

## Advanced Practice Nurses and Public Policy, Naturally

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### KEY TERMS

WWW 

**Advanced practice nurse (APN):** A registered nurse with a master's or doctoral degree in nursing who demonstrates expert knowledge, skills, and attitudes in the practice of nursing.

**Nursing's agenda for health:** Policy expectations of a vision for nursing practice that includes prevention of illness, promotion of health, empowerment of individuals to assume responsibility for the state of their own health, expertise in the provision of direct nursing care, delegation and supervision of selected care to appropriate individuals, and the political influence to accomplish these goals.

**Policy process:** The course of bringing problems to government and obtaining a reply. The process includes agenda setting, design, government response, implementation, and evaluation.

**Public policy:** Actual directives that document government decisions; also, the process of taking problems to government agents and obtaining a decision or reply in the form of a program, law, regulation, or other legal directive.

### INTRODUCTION

This book addresses the policy process as a broad range of decision points, strategies, activities, and outcomes that involve elected and appointed government officials and their staffs, bureaucratic agencies, private citizens, and interest groups. The process is dynamic, convoluted, and ongoing, not static, linear, or concise. The idea of “messy” may be uncomfortable to nurses who are known to expect action immediately, but the political arena requires patience, tact, diplomacy, and persistence. Knowledgeable nurses in advanced practice must demonstrate their commitment to action by being a part of relevant decisions that will ensure the delivery of quality health care by appropriate providers in a cost-effective manner. So why would anyone suggest that working at the policy level is “natural” to our profession? Some nurses are experienced in their political activity. They have served as chairs of legislative committees for professional organizations, worked as campaign managers for elected officials, or presented testimony at congressional or state hearings; a few actually have run for office. Still, there is a perception that “legislation” and “policy” are interchangeable, and that perception misses a lot of what policy is about.

Nursing as a practice profession is based on theory and evidence. For many years, that practice has been interpreted as direct, hands-on care of individuals. Although this still is true, the profession has matured to the point where the provision of expert, direct care is not enough. Nurses of the third millennium can stand tall in their multiple roles of provider of care, educator, administrator, consultant, researcher, political activist, and policymaker. The question of how much a nurse in advanced practice can or should take on may be raised. The Information Age continues to present new knowledge exponentially. Nurses have added more and more tasks that seem important to a professional nurse and are essential for the provision of safe care to the client. Is political activism necessary? All health professionals are expected to do more with fewer resources. Realistically, how much can a specialist do?

Drucker (1995), in addressing the need for more general-practitioner physicians rather than specialists, redefined the generalist of today as one who puts multiple specialties together rapidly. Nursing can benefit from that thought. In Drucker's definition, the **advanced practice nurse (APN)** must be a multidimensional generalist/specialist. This means that the APN combines knowledge and skills from a variety of fields or subspecialties effectively to design the new paradigm of healthcare delivery. This also means that the APN must demonstrate competence in the multiple roles in which he or she operates. To function effectively in the role of political activist, the APN must realize the scope of the whole policy process, and the process is much broader than how a bill becomes a law.

It is natural for nurses to talk with bureaucrats, agency staff, legislators, and others in public service about what nurses do, what nurses need, and the extent of their cost-effectiveness and long-term impact on health care in this country. For too long, nurses only talked to each other. Each knew their value, and each told great stories; they "preached to the choir" of other nurses instead of sharing their wisdom with those who could help change the healthcare system for the better. We finally are listening to those who have espoused interprofessional collaboration, and we are realizing that, together with our colleagues in medicine, psychology, pharmacy, allied health, and other professions, we can join forces and make a stronger presence in determining policy. In the end, the patient is the winner.

Today's nurses, especially those in advanced practice who have a solid foundation of focused education and experience, know how to market themselves and their talents and know how to harness their irritations and direct them toward positive resolution. Nurses are embracing the whole range of options available in the various parts of the policy process. Nurses are initiating opportunities to sustain ongoing, meaningful dialogues with those who represent the districts and states and those who administer public programs. Nurses are becoming indispensable to elected and appointed officials, and nurses are demonstrating leadership by becoming those officials and by participating with others in planning and decision-making.

The advanced practice nurse of the third millennium is technically competent; uses critical thinking and decision models; possesses vision that is shared with colleagues, consumers, and policy makers; and functions in a vast array of roles. One of these roles

is policy analyst. Although Florence Nightingale demonstrated great political influence in the 19th century (Nightingale, 1859), this aspect of the nurse's role was slow to become integrated into the scope of practice of the advanced practice nurse. Policy and politics is a natural domain for nurses. We are on the brink of an opportunity for the full integration into practice of the impending major changes in the delivery of care in the United States. Nurses have prepared for these changes by initiating new nurse education programs, expanding the number of master's and doctoral programs, and focusing on issues important to patients such as the just and equitable delivery of health care.

## CHANGES IN NURSING EDUCATION AND PRACTICE

Education and practice reflect or direct alterations in the delivery of health care. According to a 2008 survey of registered nurses (Health Resources and Services Administration, 2008), there are 3,063,162 registered nurses in the United States, 84.8% of whom are working in nursing. Projections indicate that the long-standing nurse shortage will become worse as baby boomers retire. This group of consumers grew up in a time of abundance and will expect an abundance of health services when they leave the workforce. Nurse education programs recognize the opportunity to expand program enrollment but are faced with a dearth of qualified faculty and appropriate clinical space.

Nurse educators and administrators are using technology to enhance and supplement the learning process. Patient simulators are models that can mimic healthcare problems in a laboratory. These models are very sophisticated and expensive, and can be programmed to mirror a heart attack, congestive heart failure, or any number of health conditions and emergencies. For best effect, students work in teams with colleagues from nursing, medicine, physical therapy, emergency medical technology, medical residents, and others. The lab approach can ease the need for clinical experience because of the focused approach and because a scenario can be analyzed and re-played for different outcomes. Boards of nursing are concerned about how much simulation is appropriate, but it is clear that simulation is an asset to learning. Another benefit of simulation is the experience of working with a team. Interprofessional education is fairly new in most educational programs, although the concept has been discussed for many years. The use of simulators may be a way to implement the idea of interprofessional collaboration.

Online education has become a major force in the United States, as well. Whether described as *distance learning*, *electronic education*, or another similar term, most nurse education programs use at least some form of teaching that is not face-to-face (F2F) in a single classroom. Distance learning was pioneered as "television courses" in the 1960s, in which a group of students met together at a location remote from the customary classroom and were taught by a faculty member in the primary classroom. Today's e-learning affords opportunities to learn in a flexible, "anytime" schedule that is not grounded in geography or time. The sophistication of software systems provides students and faculty with a wide range of presentations.

