CHAPTER 5

Public Policy Design

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This chapter retains several older but classic references from the previous texts because they are considered seminal works that define the topics discussed.

KEY TERMS

Health services research (HSR): A multidisciplinary scientific field that examines a multitude of factors, systems, and processes in the delivery of health care.
Policy tools: Those methods chosen by policymakers to help solve a problem or social issue.
Unfunded mandate: A statute or regulation that requires a state, local government, organization, or individual to perform certain actions, with no money provided for fulfilling the requirements.

Introduction

In today's world and political climate, it is imperative that healthcare providers, administrators, and educators be knowledgeable about and active in the policy process, particularly as it relates to their professional work. The purpose of this chapter is to examine public policy formulation processes and tools that governments use to solve large and complex societal problems (**FIGURE 5-1**).

The scope of government's involvement in social issues in the United States expanded rapidly in the 20th and 21st centuries. The development of federally funded public programs such as Medicare and Medicaid in 1965 made a major impact on how health care is delivered by providers and accessed by the public. National costs for health care began rising immediately after the advent of Medicare and swelled to $3.2 trillion—or $9,990 per person—in 2015 (CMS, 2017).

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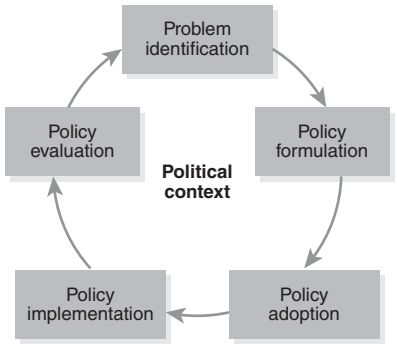

FIGURE 5-1 Stages of the policy process.

Public policy related to financing health care not only must assure access and quality but also bend this cost curve downward.

The creation of Medicare and Medicaid was preceded by efforts in the early 20th century to provide a "safety net" for more Americans in terms of ability to afford health care. The concept of a national health insurance program for Social Security beneficiaries was first proposed by the Surgeon General in 1937 (CMS, 2015). Nearly 10 years later, a federal agency was created to administer programs in health, education, and social insurance. In the two decades that followed, a social awareness of the need for a true safety net emerged. By 1965, in response to this pressure, Congress had enacted legislation creating Medicare and Medicaid as Title XVIII and Title XIX of the Social Security Act, granting hospital insurance (Part A) and medical insurance (Part B) to nearly all Americans older than age 65.

According to the Centers for Medicare and Medicaid Services (CMS), the elderly population at that time was likely to be living in poverty, and a majority of them were uninsured. In addition to extending health insurance and coverage to this population group, the law helped to desegregate hospitals, which were financially motivated to integrate given the "generous" payments offered in exchange for compliance with the Civil Rights Act of 1964. Facility costs in the form of building and renovating structures were high, and Medicare reimbursement could provide more than half of a hospital's income (Smith, 2005)—an attractive lure to hospitals.

All health insurers tend to follow and adopt whatever Medicare will reimburse, making the deliberations regarding this publicly funded program critical to the health insurance benefits available to the vast majority of the nonelderly insured population. The impact was even greater with the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. With the recent election of Donald Trump as president and Republican majorities in Congress, the ACA is expected to undergo rigorous redesign or replacement.

One of the factors that most inhibits the success of public policy is the inability to predict consumer behavior and participation in a social program. The gap in matching desired behavior with appropriate government tools is discussed in this chapter.

Health care is fraught with a multitude of factors that are difficult to identify and control, and the issue of healthcare reform has polarized the country.

Policies related to access to affordable, quality health care have complicated the debate, including raising questions about the following issues:

- How to restore Medicare and Medicaid payments to hospitals that were cut to pay for the subsidies offered under the ACA to low-income individuals
- How to implement new payment models that reward quality over quantity of the healthcare service provided
- How to provide enough public funding for basic and clinical research, provider education and professional development programs, and loan forgiveness for professional who are practicing in underserved areas

The United States has one of the most sophisticated healthcare systems in the world with respect to innovation, health information technology, and preparation of healthcare professionals. Yet in many of the health indices designed to evaluate the overall health of a country, the United States rates comparatively low. For example, the average life expectancy for females in the United States is 81.6 years, whereas in Japan, Canada, and the Netherlands—all of which are also developed countries—female life expectancy is 86.8, 84.1, and 83.6 years, respectively (World Health Organization, 2016). Infant mortality is another important measure of a nation's health. The United States ranks low among industrialized countries on this measure and also has a high rate of low and very low birth weights, a major contributor to infant mortality (Centers for Disease Control and Prevention [CDC], 2016b). The U.S. healthcare system continues to evolve and, therefore, will continue to benefit from improvements made to its performance, effectiveness, and efficiency by way of evidence-based policymaking.

