Chapter 5

Healthcare Policy for Advocacy in Health Care

Angela Mund

> *There are three critical ingredients to democratic renewal and progressive change in America: good public policy, grassroots organizing and electoral politics.*
>
> —Paul Wellstone

INTRODUCTION

In 2001, the Institute of Medicine (IOM) challenged all healthcare professionals to improve the quality of patient care with an emphasis on increasing its safety, effectiveness, efficiency, equitability, timeliness, and patient centeredness (IOM, 2001). With the release of the most recent IOM report "The Future of Nursing: Leading Change, Advancing Health" (IOM, 2011), nurses are tasked with being active partners in this transformation of health care. However, advanced practice registered nurses (APRNs) continue to be encumbered by scope of practice restrictions and challenges to obtaining parity in reimbursement. These barriers can be removed through political advocacy. In addition, in order to create widespread change in the delivery of health care and in the structure of America's health systems, policies supporting quality improvement must be researched, developed, funded, and implemented. The complexity of today's healthcare environment and the increase in volume of scientific knowledge demand the involvement of nurses educated in the legislative process and prepared to influence policy on the local, state, and national levels.

APRNs have the advantage of an appreciation of the patient care experience and the challenges of working within complex healthcare systems. However, those unique experiences must be combined with an education in the intricacies of policy and politics in order to create true and effective change. Policy activism translates into patient advocacy. In 1992, Ham described five basic elements critical to understanding the inherent complexity of policy. These elements are just as relevant today and include the following concepts:

1. Reviewing policies includes studying formal decisions and actions.
2. A policy may include a network of interacting decisions rather than a single decision.
3. Policies change over time.
4. Policies that were *not* acted on should also be included when reviewing policymaking.
5. It is important to identify the policies that were created out of clear decision-making and to use that information to develop an effective process of policy making. (Hewison, 1999, p. 1378)

During the creation of the American Association of Colleges of Nursing's (AACN's) *Essentials of Doctoral Education for Advanced Nursing Practice*, the AACN recognized and supported the integral relationship between policy and practice. Therefore, the AACN included the curricular requirement of instruction in "health care policy for advocacy in health care" in the *Essentials* (AACN, 2006). According to the AACN, doctoral-educated nurses will have the tools to engage in and serve as leaders in the development and implementation of healthcare policy that affects financing, regulation, quality improvement, and equitable access to health care.

The ability to effectively engage in influencing policy can be created by obtaining an understanding of the foundations of nursing policy, the elements of the political process, and the relationship between leadership and policy making. APRNs can be at the forefront of changing the system of healthcare delivery in the United States by shaping local and legislative decision-making processes. In 2000, Rains and Carroll asserted that there has never been a greater need for nurses to be involved in the political process in order to ensure the best use of shrinking resources, provide affordable health care for all, and advocate for changes in healthcare policy.

History of the Relationship Between Nursing and Policy Making

The integration of nursing and policy is not a new concept. During the Crimean War, Florence Nightingale recognized the connection between

policies made by Parliament and the British soldiers' poor living conditions (Ennen, 2001). Nurses' policy involvement has waxed and waned since the 19th century, when Nightingale exerted influence on the public policies of sanitation and infection control practices. There was a lack of political interest and influence in the early 20th century (Milstead, 2008, p. 2). After a few decades of silence, individual nurse leaders such as Lillian Wald and Lavina Dock spoke up and publically supported suffrage, women's rights, nursing licensure, and the right to health care (Rubotzky, 2000). Nursing as a collective field, however, did not speak out on the issues. In 1985, Huston described several factors explaining nurses' lack of political involvement, including the "socialization to view power and politics negatively and the invisibility of nurses in the media" (Rains & Carroll, 2000, p. 37). From the 1970s through the 1990s, nurses were gaining in the areas of nursing science and education, in the use of technological knowledge and clinical skills, and in the creation of a new paradigm of advanced practice nursing. Advanced practice nurses were now confronted with understanding the political and practice implications of state and national legislation and with creating policies that supported the continued advancement of the profession.