Telehealth, an outgrowth of e-learning and advanced diagnostic technology, allows patients and providers access to each other's domain without concerns about transportation, time lost from work, childcare during visits, and other major reasons why patients do not make or keep appointments. This sophisticated technology first was tested by military personnel and found to be an effective method for training and for practice. Currently, a physician in Washington, D.C., is testing the use of an Internet-ready cell phone to track disease compliance (Neergaard, 2010). Ethical issues, cost of equipment, and the learning curve of the provider and patient will dictate how much telehealth the public will embrace.

Although the profession has not solved the "entry" problem, there are efforts to move closer to requiring a bachelor of science in nursing (BSN) degree as the beginning point for professional nursing. Aiken, Clark, Cheung, Sloan, and Silber (2003) report that hospitals with higher proportions of baccalaureate-prepared nurses demonstrate decreased patient morbidity and mortality. Over 90 nurse generalist and specialty organizations are on record as supporting the BSN as an entry point to professional nursing. Some states are moving legislation or regulation to require that graduates of hospital diploma and associate degree programs obtain a BSN within 10 years of graduation in order to be relicensed as registered nurses (RNs). Academic institutions have created programs to expand the number of graduates.

Accelerated nurse education programs, recalling similar programs during World War II, have been developed at the bachelor's and master's degree levels. These programs were created to accept applicants with college degrees in fields other than nursing and provide the student with opportunities to graduate with degrees in nursing in an abbreviated time period, and graduates are eligible to sit for the National Council Licensing Exam (NCLEX-RN) to become registered nurses. These popular programs provide new avenues that address the nurse shortage.

A new education model at the master's level was created by the American Association of Colleges of Nursing (AACN), the national organization of deans and directors of baccalaureate and higher-degree nurse programs. During meetings of leaders of AACN, the American Organization of Nurse Executives, and other employers of nurses, AACN asked: Are educational institutions providing appropriate professionals for the workforce? The answer was that the nurses of today and the future should be educated to manage a population of patients/clients (such as a group of diabetics or those with congestive heart failure) both in a hospital setting and after discharge and should be able to make changes at a microsystem (i.e., unit) level. The clinical nurse leader (CNL) master's level program was proposed in 2003 to address those recommendations. In 2011 there are over 100 CNL programs, whose graduates can sit for a national certification exam that provides credibility to employers (Commission on Nurse Certification, 2011).

At about the same time as the CNL program was initiated, much work had been accomplished in moving APNs toward doctoral education as an entry point. Rationale included granting a degree appropriate to the knowledge base and credit hours required in APN programs and placing the advanced practitioner on a level with other health

professionals. Note that a physician (MD), dentist (DDS), physical therapist (DPT), occupational therapist (OTD), and audiologist (AuD) require a practice doctorate. In 2004 AACN members voted to establish a Doctor of Nursing Practice (DNP) and to require that all APN education be offered through DNP programs by 2015 (American Association of Colleges of Nursing [AACN], 2010a). The DNP will be an expert in patient care and will design, administer, and evaluate the delivery of complex health care in new organizational arrangements. Areas of concentration are offered in direct care, informatics, executive administration, and health policy. Although some nurse educators still debate AACN's decision (Cronenwett et al., 2011), over 153 DNP programs currently exist. A concern that DNP programs would siphon students from PhD programs was unfounded (AACN, 2011).

The CNL and DNP also reflect a change in how health care is provided. Certified CNLs work at the unit micro level (not the health systems macro level) and provide direct care to groups of patients, which includes teaching with the goal of self-management of their own health problems. Patients learn to notice early indicators of changes in their conditions so that they may seek help before serious symptoms arise, with the goal being to keep patients as healthy as possible and to reduce hospital readmissions. The DNP provides care at the systems level; that is, this provider is alert to problems in the healthcare organization and can seek solutions through policy changes. DNPs develop relationships within and outside the healthcare network in order to facilitate transformation.

Perhaps the greatest potential for change in the education of nurses will be the effect of the report from the Institute of Medicine (IOM) of the National Academies, *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine [IOM], 2010). Under the aegis of the IOM and funded by the Robert Wood Johnson Foundation (RWJF), the report recognizes that nurses (the largest healthcare workforce in the United States) must be an integral part of a healthcare team. The report provided four key messages:

1. Nurses should practice to the full extent of their education and training;
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression;
3. Nurses should be full partners with physicians and other healthcare professionals in redesigning health care in the United States; and
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure (IOM, 2010, pp. 1–3).

How the messages will be received by the intended audiences—“policy makers; national, state, and local government leaders; payers; and health care researchers, executives, and professionals—including nurses and other—as well as to licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations” (IOM, 2010, p. 4)—can have a seismic impact on nursing education, practice, administration, and research. Removing barriers to practice, expanding leadership opportunities, doubling the number of nurses with doctorates, and greatly increasing

bachelor's degrees to 80 percent of the workforce will require money, commitment, energy, and creativity. As Donna Shalala, chair of the committee that initiated the report, noted at the 2010 annual meeting of the American Academy of Nursing, this report is the most important report on nursing in the past century.

It is now up to nurses to use the report to advance health care so that both patients and professionals will benefit. Nurses must not only reform nurse education and practice, but they must also provide leadership in gathering other healthcare professionals (practitioners and educators) together to begin paradigm-changing discussions to reform the entire system. The new system will focus on sick care, prevention of disease/disability, and health promotion. Research will continue to produce breakthroughs in medical science. Research on outcomes of treatment will become essential. **Exhibit 1-1** compares the old paradigm of sick care and the new paradigm of health care.

### **Exhibit 1-1 Comparison of Old Sick Care Paradigm with New Healthcare Paradigm**

<b>Old Paradigm</b>	<b>New Paradigm</b>
Hospital-based acute care	Short-term hospital, outpatient surgery, mobile/satellite clinics, telehealth/telemedicine
Physician in charge	Team approach
Nurse as subordinate	Nurse as full team member
Physician as primary decision maker	Relevant professionals and patient make treatment decisions
Segmented care focused on separate body parts/systems	Seamless, coordinated, holistic care
Primary care physician and specialist separated	Patient-centered home health
Paper records; some electronic health records (EHRs)	HER systems that generate data used for change
Fee-for-service	Mix of reimbursement packages
Hierarchical organizations	Value-based organizations
Positivist, linear thinking	Complexity science: patterns noted in chaos, networks essential, quantum principles

There has been talk for decades about reforming the U.S. healthcare system. In the 1990s, President Clinton established a group that made major recommendations, but the constant pressure of special interest groups, such as pharmaceutical and insurance companies that protected their own interests, delayed and ultimately de-railed any serious attempt at overhauling this huge system. During the George W. Bush Administration, defense was the number one issue on the agenda and health care was not a priority.