Efforts have been made by previous administrations to address the issues of access, cost, and quality—often referred to as the three pillars of healthcare policy—but past policy proposals have reflected the prevailing political philosophies and ideologies popular at the time. For example, government programs in the 1960s, under Democratic administrations, reflected an ideology wherein there was less concern with outcome-based planning and more concern with access. Two decades later, under a Republican administration, regulatory efforts attempted to reduce costs through outcome-based choices, individual responsibility for cost, and smaller expansion of healthcare coverage. Policy changes designed to influence one of the three pillars (access to care, quality of care, and cost of care) inevitably affect all three; that is, none of the pillars may be altered without consequences to the other two.

Policies are usually designed to influence behavior and motivate individuals to do what they ordinarily might not do. Although many studies regarding the policy process have been conducted, few have examined the process of policy design specific to individual issues of health care. The focus of most policy studies has been on the implementation of effective programs, and data have been gathered on statistical outcomes. A policy may be more successful if its design is incorporated into all phases of the policy process. For example, in the agenda-setting phase, the problem or social issue could be stated in such a way that it will capture the attention of lawmakers and framed so that government response will be feasible and adaptable. During the implementation phase, the policy's design provides guidance and an overall picture of the plan by specifying the intended outcomes. During the evaluation phase, the program objectives are clearly identified and measurable to ensure that the proposed change produces the desired outcome.

Public policy is, by nature, complicated. The root of public problems has no simple single answer; if it did, more than likely the effort to address those problems would take the form of a guideline, recommendation, or rule implemented by the private sector. Health care is perhaps the most convoluted of public issues because it is affected by a multitude of factors, such as state, federal, and international economies; social movements; education; resources; and religion. As a result, solutions that seek to provide accessible, affordable, and quality health care without leaving a large segment of the population uninsured, driving up the costs of health care, and sacrificing quality are often complicated, fragmented, and difficult to implement across various healthcare settings and populations. The nursing profession should engage in providing stories, data, and insight to help policymakers design the most effective policies to improve access and quality and reduce costs.

The Policy Design Process

Policies reflect public opinion as well as evidence-based data. The policymakers comprise a collection of stakeholders whose task is to find solutions to problems that cannot be resolved by nongovernmental or philanthropic organizations. Policies that address social problems in the United States usually are formulated by a combination of legislators and aides, the executive branch, and special-interest groups and advocates on both the federal and the state levels. Policies may subsequently be altered or struck down by the judicial branch (the courts).

Professional experts such as registered nurses are often asked to serve as panel members or consultants or to serve on committees that provide input to policymakers. Other nurse leaders also are increasingly playing leadership roles in critical policy arenas. For example, under the Obama administration, Marilyn Tavenner became the first nurse to lead the Centers for Medicare and Medicaid Services, while Lieutenant General Patricia Horoho became the first nurse appointed as the Surgeon General for the U.S. Army. State nurses associations also have increasingly taken on a leadership role in advocating directly for change, leaving the sidelines of simply monitoring policy proposals under consideration. Nurses and organizations representing nurses advocate for policies that may be seen as self-serving: Policies that include advanced practice registered nurses (APRNs) in reimbursement models, eliminate supervisory requirements, or increase scope of practice fall into this category. Labor unions representing registered nurses often advocate for policies that may improve working conditions for nurses, with staffing and safety being perennial topics of debate.

The proliferation of participants in policy formation makes systematic program design that is focused on outcomes difficult to achieve. In her classic research, Safriet (2002) reports that most social issues are not brought to the attention of policymakers until there is a crisis with multiple causative factors. The decisions that relate to or have an impact on perceived social problems often are made hastily because of lack of information, constituency impatience, and lack of expertise.