During the 1970s, the Department of Health, Education, and Welfare created the Committee to Study Extended Roles for Nurses. This committee recommended further studies on cost-benefit analysis and attitudes toward the use of APRNs and recommended increased federal funding for nurse practitioners (Hamric, Spross, & Hanson, 2000). The 1970s also brought battles over prescriptive authority, the right for APNs to use the word *diagnose*, and the right to directly bill Medicare for nurse anesthesia services (Hamric et al., 2000). The 1980s brought the concepts of cost containment and diagnosis-related groups and the associated legislation that would have an impact on APRN practice. Nurse practitioners and nurse anesthetists encouraged lawmakers and the Health Care Financing Administration, currently the Centers for Medicare and Medicaid Services, to create policies and pass legislation concerning reimbursement procedures that would support the profession of advanced practice nursing. In 1989, nurse anesthetists became the first APRN group allowed to obtain direct reimbursement from Medicare for anesthesia services. The passage of this legislation is considered to be "one of the greatest lobbying achievements not only of the American Association of Nurse Anesthetists (AANA) but of the whole of nursing" (Bankart, 1993, p. 167).

Throughout the 20th century, nursing organizations were created and led by nurses who acknowledged the need for involvement in the policy

arena, the necessity of professional leadership, and the importance of strong grassroots efforts by their nurse members. The 1990s were a decade of growth in the numbers of APNs and of both nurse practitioner and nurse anesthetist programs. Comprehending the increased complexity of patients and of healthcare systems, APRN educational programs transitioned to requiring a master's-level education for entry to practice. APRN organizations continued to develop a voice, while the American Nurses Association (ANA), realizing the need for access to legislators, moved its headquarters to Washington, D.C. (Hamric et al., 2000; Milstead, 2008).

As we begin the 21st century, conflicts over physician supervision, prescriptive authority, scope of practice, equal access to healthcare providers, and the quality, safety, and cost-effectiveness of health care are still being waged at the state and federal levels. The recent incorporation of policy into the APN role and the doctor of nursing practice (DNP) degree requirements is leading to a resurgence of interest in the responsibility of influencing healthcare reform, the promotion of global health, and the protection of the profession.

INFLUENCING THE HEALTH POLICY AGENDA

Public policy is created by governmental legislation and involves laws and regulations. It has been defined as "the purposeful, general plan of action developed to respond to a problem that includes authoritative guidelines" (Sudduth, 2008, p. 171). According to Mason, Leavitt, and Chafee (2002), "public policy often reflects the values, beliefs and attitudes of those designing the policy" (p. 8). Public policy can be further divided into social policy, which concerns communities, and then into health policy, which focuses on the health of the individual (Mason et al., 2002). The word *politics* has both positive and negative connotations. On one hand, it brings to mind images of corruption, misbehavior, and "politics as usual." However, politics should also have positive undertones as the decision-making process whereby APRNs can influence the development of legislation and the allocation of resources. As APRNs are increasingly becoming empowered to engage in the process of transforming health care, they must be actively engaged in influencing the health policy agenda. DNP graduates are well positioned to influence the content and quality of healthcare legislation. Along with their extensive clinical background and a well-developed comprehension of the issues, APRNs must have a working knowledge of the language of legislation and regulation. (See Appendix 5-1 for definitions of common legislative language)

The Process of Legislation

The legislative process is rarely the very linear, rational process described in textbooks. Instead, it is a process whereby competing interests attempt to influence policy making by creating bargains, trading votes, and using rhetoric to convince legislators that their policy agenda is the best. APRNs have the opportunity and responsibility to educate lawmakers as legislation moves through the legislative bodies and government agencies. **Figure 5-1** notes the basic steps of moving a bill through the state or federal process. In the federal policy arena, proposed legislation is called a bill until it is passed by both houses of Congress and signed into law by the president. At the state level, a bill moves via a similar process and is passed by the state legislature and signed into law by the governor.