Today's policymakers seem to be more polarized than at any time in recent history; choices often are dichotomous or mutually exclusive and rulings follow a strict party line. Compromise can be perceived as losing power, and power seems to be revered over common sense or the common good. Splinter groups or loose arrangements of radical thinkers have appeared on the political scene and are challenging the traditional two- or three-party system. A long-time congressperson told this author that she has never seen this much bitterness and antagonism in her 30+ years of elected office. Nurses will have to be especially sensitive to the political positions of all policymakers when working in this arena. Communications techniques learned in basic baccalaureate and graduate programs will enable the nurse to transcend some of the pressures encountered in working through the political process.

The healthcare system in the United States is on the brink of huge changes. Many health problems are the result of lifestyles that do not support health. Obesity, hypertension, and cardiovascular illnesses are only three that are mentioned frequently. In order to promote a healthy population, we are in the early phases of a move toward prevention of illness and disability and promotion of healthy living. Many people know how to live a healthy life, but just as many do not actually engage in healthy practices. Healthcare professionals are changing the way they assess, diagnose, counsel, and treat patients.

People are living longer and are encountering many chronic problems. Who would have thought five years ago that cancer today is considered a chronic disease? Surgery has made great strides, especially as minimally-invasive methods and robotics are perfected. Genetics has opened up a whole discipline that incorporates gene splicing and manipulation, genetic testing and counseling, and many other approaches to what have been considered irreversible or inevitable conditions. The use of prosthetics in many forms and for many body parts is maturing into a fast-growing business, especially with the recovery and return of military personnel from wars. Body parts grown in laboratories from stem cells taken from a recipient will reduce the probability of autorejection. Ethical questions are integral to policy arguments, especially as appropriations are examined with a critical eye toward costs.

Federal reform has mandated programs and policies that will demand action that is different from what is available today. The Patient Protection and Affordable Care Act of 2010 (commonly known as the Affordable Care Act, or ACA) is a federal law that will transform how, where, and by whom health care is provided. Whether or not the programs envisioned in the law will succeed (i.e., meet the needs of the populace and be politically acceptable) will be played out through federal and state legislatures,

presidential influence, and judicial decisions. Already in 2011, bills have been introduced to seriously amend and terminate the law. Nurses and nurse organizations will be strong voices in the debates that will have lasting influence on health care in this country.

Hospitals are concerned with staffing the workforce with nurses and other health-care providers. Staffing levels have become a huge issue, with two opposing camps: one supports actual numbers of nurses per patient or per unit and the other supports principles of staffing rather than actual numbers. The California Nurses Association (CNA), originally a state affiliate of the American Nurses Association, broke from ANA mainly over staffing issues. The CNA (the group kept the name), under the umbrella of the National Nurses Organizing Committee (NNOC), became politically active in several states in their requirements to establish legal, specific, numerical nurse-to-patient ratios. ANA, in contrast, established “principles of staffing” that required including patient acuity, diagnosis, type of nursing unit, and other considerations rather than specific numbers. Buerhaus (2008, 2009) presents data and thoughtful discussion to support the need for nurses as the primary workforce in the United States.

Most care providers recognize the problems inherent in offering care to the uninsured and underinsured. The disparity in care seen in low socioeconomic groups and vulnerable populations (e.g., children, the elderly) and groups with specific health concerns (e.g., diabetics, smokers) presents enormous challenges. Nurses have proffered solutions that have not been taken seriously by major policy players.

For some policymakers, this seems as if nurses are trying to expand the scope of their practice. This often comes as a reflection that policymakers do not know what nurses do or the actual dimensions of their roles. The nurse of today and the future is “not your mother’s nurse,” to paraphrase an automobile commercial. Haas’s (1964) early study of nurses clarified that their role had four dimensions: task, authority or power, deference or prestige, and affect or feelings. Each of those dimensions has changed drastically over the past 10 years. Nurses simply want to practice at the level of their education and within legal and professional definitions.

Expanding the boundaries of historical nursing takes skill in negotiation, diplomacy, assertiveness, expert communication, and leadership. Sometimes physician and nurse colleagues are threatened by these behaviors, and it takes persistence and certainty of purpose to proceed. Nurses must speak out as articulate, knowledgeable, caring professionals who contribute to the whole **health agenda** and who advocate for their patients and the community.

The American Academy of Nursing (AAN), a prestigious organization of approximately 1500 select nurse leaders, created a Raise the Voice campaign that “provides a platform to inform policymakers, the media, health providers and consumers about nurse-driven activities and solutions for an ailing health care system” (American Academy of Nursing, 2010, p. 1). This program, funded by a grant from the Robert Wood Johnson Foundation, cites “Edge Runners”—nurses who are leading the way to



healthcare reform by creating models of care that “demonstrate significant clinical and financial outcomes” (p. 2). AAN members are committed to transforming the healthcare system from the “current hospital-based, acuity-oriented, physician-dependent paradigm towards a patient-centered, convenient, helpful, and affordable system” (p. 1).

A major influence in how health care is delivered is occurring as more and more people use social media. Patients bring articles about diseases and conditions to their healthcare providers. Providers surf the Internet and other social networks in search of accurate information. The expansion of knowledge and the rapidity with which it can be disseminated has grown exponentially in ways that were not possible even five years ago. A unique resource, *The Nurse’s Social Media Advantage* (Fraser, 2011), explains social media and, more importantly, discusses the necessity for nurses to understand how to use media resources in order to practice effectively in a fast-changing world.

## **DEVELOPING A MORE SOPHISTICATED POLITICAL ROLE FOR NURSES**

There has been a major shift in the roles that nurses assume. In addition to clinical experts, nurses are entrepreneurs, decision makers, and political activists. The nurse’s role must be examined to determine if there is a power differential, what the unwritten rules are that acknowledge deference, and how both actors exhibit or control feelings. Many nurses realize that to control practice and move the profession of nursing forward as a major player in the healthcare arena, nurses have to be involved in the legal decisions about the health and welfare of the public, decisions that often are made in the governmental arena.

For many nurses, political activism used to mean letting someone else get involved. Today’s nurse “tunes in” to bills that reflect a particular passion (e.g., driving and texting), disease entity (e.g., diabetes), or population (e.g., childhood obesity). Although this activity indicates a greater involvement in the political process, it still misses a broader comprehension of the whole policymaking process that provides many opportunities for nurse input before and after legislation occurs.

Nurses who are serious about political activity realize that the key to establishing contacts with legislators and agency directors is through ongoing relationships with elected and appointed officials and their staffs. By developing credibility with those active in the political process and demonstrating integrity and moral purpose as client advocates, nurses are becoming players in the complex process of policymaking.

Nurses have learned that by using nursing knowledge and skill they could gain the confidence of government actors. Communications skills that were learned in basic skills classes or in psychiatric nursing classes are critical in listening to the discussion of larger health issues and in being able to present nursing’s agenda. Personal stories gained from professional nurses’ experience anchor altruistic conversations with legislators and their staffs in an important emotional link toward policy design. Nurses’

vast network of clinical experts produces nurses in direct care who provide persuasive, articulate arguments with people “on the Hill” during appropriations committee hearings and informal meetings.

