacted communities.

- Discuss with the media exactly what they need and use their expertise in terms of length of announcements and the best ways to distribute information.

Although the entire process took more than 2 years, in the end the transition has been very smooth, and few problems have been identified at any level. Having a diverse group on the committee was a strength because different members had different perspectives. This gave us much greater ability to anticipate problems and coordinate care, and in the end the program will benefit newborns in Arkansas for years to come.

Case Study Questions

- This case is a good example of how the stakeholders adapted as the intended policy change moved from internal adoption of policy to legislation back to internal adoption of policy within an existing organization. Can you see how the nature of the stakeholders defined for a legislative change is different from stakeholders for adaptation of existing policy?
- The initial group involved in this process was established primarily as an informational group, but it was modified to advocate change. How did the group evolve to influence policy differently? If the initial group had been more broadly defined at the start, would it have made the same mistake about requiring legislative change to adopt the policy? Why or why not?

Final Case Study

This final case study is presented to stimulate the reader's political thinking. We encourage you to read the case carefully and then consider how you would go about creating an environment for policy change.

Case Study

Workplace Violence

Steven L. Baumann and Eileen Levy

In the wake of the terrorist attack of September 11, 2001, and a series of tragic school shootings, workplace violence has gained national attention in the United States. Although nurses and other healthcare workers are generally well educated and regularly reminded to practice good hand washing and infection control, there is little attention given to the potential for violence in hospitals and other healthcare settings, even though it is common and can have devastating long-term consequences (Department of Health and Human Services, 2002; U.S. Department of Labor, 2004). According to Love and Morrison (2003), nurses who sustain injuries from patient assaults, in addition to suffering psychological trauma, are often out of work for periods of time, have financial problems, show decreased work productivity, make more errors at work, and report a decreased desire to remain a nurse. In addition to these problems, nurses who have been assaulted report feeling less able to provide appropriate care to their patients (Farrell, Bobrowski, & Bobrowski, 2006) and are reluctant to make formal complaints (Love & Morrison, 2003). As was the case with needlestick injuries in the past, many organizations do not openly discuss problems that increase the risk for violence, nor do they adequately prepare for episodes of violence, leaving nurses more likely to blame themselves for its occurrence.

The National Institute for Occupational Safety and Health (NIOSH), the same organization that requires hospitals to be attentive to infection control strategies and proper handling of hazardous materials, also provides clear definitions and guidelines to reduce the potential for violence in the workplace. According NIOSH,

workplace violence includes acts of physical violence or threats of violence directed toward people on duty or at work (Department of Health and Human Services, 2002). NIOSH has recognized employer responsibilities in mitigating workplace violence and assisting employees who are victims (Love & Morrison, 2003). The U.S. government has required employers to provide safe workplaces since 1970 (U.S. Department of Labor, 2004). These federal guidelines call for hospitals and other organizations to incorporate written programs to assure job safety and security into the overall safety and health program for their facilities. Violence prevention, they suggest, needs to have administrative commitment and employee involvement.

This case study is of a moderate-sized, nonprofit community hospital in the New York metropolitan area. As in many parts of the United States, this hospital and the communities it serves are becoming increasingly crowded and diverse. In this environment of change and tension, the hospital is a meeting place of people, many not by choice but in crisis, bringing together dramatically different histories, backgrounds, educational attainment, and cultures. The hospital and its clinics have become increasingly stressful, unpredictable, and at times hostile places. For example, the use of hospitals as holding tanks for acutely disturbed and violent individuals, the release of mentally ill persons from public hospitals without adequate outpatient programs and follow-up services, and the accessibility of handguns and drugs in communities all contribute to hospital and community violence. A failure of leadership at various levels, as well as inadequate reimbursement from payers, has contributed to violence that can occur on its premises.

The case study hospital, like most in the United States, has dramatically reduced the number of public psychiatric beds. Many of these former psychiatric patients have to rely on outpatient mental health services supported by community hospitals with a limited number of beds on one or two psychiatric units. In addition, the case study hospital reduced inpatient and outpatient addiction services. New research suggests that actively psychotic patients with schizophrenia and patients with schizophrenia who had a premorbid conduct problem or exposure to violence are more likely to be violent than less acutely ill patients and those without substance abuse or antisocial personality comorbidity (Swanson et al., 2008). Nevertheless, it is a mistake to consider persons with mental illness or substance abuse as the only individuals who can become agitated or violent in healthcare settings. It is also shortsighted to solely blame any single policy, such as the deinstitutionalization of the chronically mentally ill, for workplace violence in the United States.

At the same time that the case study hospital has cut beds and programs for persons in distress, it has a clear mission/vision/value statement that puts professional nurses in leadership positions and has taken steps to address workplace violence. It has made efforts to reduce violence in high-risk areas, such as the emergency department and psychiatric unit, by restricting access to these areas, using surveillance equipment and panic buttons, and strictly requiring all staff to wear identification, as other hospitals have. Community hospitals, like the one in this case study, however, often do not provide the kind of ongoing self-defense and violence prevention education and training that many psychiatric hospitals provide. In addition, all hospitals should have a task force and regularly meeting committee consisting of management, human resources/employee relations, employee assistance program staff, security, and the office of chief counsel with the sole purpose of developing policies and procedures to prevent and address workplace violence.