Much policy that regulates nursing practice is determined at the state level, and the policy process conducted here is no less complicated than at the federal level. In the 2016–2017 legislative session of the North Carolina General Assembly, for instance, legislation was introduced that would have made several changes to

North Carolina's Nursing Practice Act, including increasing the scope of practice for nurses in the state. Nursing advocates, including the North Carolina Nurses Association and the North Carolina Association of Nurse Anesthetists, played a significant role in designing the legislation to overhaul the existing law and expand the scope of practice of APRNs. In the most recent legislative session, advocates for change were bolstered by an economic analysis showing North Carolina could significantly reduce healthcare spending by removing physician supervision of APRNs in the state (Conover, 2015). The long-running debate over independent practice for APRNs will continue, however, as N.C. legislators declined to act again on this issue in the 2017 session.

Research Informing the Policy Process

Health services research is typically defined as a multidisciplinary scientific field that examines a multitude of factors, systems, and processes in the delivery of health care. More specifically, nursing health services research can inform policymakers of clinical practice areas that involve the direct patient care experience of the nursing community (Jones & Mark, 2005). In their assessment, Jones and Mark note that nursing health services research can lead to the development of knowledge that improves access, health, and patient safety, among other things. Over the long term, they argue, such research can improve nursing care and patient outcomes—two broad policy issues that benefit in some ways from state or federal regulation.

A recent example of how clinical practice has informed policy involves safe patient handling to protect nurses from musculoskeletal disorders and injuries. The American Nurses Association (ANA, n.d.) notes how common these disorders are in nurses and endorses the call for safe patient handling and mobility (SPHM) programs and policies that protect the nursing workforce from manual lifting and repositioning of patients.

In the 114th Congress (2015–2017), the ANA advocated for the Nurse and Health Care Worker Protection Act, which was introduced to require the Occupational Safety and Health Administration to develop and implement an SPHM standard to eliminate manual lifting of patients by nurses; require employers to purchase, use, and maintain equipment; and require employers to train healthcare workers annually on proper usage of equipment. Congress did not consider the bill before it adjourned, but it is likely similar legislation will be reintroduced in the current Congress (115th), and the nursing workforce community will continue to pursue a strengthening of SPHM programs.

Schneider and Ingram (2005) suggest several issues that may affect failure to take actions needed to ameliorate social, economic, or political problems: (1) lack of incentives or capacity; (2) disagreement with the values implicit in the means or ends; and (3) the existence of high levels of uncertainty about the situation that make it unclear what people should do or how to motivate them.

Health services researchers can inform policy in a myriad of ways, ranging from identifying a problem, to weighing the risks and benefits of possible solutions, to providing estimates for how much a solution may cost government and society (Clancy, Glied, & Lurie, 2012). Such research often relies on large national data sets that offer insight into a particular problem. The Medical Expenditure

Panel Survey (MEPS), for example, consists of large-scale surveys of families and individuals, their healthcare providers, and employers across the country. According to the Agency for Healthcare Research and Quality (AHRQ; the federal agency responsible for producing evidenced-based information to make health care safe, high quality, and accessible), MEPS gives researchers the most complete data on the cost and use of health care and health insurance coverage in the United States (AHRQ, 2017). Another helpful resource is the National Healthcare Quality and Disparities Reports housed on the AHRQ website and retrievable at https://www.ahrq.gov/research/findings/nhqrdr/index.html (AHRQ, 2015). These annual reports offer summarized data that can stimulate ideas for further study or research as well as cursory analyses to jumpstart projects. The reports provide reliable and updated data that can lead to meaningful policy change in improving care, lowering costs, and reducing health disparities.

The Design Issue

Unclear mandates often result in a mismatch between legislative intent and bureaucratic behavior. For instance, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 to ensure access to emergency care for patients with unstable conditions. Although the legislation requires hospitals to provide specific emergency services to patients seeking treatment, regardless of their citizenship, legal status, or ability to pay, the federal government does not reimburse for the cost of that care. EMTALA was intended to eliminate the practice of hospitals refusing to accept or treat unstable patients without proof of insurance; patients were sometimes sent over long distances to a public or county hospital. Despite the good intentions to ensure care for those in need, an **unfunded mandate** puts pressure on hospitals, which can face high costs when they are required to provide uncompensated care.