Nurses participate in formal, short-term internship programs with elected officials and in bureaucratic agencies. Most of the programs were created by nurse organizations that were convinced of the importance of political involvement. The interns and fellows learn how to handle constituent concerns, how to write legislation, how to argue with opponents yet remain colleagues, and how to maneuver through the bureaucracy. They carry the message of the necessity of the political process to the larger profession, although the rank and file still are not active in this role.

As nurses move into advanced practice and advanced practice demands master’s and doctoral degree preparation, the role of the nurse in the **policy process** has become clearer. Through the influence of nurses with their legislators, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, and certified nurse practitioners are named in several pieces of federal legislation as duly authorized providers of health care. The process has been slow; however, the deliberate way of including more nurse groups over time demonstrates that “getting a foot in the door” is an effective method of instituting change in the seemingly slow processes of government. Some groups of nurses do not understand the political implications of incrementalism (the process of making changes gradually) and want all nurse groups named as providers at one time. They do not understand that most legislators do not have any idea what registered nurses do. Those nurse lobbyists who worked directly with legislators and their staff in early efforts bore the brunt of discontent within the profession and worked diligently and purposefully to provide a unified front on the Hill and to expand the definition of provider at every opportunity. The designation of advanced practice nurses as providers was an entry to federal reimbursement for some nursing services, a major move toward improved client and family access and health care. Advanced practice nurses became acutely aware of the critical importance of the role of political activist. Not only did APNs need the basic knowledge, they understood the necessity of practicing the role, developing contacts, working with professional organizations, writing fact sheets, testifying at hearings, and maintaining the momentum and persistence to move an idea forward.

However, many nurses still focus their political efforts and skills on the legislative process. They understand the comprehensiveness of the policy process, the much broader process that precedes and follows legislation. For APNs to integrate the policy role into the character of expert nurse, they must recognize the many opportunities for action. APNs cannot afford to “do their own thing”—that is, only provide direct patient care. They cannot ignore the political aspects of any issue. Nurses who have fought the battles for recognition as professionals, for acknowledgment of autonomy, and for formal acceptance of clinical expertise worthy of payment for services have enabled APNs today to provide reimbursable, quality services to this nation’s residents.

The American Association of Colleges of Nursing continues to emphasize the importance of understanding and becoming involved in policy formation, and the organization and financing of health care for the registered nurse and the APN through documents on essential components of baccalaureate, master's, and doctoral education in nursing. Content essential at the undergraduate level includes “policy development . . . legislation and regulatory processes . . . social policy/public policy . . . and political activism and professional organizations” (AACN, 2008a, p. 21). Content at the master's level for all students, regardless of their specialty or functional area, includes “policy, organization, and finance of health care” (AACN, 2008b, p. 6). Required content for doctoral students in advanced practice includes behaviors to “critically analyze . . . demonstrate leadership . . . inform policy makers . . . educate others . . . advocate for the profession” (AACN, 2006, p. 13).

Today's nurses have a much clearer understanding of what constitutes nursing and how nurses must integrate political processes into their practices to further the decisions made by policymakers. Nurses continue to focus on the individual, family, community, and special populations in the provision of care to the sick and infirm and on the activities that surround health promotion and the prevention of disease and disability. Advanced practice nurses have a foundation in expert clinical practice and can translate that knowledge into understandable language for elected and appointed officials as the officials respond to problems that are beyond the scale or impact of individual healthcare providers. As nurses continue to refine the art and science of nursing, forces external to the profession compel the nursing community to consider another aspect—the business of nursing—that is paradoxical to the long history of altruism.

## 21ST CENTURY ORGANIZATIONS

The whole economic basis of capitalism—that is, the manufacturing system—had become rapidly outdated by the beginning of the 21st century. The new paradigm for organizations in the 21st century began with changes within one's head with a move to a perspective that is outside the usual way of thinking. What work is done, where it is done, how it is done, and what it costs are mundane questions that demand creative answers.

Complexity science acknowledges patterns in chaos, complex adaptive systems, and principles of self-organization and has great applicability to nursing (Curtin, 2010; Lindberg, Nash, & Lindberg, 2008). “The quantum concept of a matrix or field . . . that connects everything together” (Curtin, 2011) informs us that nurses are focused masses of energy who direct their behaviors and actions with patients in an intentional way towards accomplishing healthy states. The nurse–patient (or nurse–provider) relationship is not incidental or haphazard, but fully cognizant of purpose (Curtin, 2010; Husted & Husted, 2008).

Quantum thinking also is crucial to the effectiveness of an organization in the 21st century (Porter-O'Grady & Malloch, 2011). Partnerships are valued over competition,

and the old rules of business that rewarded power and ownership have given way to accountability and shared risk. Transforming the old systems to the new systems does not mean merely automating processes or restructuring the organizational chart. Transformation involves a radical, cross-functional, futuristic change in the way people think. Long-term planning is balanced with strategic planning, and vertical work relationships are replaced with networks and webs of people and knowledge. All workers at all levels share a commitment to the organization and an accountability to define and produce quality work. Rhoades, Covery, and Shepherdson (2011) are “convinced that positive, people-centered cultural values lead to higher performance” (p. 1). All workers share responsibility for self-governance, from which both the organization and the worker benefit (Porter-O’Grady, Hawkins, & Parker, 1997). Control is replaced by leadership. The new leader does not use policing techniques of supervision, but enables and empowers colleagues through vision, trust, and respect (Bennis & Nanus, 1985; Kouzes & Posner, 2007; Porter-O’Grady & Wilson, 1999). Encouragement, appreciation, and personal recognition are celebrated together in an effective organization (Kouzes & Posner, 1999).

## WHAT IS PUBLIC POLICY?

So, what do the changes in education, practice, and organizations have to do with policymaking, especially in the public arena? A brief overview of the entire policy process will clarify what policy is and how influencing government policies has become crucial to the profession of nursing.

In this chapter, *policy* is an overarching term used to define both an entity and a process. The purpose of **public policy** is to direct problems to government and secure government’s response, while politics is the use of influence to direct the responses toward goals. Although there has been much discussion about the boundaries and domain of government and the extent of difference between the public and private sectors, that debate is beyond the scope of this chapter.

The definition of public policy is important because it clarifies common misconceptions about what constitutes policy. In this book, the terms *public policy* and *policy* are interchangeable. The process of creating policy can be focused in many arenas and most of these are interwoven. For example, environmental policy deals with health issues such as hazardous material, particulate matter in the air or water, and safety standards in the workplace. Education policy, more than tangentially, is related to health—just ask school nurses. Regulations define who can administer medication to students; state laws dictate what type of sex education can be taught. Defense policy is related to health policy when developing, investigating, or testing biological and chemical weapons. Health policy directly addresses health problems and is the specific focus of this book.