Although APRNs can draft legislation, it is more common to partner with an interested and supportive legislator in either the state or federal House of Representatives or the Senate. The drafting process may include only a small number of persons, or it may involve a significant number of interested parties. It will be beneficial at this stage to allow any stakeholder nursing groups to review the language of the proposed legislation. Why is this important? Not all language is viewed the same by all groups, and what may be good for one APRN group may be detrimental to another. The time to find this discrepancy is not during the hearing phase, when the ability to influence legislation may be limited by time constraints and lack of coalition support.

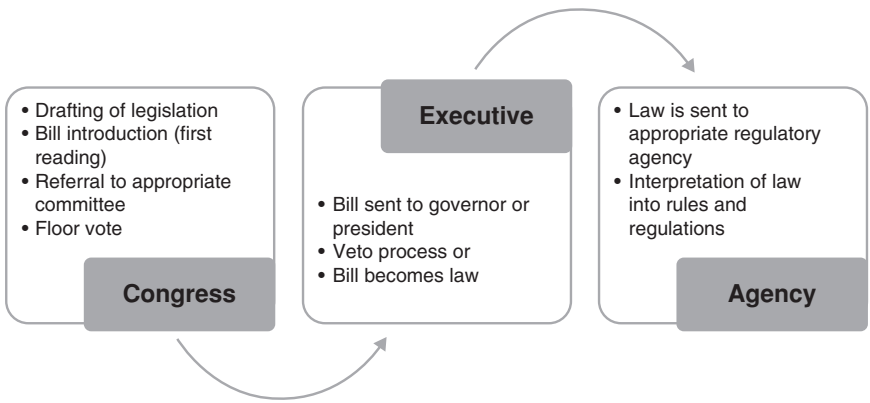

Figure 5–1 Movement of a Bill

The greater the political power of the sponsoring legislator, the greater the probability of successfully passing a piece of legislation. The likelihood of successful passing of legislation will also improve if supportive legislators introduce the bill to both chambers of Congress at the same time. Bipartisan support from both Republican and Democratic sponsors further increases the likelihood of successful movement of legislation through Congress. Following the drafting of the legislation, the senator or representative will introduce the proposed legislation to the chamber; the legislation will then be referred to the proper committee, typically based on the recommendation of the sponsoring legislator. The bill is given a number corresponding to the chamber in which it was introduced (e.g., S.252). The details of each bill can be found at www.thomas.gov. The selection of the "proper" committee is based primarily on the appropriateness of the committee but can also be a political decision based on whether members of the committee support or oppose the proposed legislation. In theory, members usually author bills that will be referred to the committees where they have jurisdiction. While the legislation is in committee, interested parties and stakeholders may be invited to submit written or oral testimony either supporting or refuting the legislation. The legislation then undergoes a process called markup in which the committee debates the legislation, discusses the flaws, and amends the legislation as necessary.

During this process, APRNs should be prepared to serve as content experts while advocating for the profession of nursing and shaping the healthcare agenda. It is imperative at this point to know the "enemies" of your legislation and be able to generate a strategy for managing controversy. Well-prepared testimony includes a description of who is doing the testifying (e.g., a family nurse practitioner in a rural practice), the background of the issue, and why the legislation is supportive or detrimental in resolving the issue. Effective testimony must also include what the APRN testifying would like the committee to do. Submitting oral testimony may be a stressful situation, but the key to presenting a logical, persuasive report is to prepare in advance. When preparing testimony, it is very important to be able to discuss the issue in great detail, know the influential legislators on the committee, and include the potential impact on patient care.

Once the committee agrees on the content and language of the bill, it is then moved to the Senate or House floor and voted on by the members. The submitting committee must create a report to accompany the bill. The report includes such information as the intent of the legislation, the potential financial implications, dissenting opinions, and amendments to the initial bill. The bill may be referred back to committee, approved, or voted down. Meanwhile, "companion legislation" is introduced in the other chamber

of Congress, typically with similar wording; however, rarely is the wording exactly the same. The passage of the original legislation in one chamber encourages the forward movement of the companion legislation in the other chamber. Following the passage of both companion bills, one in the Senate and one in the House, the bill may be moved to a conference committee to work out any differences. The conference committee is composed of both senators and representatives. Both chambers must concur and approve their respective bills prior to the bill passing out of Congress and moving to the executive branch. If the bill does not come out of committee prior to the end of the legislative session, the bill is dead and must be reintroduced during the following session.