Policy design became a focus of research studies several decades ago. Linder and Peters (1987), whose work established a classical starting point for design research, reported that poor policy design is often the reason for policy failure. Describing some programs as "crippled at birth," these scholars noted that the best bureaucracies in the world may not be able to achieve desired goals if an excessively ambitious policy is used (i.e., the problem is too complex for a single policy or agency). A recent example of complexity was the launch of the healthcare.gov website to guide Americans in obtaining health insurance under the ACA (also known as "Obamacare"). The extreme complexity of this project resulted in multiple delays and frustration with the launch. Also, if there is a misunderstanding of the nature of the problem, inappropriate policies may be formulated. Linder and Peters proposed that implementation should be examined but only as one of the conditions that must be satisfied for successful policymaking. They maintain that by shifting the focus of study to policy design, more reliable and explicit answers can be found, leading to greater chances of policy success.

The design phase remains an integral part of the policy process. An understanding of the policy tools or instruments chosen for policy design and the underlying assumptions of policymakers during the design process is critical to an understanding of the overall policy process.

Policy Instruments (Government Tools)

The study of the instruments or tools by which the government achieves desired policy goals has shed light on lawmakers' intentions during policymaking and allowed researchers to infer the predictive capabilities of tools. Two scholars proposed a framework for studying policy based on policy tools. Schneider and Ingram (1990), in their classic work, offer a framework to analyze implicit or explicit behavioral theories found in laws, regulations, and programs. Their analysis uses government tools or instruments and underlying behavioral assumptions as variables that guide policy decisions and choices. Their contention is that target group compliance and utilization are important forms of political behavior that should be examined closely. When these tools are combined with process variables such as competition, partisanship, and public opinion, Schneider and Ingram argue, the tools approach moves policy beyond considering the standard analysis and improved frameworks. They note that policy tools are substitutable, and states often use a variety of tools to address a single problem.

To understand which tools are most efficient, emphasis should be placed on using them in conjunction with a particular policy design. According to Howlett, Mukherjee, and Rayner (2014), **policy tools**—that is, those methods chosen by policymakers to help solve a problem or social issue—are so critical in policy design that policy implementation cannot be achieved without them.

Howlett (2011) describes five specific policy tools used by governments in designing policy. In addition, he identifies five broad categories of tools: authority, incentives, capacity building, symbolic or hortatory, and learning. Professional nurses can use their knowledge of policy tools to make suggestions and recommendations to government leaders who are designing policies and programs.

Authority Tools

Authority tools are used most frequently by governments to guide the behavior of agents and officials at lower levels. Authority tools are statements backed by the legitimate power of government that grant permission and prohibit or require action under designated circumstances. An example of an authority tool is a law, regulation, or mandate that requires vaccination for daycare and school entry under regulated criteria.

Incentive Tools

Incentive tools assume individuals have access to the resources they desire most and will not be motivated positively to take action without encouragement or coercion. Having access to what is most desired leads to wanting to get the greatest value for each expenditure. Incentive tools rely on tangible payoffs (positive or negative) as motivating factors. Incentive policy tools manipulate tangible benefits, costs, and probabilities that policy designers assume are relevant to the situation. Incentives assume individuals have the "opportunity to make choices, recognize the opportunity, and have adequate information and decision-making skills to select from among alternatives that are in their best interests" (Schneider & Ingram, 1990, p. 516).

An example of an incentive tool is payment or reimbursement for travel costs to eligible veterans seeking health care at Veterans Affairs medical centers.

However, if the professional nurse assumes that lack of transportation is a barrier to accessing primary care (in that transportation options do not exist, regardless of cost), the outcome from an attempt to use this particular incentive may fail.

Capacity-Building Tools

Capacity-building tools provide information, training, education, and resources to enable individuals, groups, or agencies to make decisions or carry out activities. These tools assume that incentives are not an issue and that target populations will be motivated adequately. For capacity-building tools to work, populations must be aware of the risk factors inherent in the tools and the ways in which these tools can help.

Capacity-building tools focus on education and technical support. For example, information may point out the risks of drugs, and information on such risk factors may be distributed to the target population through brochures, email, online videos, or other presentations. The underlying assumption is that information regarding the importance of addiction cessation is considered valuable and users will stop using substances of abuse to protect their health. Capacity-building tools also are used to encourage people to recognize the value of health care and to sign up for healthcare insurance.