## **Policy as an Entity**

As an entity, policy is seen in many forms as the “standing decisions” of an organization (Eulau & Prewitt, 1973, p. 495). As formal documented directives of an organization, official government policies reflect the beliefs of the administration in power and provide direction for the philosophy and mission of government organizations. Specific policies usually serve as the “shoulds” and “thou shalt” of agencies. Some policies, known as position statements, report the opinions of organizations about issues that members believe are important. For example, state boards of nursing (government agencies created by legislatures to protect the public through the regulation of nursing practice) publish advisory opinions on what constitutes competent and safe nursing practice.

Agency policies can be broad and general, such as those that describe the relationship of an agency to other governmental groups. Procedure manuals in government hospitals that detail steps in performing certain nursing tasks are examples of the results of policy directives, but are not considered policies. Policies serve as guidelines for employee behavior within an institution. Although policies and procedures often are used interchangeably, policies are considered broader and reflect the values of the administration.

Laws are types of policy entities. As legal directives for public and private behavior, laws serve to define action that reflects the will of society—or at least a segment of society. Laws are made at the international, federal, state, and local levels and have the impact of primary place in guiding conduct. Lawmaking usually is the purview of the legislative branch of government in the United States, although presidential vetoes, executive orders, and judicial interpretations of laws have the force of law.

Judicial interpretation is noted in three ways. First, courts may interpret the meaning of laws that are written broadly or with some vagueness, though laws often are written deliberately with language that addresses broad situations. Agencies that implement the laws then write regulations that are more specific and that guide the implementation. However, courts may be asked to determine questions in which the law is unclear or controversial (Williams & Torrens, 1988). For example, the 1973 Rehabilitation Act prohibited discrimination against the handicapped by any program that received federal assistance. Although this may have seemed fair and reasonable at the outset, courts were asked to adjudicate questions of how much accommodation is “fair” (Wilson, 1989). Second, courts can determine how some laws are applied. Courts are idealized as being above the political activity that surrounds the legislature. Courts also are considered beyond the influence of politically-active interest groups. The court system, especially the federal court system, has been called upon to resolve conflicts between levels of government (state and federal) and between laws enacted by the legislature and their interpretation by powerful interest groups. For example, courts may determine who is eligible or who is excluded from participation in a program. In this way, special

interest groups that sue to be included in a program can receive “durable protection” from favorable court decisions (Feldstein, 1988, p. 32). Third, courts can declare the laws made by Congress or the states unconstitutional, thereby nullifying the statutes entirely (Litman & Robins, 1991). Courts also interpret the Constitution, sometimes by restricting what the government (not private enterprise) may do (Wilson, 1989).

Regulations are another type of policy initiative. Although they often are included in discussions of laws, regulations are different. Once a law is enacted by the legislative branch, the executive branch of government is charged with administrative responsibility for implementing the law. The executive branch consists of the president and all of the bureaucratic agencies, commissions, and departments that carry out the work for the public benefit. Agencies in the government formulate regulations that achieve the intent of the statute. On the whole, laws are written in general terms, and regulations are written more specifically to guide the interpretation, administration, and enforcement of the law. The Administrative Procedures Act (APA) was created to provide opportunity for citizen review and input throughout the process of developing regulations. The APA ensures a structure and process that is published and open, in the spirit of the founding fathers, so that the average constituent can participate in the process of public decision-making.

All of these entities evolve over time and are accomplished through the efforts of a variety of actors or players. Although commonly used, the terms *position statement*, *resolution*, *goal*, *objective*, *program*, *procedure*, *law*, and *regulation* really are not interchangeable with the word policy. Rather, they are the formal expressions of policy decisions. For the purposes of understanding just what policy is, nurses must grasp policy as a process.

### **Policy as a Process**

In viewing policy as a guide to government action, nurses can study the process of policymaking over time. Milio (1989) presents four major stages in which decisions are made that translate to government policies: 1) agenda setting, 2) legislation and regulation, 3) implementation, and 4) evaluation. Agenda setting is concerned with identifying a societal problem and bringing it to the attention of government. Legislation and regulation are formal responses to a problem. Implementation is the execution of policies or programs toward the achievement of goals. Evaluation is the appraisal of policy performance or program outcomes.

In each stage, formal and informal relationships are developed among actors both within and outside of government. Actors can be individuals, such as a legislator, a bureaucrat, or a citizen, but they also can be institutions, such as the presidency, the courts, political parties, or special-interest groups. A series of activities occurs that brings a problem to government, which results in direct action by the government to address the problem. Governmental responses are political; that is, the decisions about who gets what, when, and how are made within a framework of power and influence, negotiation, and bargaining (Lasswell, 1958).

Even as this book explains each of the stages of the policy process and explores them for areas in which nurses can provide influence, one must recognize that the policy process is not necessarily sequential or logical. The definition of a problem, which usually occurs in the agenda-setting phase, may change during legislation. Program design may be altered significantly during implementation. Evaluation of a policy or program (often considered the last phase of the process) may propel onto the national agenda (often considered the first phase of the process) a problem that differs from the original. However, for the purpose of organizing one's thoughts and conceptualizing the policy process, the policy process is examined from the linear perspective of stages.

Even before the process itself can be studied, nurses must understand why it is so important to be knowledgeable about the components and the functions of the process and how this public arena has become an integral part of the practice of advanced nursing.

## **WHY NURSES AND PUBLIC POLICY?**

Registered professional nurses have studied the basics of how a bill becomes a law in their baccalaureate programs. An extension of the focus on legislation usually is provided in graduate schools. However, most nurses (and most nurse educators) do not have a clear understanding of the total policy process. To focus on legislation misses a whole range of governmental and political activities—activities in which professional nurses should have a central place.

Nurses and nursing are at the center of issues of tremendous and long-lasting impact, such as access to providers, quality of care, and reasonable cost. Issues crucial to the profession are being decided, such as who is eligible for government reimbursement for services and what is the appropriate scope of practice of registered nurses in advanced practice. If nurses wait until legislation is being voted on before they become involved, it is too late to affect decisions.

Nurses have learned the legislative process. Nurses have written letters and made visits to their legislators. Now nurses must move forward and apply the knowledge of the whole policy process by speaking out to a variety of appropriate governmental actors and institutions so that nurses can move issues onto the national agenda, lobby Congress with alternative solutions, and provide nursing expertise as policies and programs are being designed. In addition, nurses must be the watchdogs as programs are implemented so that target groups are served and services are appropriate. Nurses should be experts at program evaluation and continuing feedback to ensure that old problems are being addressed, new problems are being identified, and appropriate solutions are being considered.