Following The Joint Commission's (2008) lead, the case study hospital and nursing administration have hospital-wide discussions and training on behaviors that undermine a culture of safety. In addition, the hospital requires workplace violence risk assessment, hazard prevention and control, and safety and health training, as well as careful record keeping and program evaluation (U.S. Department of Labor, 2004). Hospitals need to keep in mind the malpractice crisis in this country. The move to put patients first does not turn over control of the hospital to patients or their families. Indeed, to understand Friedman (2007) correctly, to put patients' health and satisfaction first, the hospital needs effective leadership at the top and from its professional nurses. To prevent violence in the workplace, nurses need to strive to be as authentic in their patient contact as possible and to avoid detached impersonal interactions (Carlsson, Dahlberg, Ekcbergh, & Dahlberg, 2006). The case study hospital provides considerable avenues of reward for individual nurses and other staff members to advance themselves and stand out as innovative, which helps mitigate the tendency for workers to herd, that is, to avoid developing themselves and improving the institution for the sake of togetherness with selected coworkers (Friedman, 2007).

The case study hospital does provide a psychiatric nurse practitioner on staff and onsite one day per week as an employee assistance provider. Having this person onsite provides an opportunity for hospital staff to be counseled on becoming less reactive to emotionally intense environments, as recommended by Friedman (2007). Healthcare organizations also need to provide referral information, such as to employee assistance programs or clinicians experienced in trauma care, for employees who may exhibit more serious and persistent reactions to perceived violence and aggression (Bernstein & Saladino, 2007). Nurses and nursing organizations should become more familiar with national guidelines and recommendations and persuade their hospitals to adopt and implement them. The process for nurses is to focus more on taking responsibility for their own condition, practice self-regulation, and have a wide repertoire of responses to stressful situations. Although this does not guarantee that violence will be avoided, it does make it less likely to happen and makes nurses better able to keep it in perspective. Friedman (2007) described this as being able to turn down the dial or volume. Nurses need to be just as effective in managing toxic emotional environments as in handling toxic chemicals and infections. Nurses' interpersonal effectiveness is increased when they look for and support strengths in others. Postincident debriefing helps transform the experience into a team building and learning opportunity. Leaders should involve all staff and review events, including what precedes and follows an incident.

Case Study Conclusion

A community hospital in the New York metropolitan area is presented as a case study of an organization struggling to carry out its mission in a way that facilitates the growth and well-being of its employees. The hospital is experiencing different pulls. On one hand, it has had to cut back on essential programs. On the other hand, the nurses and the central leadership in the hospital need to work together to avoid quick-fix solutions and suffer the failure of nerve that Friedman (2007) talked about. The busy hospital environment in a changing society is stressful and, at times, hostile and violent. Nurses need to be effective leaders to help protect the integrity of the hospital as an organization—to maintain its self-definition. They can best do this by becoming as self-defined as possible and by consistently implementing federal guidelines to prevent and manage workplace violence.

Case Study Questions

In this case there is a need for policy change—the need for workplace violence policies. Here is our challenge to the reader. Can you take our two components, both an internal and external role, and define what needs to be done to accomplish this policy change? We suggest that you define the work in terms of your most likely environment, whether it is a psychiatric facility or a hospital or clinic. How would you go about creating an environment for policy change here?

Some core questions should guide you. First, what key stakeholders are in the initial stakeholder group (i.e., those most likely to feel the strongest need for the policy)? Remember, it is essential that stakeholders are identifiable and represent a clear position on this topic. Can you identify both internal and external stakeholders? Are they organized around various professional lines within your organization? How do you begin to create a shared view among these stakeholders? As you begin to broaden the network, which groups should be brought into the discussion? Let us give you an example: The human resource specialists in your organization will need to be involved at some point in creating a policy about the elimination and reduction of workplace violence. Should they, however, be in your initial set of stakeholders? Why or why not?

Now are the more difficult questions:

- What expertise is needed to make such a policy change?
- What kinds of facts (someone has to gather the data in a systematic way) need to be gathered?
- Are we discussing violence between patients and those providing medical services, or violence among fellow professionals within the organization?
- What kind of violence and danger are we discussing here—physical or verbal violence, or both?
- What about safety issues (including other types of danger to employees and patients)?
- Would you agree that an emergency room might see these questions a bit differently from those handling financial claims (although both have real needs)?
- How do you build expert power? Who shares it, and who might be expert in defining these issues over time?

As you create the case, think about developing it in two stages: the initial definition of the issues (expertise), and who needs a seat at the table (stakeholders) both inside and outside the organization. The second stage is writing and defining the policy. If the issue is defined well by all the stakeholders, the delineation of the necessary expertise of workforce violence will become a shared view among the stakeholders. Then, and only then, can one move to the writing of a policy about dealing with workplace violence. Do all the stakeholders need to be involved in writing that policy? We suggest that is not necessary for those involved to reach a broad agreement about the issues that define the policy itself.

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Conclusion

Politics and policy requires an understanding of how to build support and adapt to change. If we are to be effective advocates, we must be responsive to broader societal needs. Building support is not done simply by presenting the facts. This toolkit is designed to help readers know what it takes in a political environment to build a case and adapt when necessary. A huge mistake in advocacy is to simply believe that the facts are on our side, and if we just continue to list the facts, everyone will believe! In reality, values and political issues are at the core of successful change. Our tasks as political advocates for change are as follows:

- Believe we can convince others to adapt
- Adapt ourselves to handle broader political value issues
- Learn to mobilize our expert power as one of the largest groups of stakeholders in the healthcare field

Discussion Questions

1. As you read through this chapter, describe the political environment of your own organization, both at the largest level and at a division or office level.
2. Internal and external stakeholders are important to any organization or policy. Describe your view about reliance more on internal stakeholders than on external stakeholders, and vice versa. Why do you think there are differences?
3. Expertise power is often difficult to define in detail, but how do we build a stronger perception of the importance of our expertise with those who work with our programs and agencies?
4. Looking at Figure 3-1, how do organizations overutilize the force component in organizational power? What kinds of evidence would you expect to see in an organization that is not using influence or authority well?
5. Given the need for greater collaboration in the health policy arena, how does improving your stakeholder relationships with other organizations and interests become even more important?

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