Symbolic or Hortatory Tools

Symbolic or hortatory tools assume that people are motivated from within and decide whether to take policy-related actions on the basis of their beliefs and values. An example of this type of tool is the use of lower-number legislative bills reserved by congressional leadership. Procedural rules in the U.S. House of Representatives allow certain bill numbers, such as House of Representatives (H.R.) 1, to be reserved and assigned to significant legislation. For example, Congress approved H.R. 1, legislation to create the Part D program under Medicare—the Medicare Prescription Drug, Improvement, and Modernization Act—in 2003. Some of the lowest bill numbers are also reserved for use by leadership in the U.S. Senate (Congress.gov). The way in which bill numbers are assigned indicates their legislative significance (often symbolic) and signals that certain policy changes are a high priority for the majority party.

Another hortatory tool is a federal request for proposals to research a particular topic of significant interest to the government. Universities capable of conducting such research will apply for available grant awards, both to undertake the research and to enjoy the benefits that accompany such funding.

Learning Tools

These tools are used when the basis upon which target populations might be moved to take problem-solving action is unknown or uncertain. Policies that use learning tools often are open-ended in purpose and objectives and have broad goals. A needs assessment of the target population may be conducted by a task force, which provides knowledge and insight for policymakers. For example, if a community program addressing childhood obesity is proposed, a needs assessment must be conducted beforehand to determine which information is needed before a proposal is presented to the county council.

Policy tools are important resources for the professional nurse because experience using them can enlighten policymakers and persuade them to support or oppose a policy. Policy tools are similar to educational brochures and other materials that nurses provide to patients and families so that the patient can make informed decisions. For example, one of the primary goals of nursing is to provide the patient with comprehensive information regarding whether the patient has a chronic or acute illness or has undergone a stress-causing, life-changing event. More specific educational guidelines relating to health promotion behaviors and signs and symptoms of illness can reinforce information received from the care provider. Similarly, policy briefs, talking points, and factsheets about specific health conditions often are given to policymakers to help them understand a health policy issue.

Behavioral Dimensions

In addition to understanding the types and roles of tools in formulating policy, professional nurses must understand behavioral assumptions and the political context in which tools exist. The political climate in which social problems are addressed often prescribes the choice of tools to be implemented. Various tools are used when addressing social problems, and often these tools are interchanged, frequently resulting in differing outcomes when the tools are applied by different agencies, states, or countries. In the United States, for example, liberal policymakers are inclined to use capacity-building tools when developing policies for poor and minority groups, such as grants to communities for social programs, whereas conservative policymakers might use the same types of tools in developing policies applicable to businesses, such as strategic planning and business development activities.

For example, with the growing incidence and prevalence of opioid abuse across the United States, advocacy groups, healthcare providers, and federal and state government have sought to propose policy and other interventions that alleviate the epidemic's burden while maintaining access to legitimate prescription drug care (Bagalman, Sacco, Thaul, & Yeh, 2016).

CASE STUDY 5-1: *The Opioid Epidemic*

In 2013, the Trust for America's Health characterized prescription drug abuse as an epidemic, noting drug overdose deaths had doubled in 29 states since 1999 and outnumbered deaths from heroin and cocaine combined as well as deaths from motor vehicle–related accidents. According to the CDC (2016a, 2016b), more than 500,000 people died from drug overdoses between 2000 and 2015, and 91 Americans die every day from an overdose of prescription pain relievers, or opioids.

In 2014, the U.S. Department of Health and Human Services estimated that 4.3 million individuals abused opioids. The amount of prescription drugs administered and sold continues to increase significantly, despite a lack of corresponding pain reported by Americans (Chang, Daubresse, Kruszewski, & Alexander, 2014; Daubresse et al., 2013).

Public opinion also may have influenced government action in addressing the opioid epidemic. In April 2016, the Kaiser Family Foundation's Health Tracking Poll found that nearly two-thirds of Americans blame the federal and state governments for not doing enough to fight the opioid epidemic. In addition, 44% of those surveyed said they personally knew someone addicted to prescription painkillers.