The opportunities for nurse input throughout the policy process are unlimited and certainly not confined narrowly to the legislative process. Nurses are articulate experts who can address both the rational shaping of policy and the emotional aspects of the process. Nurses cannot afford to limit their actions to monitoring bills; they must seize

the initiative and use their considerable collective and individual influence to ensure the health, welfare, and protection of the public and healthcare professionals.

## **AN OVERVIEW OF THE POLICY PROCESS**

Most of the chapters in this book address specific components of the policy process in depth and from a theoretical perspective. However, at the outset, advanced practice nurses should have an overview of the total process so that they do not get stuck on legislation. Many useful articles and books have been written about policy in general and even about specific policies, but few have addressed the scope of the policy process or defined the components. The elements of agenda setting (including problem definition), government response (legislation, regulation, or programs), and policy and program implementation and evaluation are distinct entities, but are connected as parts of a whole tapestry in the process of public decision making.

### **Agenda Setting**

Getting a healthcare problem to the attention of government can be a tremendous first step in getting relief. The actual mechanism of defining a healthcare problem is a major political issue. APNs have the capacity and opportunity to identify and frame problems from multiple sources.

The choice of a clinical problem on which to focus one's energy is a major decision. A nurse may be working in a specialized area and may see a need for more research or alternatives to existing treatment options; for example, those who work with patients and families with breast cancer already may have a passion for issues critical to this area. Other topics receiving attention include diabetes, obesity, AIDS, early detection and treatment of prostate cancer, child and parent abuse, cardiac problems in women, and empowering caregivers (Hash & Cramer, 2003; Pierce & Steiner, 2003).

Professional problems that are especially critical to nurses in advanced practice include reducing barriers to autonomy and reimbursement for nursing services. Workplace issues include advocacy for workplace safety and management strategies for training and redeploying nurses as work sites change. Related social problems that affect nurses include the increase of street violence and bioterrorism. A plethora of problems and "irritations" can arouse the passion of a nurse in advanced practice.

APNs must come to understand the concepts of windows of opportunity, policy entrepreneurs, and political elites. "Sound bites" and "word bites" are tools that are used to gain the attention of viewers and readers and serve as a shortcut or an abbreviated version of a statement. Originally created as off-hand remarks, these oral and written snippets have become planned tactics. For example, a nurse who speaks at a press conference or who delivers a message to a politician should have a written message that includes bulleted sound or word bites that underscore the message and that emphasize the important points. These brief, focused points can serve as references for the media or a politician as they consider the message later.



## Government Response

The government response to public problems often emanates from the legislative branch and usually comes in three forms: 1) laws, 2) rules and regulations, and 3) programs. Because only senators and representatives can introduce legislation (not even the president can bring a bill to the floor of either house), these elected officials command respect and attention. The work of legislation is not clear-cut or linear. Informal communication and influence are the coin of the realm when trying to construct a program or law from the often vague wishes of disparate groups. The committee structure of both houses is a powerful method of accomplishing the work of government. Conference committees are known as the “Third House of Congress” (*How Our Laws Are Made*, 1990) because of their power to force compromise and bring about new legislation. APNs must appreciate the difference between the authorization and appropriations processes and seek influence in both arenas. Becoming involved directly with legislators and their staffs has been a training ground for many APNs. Supporting or opposing passage of a bill often has served as the first contact with the political process for many nurses, but this place often has been the stopping point for many nurses because they were unaware of other avenues of involvement, such as the follow-up process of regulations and rulemaking.

Lowi (1969) notes that administrative rulemaking is often an effort to bring about order in environments that are unstable and full of conflict. Some regulations codify precedent; others break new ground and address issues not previously explicated. An example of the latter is the Federal Trade Commission’s (FTC) Trade Regulation Rules. In 1964, the FTC, whose mission is to protect the consumer and enforce antitrust legislation, wrote regulations requiring health warnings on cigarette packages. The tobacco industry reacted so fiercely that Congress quickly passed a law that nullified the regulations and replaced them with less stringent ones (West, 1982). Decades passed before no-smoking rules actually were mandated in public places. Other ways to sanction agencies whose rules are viewed as too restrictive are to reduce budget allocations and increase the number of adjudications or trial-like reviews. Advanced practice nurses must become knowledgeable about the regulatory process so that they can spot opportunities to contribute or intervene prior to final rulemaking (“The Regulatory Process,” 1992).

Programs are concrete manifestations of solutions to problems. Program design often is a joint effort of legislative intent, budgetary expediency, and political feasibility. There are many opportunities for nurses in advanced practice to become involved in the design phase of a program. Selecting an agency to administer the program, choosing the goals, and selecting the tools that will ensure eligibility and participation are all decisions in which the APN should offer input.

## Policy and Program Implementation

It is important that APNs keep reminding their colleagues that the phases of the policy process are not linear and that policy activities are fluid and move within and among

the phases in dynamic processes. The implementation phase includes those activities in which legislative mandates are carried out, most often through programmatic means. The implementation stage also includes a planning ingredient. Problems occur in program planning if technological expertise is not available. This is particularly important to nurses, who are experts in the delivery of health care in the broadest sense.

If government officials do not know qualified, appropriate experts, decisions about program planning and design often are determined by legislators, bureaucrats, or staff who know little or nothing about the problem or the solutions. As excellent problem solvers, APNs have many opportunities to offer ideas and solutions. One strategy is to employ second-order change to reframe situations and recommend pragmatic alternatives to implementers (de Chesnay, 1983; Watzlawick, Weakland, & Fisch, 1974). Bowen (1982) uses probability theory to demonstrate how program success could be improved. She suggests putting several clearance points (instances where major decisions are made) together so that they could be negotiated as a package deal. She also advocates beginning the bargaining process with alternatives that have the greatest chance for success and using that success as a foundation for building more successes, a strategy she refers to as a “bandwagon approach” (p. 10). In the past, nurses have done the opposite: focused on failure and perceived lack of nursing power. APNs have begun to note successes in the political arena and are building a new level of success and esteem. The nurse in advanced practice today uses the strategies of packaging, success begets success, and persistence in a deliberate way so that nurses can increase their effective impact in the implementation of social programs.

Although nurses most often work toward positive impact, they have found that opposition to an unsound program can have a paradoxical positive effect. Although not in the public arena, an example of phenomenal success in the judicious use of opposition occurred when the professional body of nursing rose up as one against the American Medical Association’s 1986 proposal to create a new type of low-level healthcare worker called a registered care technician. The power emerged as more than 40 nurse organizations stood together in opposition to an ill-conceived proposal that would have placed patients in jeopardy and created dead-end jobs.