An important role for APRNs during this phase is to contact their representatives or senators and to build coalitions with other professional associations. The importance of creating these relationships prior to the introduction of any legislation will become evident as the bill moves through Congress. Nurses must not wait until the proposed legislation is being voted on—this is too late! Instead, nurses must be involved during the very early stages. Although the emphasis of influencing legislation often lies within Congress, at the federal level, the executive branch has the power either to veto the legislation or to sign the legislation. Again, a similar process occurs at the state level. Another import factor to consider is the power of the office of governor or president in supporting or blocking the legislative effort.

The Process of Regulation

An equally important but maybe more complex segment of policy is regulation. Regulation is the implementation process of legislation and occurs at both the state and federal levels. After a bill is passed through Congress and signed into law by the president, it is sent to a regulatory agency within the government, which then interprets the law and creates the rules and regulations that shape the way the new law is executed. Congress rarely includes explicit directions for implementation within the legislation and, in fact, may be purposefully vague. Again, stakeholders are invited to comment on the proposed draft of the rules and regulations. It is important not to overlook this phase since a hard-fought battle to produce legislation favorable for nursing may become something completely different during the regulatory process. Conversely, if policy cannot be changed in the legislative arena, APRNs may be able to persuade the regulatory agency to publish rules that are favorable to nursing. This may be a dangerous game to play, because regulations must be consistent with the enabling statute. In the event that the regulation is inconsistent with the law, the law supersedes the regulation.

Federal agencies of interest to APRNs include the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the Department of Veterans Affairs, the Indian Health Service, and the Armed Forces. CMS is the primary agency regulating reimbursement for APRN services, including supervision requirements. Prior to a regulation being put into effect, two steps must occur. First, the proposed rule is published in the *Federal Register*, and information is included on how the public can participate in the process by providing comment and attending the meetings (Loversidge, 2008). The second step involves the agency considering all the information and deciding on a course of action. The final regulation is then published in the *Federal Register* and becomes effective after 30 days. The *Federal Register* is a daily journal of the government of the United States that contains the public notices of all the government agencies, executive orders, and presidential proclamations. All the information from the *Federal Register* is in the public domain and can be accessed by any APRN at www.gpoaccess.gov/fr/index/html. Many professional organizations have paid staff to monitor the *Federal Register* for regulations that may have an impact on APRNs.

Boards of nursing, medicine, and pharmacy are examples of state regulatory agencies that may create rules and regulations affecting nurses and the delivery of health care within states. These agencies have the power to control entry into the profession, monitor and discipline licensees, and ensure continued competency of licensees (Loversidge, 2008). State agencies obtain their rulemaking authority through enabling laws. An enabling law is "one in which the state legislature delegates to an administrative agency the authority to adopt regulations to implement the law's purposes" (Tobin, 2001, p. 113). In essence, enabling laws give regulatory agencies the power to create rules and regulations. APRNs should assist in maintaining a collegial relationship between their state professional organizations and the board of nursing. Most appointments to state boards are made by the governor and necessitate the support of legislators and professional organizations. APRNs must be represented on boards of nursing to monitor the actions of the board and offer recommendations related to advanced nursing practice.

Boards of medicine may attempt to regulate nursing practice through language concerning supervision and collaboration. Therefore, it is advisable for APRNs to be aware of the regulatory agenda of all state boards that may have an interest in limiting APRNs' scope of practice and patient access. This involvement may include having an APRN presence at the board meetings of nursing and non-nursing state boards. When reviewing proposed regulations, it is important to understand the intent of the regulation and evaluate the language of the regulation for possible limits to APRN

scope of practice and reimbursement. Other possible avenues to influence the regulatory process include seeking appointment to CMS panels, providing testimony at regulatory hearings, obtaining a position on advisory panels to the National Council of State Boards of Nursing (NCSBN), or agreeing to serve as an APRN expert during drafting of regulatory policy.