At the federal level, multiple members of Congress introduced legislation to address the opioid epidemic in a variety of ways. The Comprehensive Addiction and Recovery Act (CARA, S. 524), which Congress enacted in July 2016, represented a comprehensive approach to addressing the problem, ranging from strengthening of efforts at the primary care level to improvements to criminal justice reform. Among other things, the law authorized grants to states and federally qualified health centers (FQHCs) to improve access to overdose treatment, reversal medicine access, and education programs. It also authorized grants to states to develop a treatment alternative to incarceration programs and to train first responders to administer opioid overdose treatments. Other provisions of the law support treatment and recovery organizations and provide incentives to states to address prescription opioid abuse through education, prescription drug monitoring programs, and prevention efforts.

The CARA bill was the first major federal addiction legislation in 40 years. Despite the bill being enacted following lengthy negotiations between lawmakers and the advocacy community, including physician groups and addiction advocates, the bill's passage was not heralded as a complete success. Congress authorized a number of new programs to overhaul the way in which opioid abuse is treated and prevented, but it failed to appropriate any funding for their implementation. Not until the end of 2016 did Congress include $1 billion in funding to states to combat the epidemic. Congressional Republicans, who held the majority in the 114th Congress, sought Democratic support on another comprehensive bill designed to speed up research conducted by the National Institutes of Health and drug approvals by the Food and Drug Administration. Funding of $1 billion for anti-opioid programs and interventions in this bill was included solely for the purpose of enticing Senator Democrats to support the underlying bill.

Although the federal government is working to coordinate the national response to the opioid epidemic, states have been approving legislation and promulgating rules at a more local level, particularly in harder-hit areas. Ohio and Kentucky were two of the five states with the highest rates of death due to drug overdoses in 2015, with each state seeing nearly 30 deaths for every 100,000 people, according to the CDC. In March 2017, Ohio Governor John Kasich approved regulations that limit the amount of opiates physicians and dentists can prescribe to adults and children, requiring prescribers to include a diagnosis or procedure code on every controlled substance prescription. The state made exceptions for opioids prescribed for cancer, palliative care, or hospice care. In April 2017, Kentucky Governor Matt Bevin signed into law legislation (HB 333) that limits physicians to issuing three-day painkiller prescriptions for patients with acute pain.

The North Carolina General Assembly (2017) also approved legislation that requires pharmacists to immediately enter a patient's prescription information into a database. Under the bill, physicians will review the information before

prescribing, and they will be limited to giving five- to seven-day doses for the initial treatment. *Politico* also reports that multiple bills aimed at curbing opioid abuse have been introduced in the Michigan and Minnesota legislatures, including legislation that would increase the fee drug makers pay to sell opioids; limit dentists to prescribing medication in four-day increments; and require physicians to use the Prescription Drug Monitoring Program to prevent patients from "doctor shopping" for access to pain medication.

Conclusion

As a component of professional nursing, active participation in the policy process is essential in the formulation of policies designed to provide quality health care at sustainable costs to all individuals. To be effective in the process, RNs and APRNs must understand how the process works and at which points the greatest impact might be made. The design phase of the policy process is the point at which the original intent of a solution to a problem is understood and the appropriate tools are employed to achieve policy success.

Discussion Points

1. Using the https://www.congress.gov/ website, identify recently proposed health policy legislation.
   a. Research the background for the problem or issue being addressed by the policy.
   b. Is there an evidence base to support the proposed policy?
2. Using your understanding of the behavioral assumptions underlying the tools, predict the potential for success or failure of the policy. Identify policy variables that will affect success or failure.
3. Using the https://www.congress.gov/ website, search the 109th Congress to identify a policy (e.g., rule, regulation) that has been in use for several years yet has had little success. Identify the variables that may be inhibiting success and offer possible solutions.
4. How does the political climate affect the choice of policy tools and the behavioral assumptions made by policymakers?
5. Identify opportunities that are currently in place for RNs and APRNs to begin activity in policymaking.