## **Policy and Program Evaluation**

For nurses who have worked beyond the nursing process through the process of clinical reasoning (Pesut & Herman, 1999), evaluation seems to be a logical component of the policy process. Evaluation is the systematic application of methods of social research to public policies and programs. Evaluation is conducted “to benefit the human condition to improve profit, to amass influence and power, or to achieve other goals” (Rossi & Freeman, 1995, p. 6). Evaluation research is a powerful tool for defending viable programs, for altering structures and processes to strengthen programs, and for providing rationale for program failure. Goggin, Bowman, Lester, & O’Toole (1990) propose that researchers investigate program implementation within an analytical framework rather

than a descriptive one. They argue that a “third generation” of research established within a sound theory would strengthen the body of knowledge of the policy process. APNs can contribute to both the theory and the method of evaluation.

Evaluation should be started early and continued throughout a program. An unconscionable example of a program that should have been stopped even before it was begun is the Tuskegee “experiment.” From 1932 to 1972, a group of African Americans was used as a control group and denied antibiotic treatment for syphilis, even after treatment was known to be successful (Thomas & Quinn, 1991). Beyond evaluation research, this study clearly points out the moral and ethical concerns that are mandated when researchers work with human beings. Should a study or program be started at all? At what point should it be stopped? What is involved in “informed consent”? If a program involves experimental therapy, what are the methods for presenting subjects with relevant data so that participation preferences are clear (Bell, Raiffa, & Tversky, 1988)? These kinds of questions should be considered automatically by today’s researchers, but it is the responsibility of APNs as consumer agents to ask the questions if they have not been asked or if there is any doubt about the answers.

## **A BRIGHT FUTURE**

The multiple roles of the APN—provider of direct care, researcher, consultant, educator, administrator, consumer advocate, and political activist—reflect the changing and expanding character of the professional nurse. Today is the future; nurse action today sets the direction for what health care becomes for coming generations. As true professionals with a societal mandate and a comprehensive body of knowledge, nurses function as visionaries who are grounded in education, research, and experience. APNs serve as the link between human responses to actual and potential health problems and the solutions that may be addressed in the government arena.

Full integration of the policy process becomes evident when professional nurses discern early the social implications of health problems, seize the opportunity to inform public officials with whom the nurses have credible relationships, provide objective data and subjective personal stories that help translate big problems down to a level of understanding, propose alternative solutions that acknowledge reality, and participate in the evaluation process to determine the effectiveness and efficiency of the outcomes.

### **Educating Our Political Selves**

Nurses in advanced practice must be politically active. Basic content in undergraduate nursing programs must be reexamined in light of the needs of the profession. Educators must do more than plant the seeds of interest and excitement in baccalaureate students; they must model activism by talking about the bills they are supporting or opposing, by organizing students to assist in election campaigns, and by demanding not only that students write letters to officials but that they mail them and provide follow-up.

Educators can develop games in which students maneuver through a virtual bureaucracy to move a health problem onto the agenda. Brainstorming techniques can lead students to discover innovative alternative solutions. Baccalaureate students can analyze policy tools to discover how and when to use them. Teachers of research methods and processes can use political scenarios to point out how to phrase clinical questions so that legislators will pay attention. Program effectiveness can be studied in research and clinical courses. The theoretical components taught in class and followed by practical application through participation in political and legislative committees in professional organizations must serve as “basic training” for the registered nurse.

Graduate education must demand demonstrated knowledge and application of more extensive and sophisticated political processes. All graduate program faculty should serve as models for political activism. The atmosphere in master’s and doctoral programs should heighten the awareness of students who are potential leaders.

Faculty can motivate students by displaying posters that announce political events and by including students in discussions of nursing issues framed in a policy context. Students who spot educators at rallies and other political and policy occasions are learning by example, so faculty should advertise their experiences as delegates to political and professional conventions. A few faculty can serve as mentors for students who need to move from informal to sustained, formal contact with policymakers and who have a policy track in their career trajectories. Both faculty and students should consider actual experience in government offices as a means of learning the nitty-gritty of how government functions and of demonstrating their own leadership capabilities.

If students hesitate and seem passive about involvement, educators must help these nurses determine where their passions are, which may help students focus on where they might start. Often the novice can be enticed by centering on a clinical problem. Every nurse cannot assume responsibility for all of the profession’s problems or work on every healthcare issue. Issues can be at the practice level or the systems level (e.g., funding for nurse education or nurse-led research). Each nurse must choose the issue on which to invest energy, time, and other resources. Nurses can make a difference in the new healthcare system.

### **Strengthening Organized Nursing**

The most productive and efficient way to act together is through a strong professional organization. As organizations in general have restructured and reengineered for more efficient operation, so will the professional associations. APNs have a knowledge base that includes an understanding of how organizations develop and change. This theoretical knowledge must serve as a foundation for leadership in directing new organizational structures that are responsive to members and other important bodies. National leaders must talk with state and local leaders as new configurations are conceived. States must confer among themselves to share innovations and knowledge about what works and what does not.

Issues such as the role of collective bargaining units within the total organizational structure, the position of individual membership vis-à-vis state membership, the political role of a specialized interest group (nurses) in creating public policy, and the issue of international influence in nursing and health care require wisdom and leadership that APNs must exert as the American Nurses Association addresses its place as a major voice of this country's nurses. The National League for Nursing (NLN) will exert leadership as nurse education programs move toward baccalaureate programs. Accrediting agencies (e.g., Commission for Credentialing in Nursing Education and the NLN Accrediting Commission) must continue to be visionary and flexible in developing criteria and processes for accreditation. Boards of Nursing must not become trapped in the slowness with which government bureaucracy can be mired, but must be on the forefront of developing regulations that protect the public and allow nurses to work at their top capacity.

Issues inherent in multistate licensure are being debated today, and the outcome will reflect the extent to which nurses will use concepts of telehealth in their practices. Because APNs already are eligible for Medicare reimbursement for telehealth services that are provided in specified rural areas (Burt, 1997), these nurses are rich resources and must be included in reasoned discussions on this issue. State boards of nursing in every state and jurisdiction face issues of appropriate methods of recognizing advanced nursing practice, the role of the government agency in regulating nursing and other professions, and the analysis of educationally sound and legally defensible examinations for candidates.

Nurses who have been reluctant to become political cannot afford to ignore their obligations any longer. Each nurse counts, and, collectively, nursing is a major actor in the effort to ensure the country's healthy future. Nurses have expanded their conception of what nursing is and how it is practiced to include active political participation. A nurse must choose the governmental level on which to focus: federal, regional, state, or local. The process is similar at each level: Identify the problem and become part of the solution.

Advanced practice nurses understand the scope of service delivery, continuity of care, appropriate mix of caregivers, and the expertise that can be provided by multidisciplinary teams. By being at the forefront of understanding, nurses have a moral and ethical mandate to lead the public-policy process. Dynamic political action is as much a part of the advanced practice of nursing as is expert direct care.