References

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. (2015). National healthcare quality and disparites reports. Retrieved from https://nhqrnet.ahrq.gov/inhqrdr/

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. (2017, April). Medical expenditure panel survey. Retrieved from https://meps.ahrq.gov/mepsweb/

American Nurses Association (ANA). (n.d.). Safe patient handling and mobility. Retrieved from http://www.nursingworld.org/handlewithcare

Bagalman, E., Sacco, L., Thaul, S., & Yeh, B. (2016, February 23). Congressional research service: Prescription drug abuse. Retrieved from https://fas.org/sgp/crs/misc/R43559.pdf

Centers for Disease Control and Prevention (CDC). (2016a). Drug overdose death data. Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths.html

Centers for Disease Control and Prevention (CDC). (2016b). Infant mortality. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Centers for Disease Control and Prevention (CDC). (2016c). Understanding the epidemic. Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. (2015, July). Medicare and Medicaid milestones: 1937–2015. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. (2017). National health expenditure data: Historical NHE, 2015. Retrieved from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

Chang, H., Daubresse, M., Kruszewski, S., & Alexander, G. C. (2014). Prevalence and treatment of pain in emergency departments in the United States, 2000–2010. *American Journal of Emergency Medicine, 32*(5), 421-431.

Clancy, C., Glied, S., & Lurie, N. (2012). From research to health policy impact. *Health Services Research, 47*(1 Pt 2), 337–343.

Congress.gov. (2016). S. 524—Comprehensive Addiction and Recovery Act of 2016. Retrieved from https://www.congress.gov/bill/114th-congress/senate-bill/524?q=%7B%22search%22%3A%5B%22s524%22%5D%7D&r=2

Congress.gov. (2017). Glossary. Retrieved from https://www.congress.gov/help/legislative-glossary/#glossary_reservedbillnumbers

Conover, C. J. (2015). Economic benefits of less restrictive regulation of advanced practice registered nurses in North Carolina. Center for Health Policy & Inequalities Research. Retrieved from http://chpir.org/_homepage-content/completed-projects/economic-benefits-of-less-restrictive-regulation-of-advanced-practice-registered-nurses-in-north-carolina/

Daubresse, M., Chang, H., Yu, Y., Viswanathan, S., Shah, N. D., Stafford, R. S.,. . . Alexander, G. C. (2013). Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000–2010. *Medical Care, 51*(10), 870–878.

Howlett, M., Mukherjee, I., & Rayner, J. (2014). The elements of effective program design: A two-level analysis. *Politics and Governance*, 2(2), 1-12.

Howlett, M. (2011). Designing public policies: Principles and instruments. New York, NY: Routledge.

Jones, C. B., & Mark, B. A. (2005). The intersection of nursing and health services research: Overview of an agenda setting conference. *Nursing Outlook, 53,* 270–273.

Kaiser Family Foundation. (2016). Key facts about the uninsured population. Retrieved from http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

Kasich, J. (2017). New limits on prescription opiates will save lives and fight addiction. Retrieved from http://fightingopiateabuse.ohio.gov/Portals/0/PDF/AcutePrescribingLimits_FINAL.pdf

Linder, S. H., & Peters, G. B. (1987). Design perspective on policy implementation: The fallacies of misplaced prescriptions. *Policy Studies Review*, *6*(3), 459–475.

North Carolina General Assembly. (2017). HB 243—Strengthen Opioid Misuse Prevention (STOP) Act. Retrieved from http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2017&BillID=hb243&submitButton=Go

Pradhan, R., & Ehley, B. (2017). State Week: New opioid limits catch fire in hard-hit states. *Politico Pro Healthcare*. Retrieved from http://www.politico.com/pro

Safriet, B. J. (2002). Closing the gap between can and may in health-care providers' scopes of practice: A primer for policymakers. *Yale Journal on Regulation*, *19*, 301–334.

Schneider, A., & Ingram, H. (1990). Behavioral assumptions of policy tools. *Journal of Politics*, *52*(2), 510–529.

Schneider, A., & Ingram, H. (2005). *Public policy and the social construct of deservedness*. New York, NY: Sage University Press.

Smith, D. B. (2005). The politics of racial disparities: Desegregating the hospitals in Jackson, Mississippi. *Milbank Quarterly, 83*(2), 247–269.

Trust for America's Health. (2013). Prescription drug abuse: Strategies to stop the epidemic. Retrieved from http://healthyamericans.org/reports/drugabuse2013/

World Health Organization. (2016). World health statistics 2016: Monitoring health for the SDGs. Retrieved from http://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_AnnexB.pdf?ua=1