### **Working with the Political System**

By now, many APNs have developed contacts with legislators, appointed officials, and their staffs. A new group that holds great potential for nurse interaction is the Senate Nursing Caucus (AACN, 2010b). Established in March 2010, this group will provide a forum for educating senators on issues important to nurses, as well as for hearing concerns of the senators. Four senators established the caucus: Jeff Merkley (D-OR),

Mike Johanns (R-NE), Barbara Mikulski (D-MD), and Olympia Snowe (R-ME). The Senate Nursing Caucus follows the lead of the Congressional Nursing Caucus in the U.S. House of Representatives, begun in 2003 by Representatives Lois Capps (D-CA) and Ed Whitfield (R-KY) (American Nurses Association, 2003). Members hold briefings on the nurse shortage, patient and nurse safety issues, preparedness for bioterrorism, and other relevant and pertinent issues and concerns.

APNs must stay alert to issues and be assertive in bringing problems to the attention of policymakers. It is important to bring success stories to legislators and officials—they need to hear what good nurses do and how well they practice. Sharing positive information will keep the image of nurses in an affirmative and constructive picture. Legislators must run for office (and U.S. Representatives do this every 2 years), so media coverage with an APN who is pursuing noteworthy accomplishments is usually welcomed eagerly.

Nurses absolutely must “get their act together” and work toward a unified voice on issues that affect the public health and the nursing profession. Whatever their differences in the past—anger from entry-into-practice arguments that have dragged on for over half a century; disparagement and animosity among those with varied levels of education; cerebral and pragmatic concerns about gaps between education and practice, practice and administration; or administration and education—nurses must put these kinds of divisive, emotional issues behind them if they expect to be taken seriously as professionals by elected and appointed public officials and policymakers.

Nurses cannot afford to stop arguing critical issues internally, but they must learn how to argue heatedly among themselves—and then go to lunch together. Nurses can learn lessons from television shows such as *Meet the Press*, *This Week*, *The O’Reilly Factor*, and *The McLaughlin Group* about how to challenge, contest, dispute, contend, and debate issues passionately, then shake hands and respect the opponent’s position. Passionate issues must not polarize the profession any longer and, more important, must not stand in the way of a unified voice to the public.

## CONCLUSION

Nurses in advanced practice must have expert knowledge and skill in change, conflict resolution, assertiveness, communication, negotiation, and group process to function appropriately in the policy arena. Professional autonomy and collaborative interdependence are possible within a political system in which consumers can choose access to quality health care that is provided by competent practitioners at a reasonable cost. Nurses in advanced practice have a strong, persistent voice in designing such a health-care system for today and for the future.

The policy process is much broader and more comprehensive than the legislative process. Although individual components can be identified for analytical study, the policy process is fluid, nonlinear, and dynamic. There are many opportunities for nurses in advanced practice to participate throughout the policy process. The question

is not whether nurses should become involved in the political system, but to what extent. In the whole policy arena, nurses must be involved with every aspect. Knowing all of the components and issues that must be addressed in each phase, the nurse in advanced practice finds many opportunities for providing expert advice. APNs can use the policy process, individual components, and models as a framework to analyze issues and participate in alternative solutions.

Nursing has a rich history. The professional nurse's values of altruism, respect, integrity, and accountability to consumers remain strong. In some ways, the evolution of nursing roles has come full circle, from the political influence recognized and exercised by Nightingale to the influence of current nurse leaders with elected and appointed public officials. The APN of the 21st century practices with a solid political heritage and a mandate for consistent and powerful involvement in the entire policy process.

## DISCUSSION POINTS AND ACTIVITIES



1. Read Nightingale's *Notes on Nursing* and other historical sources of the mid-1800s and discuss how Nightingale's personal and family influence moved her agenda for the Crimea and for nursing education, and how this has implications for the future.
2. Discuss implications of the "BSN in 10" movement in relation to your own education. Research opportunities for BSNs and for APNs. Dream about positions that might not be available today.
3. Compare the definition of nursing according to Nightingale, Henderson, the ANA, and your own state nurse practice act. What are the differences in a legal definition versus a professional definition? What are the similarities? What did definitions include or not include that reflected the state of nursing at the time? Construct a definition of nursing for today and for 10 years from now.
4. Discuss the role of research in nursing. What has been the focus over the past century? What is the pattern of nursing research vis-à-vis topic, methodology, and relevance? To what extent do you think nursing research has had an impact on nursing care? Cite examples.
5. Trace the amount of federal funding for nursing research. Do not limit your search to federal health-related agencies; that is, investigate departments (commerce, environment, transportation, etc.), military services, and the Veterans Administration. What funding opportunities exist for nurse scientists?
6. Read books and articles about the changing paradigm in healthcare delivery systems. Discuss the change in nursing as an occupation and nursing as a profession. What does this mean in today's transformational paradigm?
7. Consider a thesis, graduate project, or dissertation on a specific topic (e.g., clinical problems, healthcare issues) using the policy process as a framework.

8. Identify policies within public agencies and discuss how they were developed. Interview members of an agency policy committee to discover how policies are changed.
9. Have faculty and students bring to class official governmental policies. What governmental agency is responsible for developing the policy? For enforcing the policy? How has the policy changed over time? What are the consequences of not complying with the policy?
10. Identify nurses who are elected officials at the local, state, or national level. Interview these officials to determine how the nurses were elected, what their objectives are, and to what extent they use their nurse knowledge in their official capacities. Ask the officials if they tapped into nurse groups during their campaigns. If so, what did the nurses contribute? If not, why?
11. Discuss the major components of the policy process and discuss the fluidity of the process. Point out how players move among the components in a nonlinear way.
12. Using Exhibit 1-1 as a framework, construct a healthcare organization in which access is provided and quality care is assured. What are the barriers to this type of paradigm?
13. Develop an assessment tool by which students can determine their own level of knowledge and involvement in the policy process. Reminder: Stretch your thinking beyond legislative activity.
14. Watch television programs in which participants discuss national and international issues, then analyze the verbal and nonverbal communication patterns, pro-and-con arguments, and other methods of discussion. Discuss your analysis within the framework of gender differences in communication and utility in the political arena.
15. Construct a list of ways in which nurses can become more knowledgeable about the policy process. Choose at least three activities in which you will participate. Develop a tool for evaluating the activity and your knowledge and involvement.
16. Select at least one problem or irritation in a clinical area and brainstorm with other APNs or graduate students on how to approach a solution. Discuss funding sources; be creative.
17. Attend a meeting of the state board of nursing, the district or state nurses association, or a professional convention. Identify issues discussed, resources used, communication techniques, and rules observed. Evaluate the usefulness of the session to your practice.
18. Discuss what skills (task, interpersonal, etc.) and attitudes are required for the nurse in the new paradigm. Who is best prepared to teach these skills, and what teaching techniques should be used? How will they be evaluated? Develop a worksheet to facilitate planning.
19. Discuss at least five strategies for helping nurses integrate these skills into their practices.



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