The NCSBN is a coalition of state boards of nursing that provides an avenue for state boards to examine regulatory issues and "counsel together on matters of common interest and concern affecting public health safety and welfare," including performing policy analysis, licensure, and research (NCSBN, n.d.). In 2008, the NCSBN partnered with the APRN Consensus Work Group and created the Consensus Model for APRN Regulation. The Consensus Model grew out of a concern that because each state determines the legal scope of practice and the criteria for entry to practice and competence through certification examinations, the ability of APRNs to move between states is limited, and access to health care for patients may decrease. The Consensus Model promotes a uniform regulatory process based on nationally accepted standards for certification, licensure, and practice. All APRN stakeholder professional associations were invited to comment on the proposed Consensus Model. The APRN Model Act on Rules and Regulations was approved by the NCSBN in August 2008. It was essential throughout this process that all APRN groups had a place at the table and were able to discuss concerns with the regulatory language, create a coalition of a wide variety of nursing groups, and generate a model that all the nursing stakeholders could support. The IOM (2011) has supported the NCSBN Model for Nurse Practice Act and has recommended that Congress "limit federal funding for nursing education programs to only those programs in states that have adopted this model" (p. 278). Although the intent of the IOM is to remove scope of practice barriers through consistent education and regulation, these statements could have a profound and unexpected effect on APRN practice. Therefore, as language from the Consensus Model begins to appear in proposed state legislation, it is imperative that APRNs monitor the legislative language to ensure that the intent of the model is correctly displayed in the legislation at both the state and federal levels

Therefore, in policy making, it is important to consider all phases and potential areas for influence throughout the entire process. Although similarities exist between states, APRNs should also understand the peculiarities of their state of licensure and the differences between federal and state legislation and regulation. APRNs can influence policy by providing proactive solutions to the problems facing health care rather than lamenting the problems. The solutions should contain information on practicality, feasibility, financial implications, and the benefits for the profession of

nursing and for overall health care. Armed with an understanding of the background of policymaking, the APRN will be able to build coalitions, foster grassroots lobbying efforts, and cultivate effective lobbying skills.

Professional Organizations, Grassroots Lobbying, and Coalition Building

The powerful combination of a united political voice through professional organizations and the grassroots efforts of APRNs has the power to influence the healthcare agenda. Through membership dues and other revenue sources, professional organizations have the resources to create a network of federal government lobbyists, state government political affairs directors, and political action committees.

Strength in numbers and coalition building are an important part of creating political influence. Membership in a professional organization is the responsibility of all APRNs. **Table 5-1** lists examples of APRN professional organizations. Professional organizations all have healthcare advocacy on their agenda, but their approach to influencing policy varies. The yearly legislative agenda for each professional organization is based on the current policy climate, the presence of pro-nursing members of Congress on important committees, and the current needs of the profession. Some organizations have offices based in Washington, D.C., with paid office staff, professional lobbyists, and political action committees. Others operate primarily on a grassroots-type scale, with members providing the majority of the legislative work. Regardless of the organizational makeup, all members should maintain a two-way channel of communication to facilitate the flow of policy information and generate a network of involved members for grassroots lobbying efforts.

It is important to remember that political decisions are not made in the Senate or House chamber on the day of the vote but in offices throughout

Table 5-1 APRN Professional Organizations

American Academy of Nurse Practitioners (AANP)
American Association of Colleges of Nursing (AACN)
American Association of Nurse Anesthetists (AANA)
American College of Nurse Midwives (ACNM)
American Nursing Association (ANA)
American Organization of Nurse Executives (AONE)

the legislative session. Decisions may be based on external pressures from other legislators, constituents, friends, and professional groups. A potentially powerful grassroots approach to influencing policy is to become involved in the election campaign of an official running for public office. Involvement may range from knocking on doors to discuss the campaigner's stance on the issue of access to health care, to hosting a fundraising event. Visibility is critical. When elected, the legislator will remember the supporters who were involved in the early stages of his or her run for a position in the local, state, or federal government. An indication of effective involvement can be when a legislator introduces an APRN to another legislator with the words "the APRNs were with me from the beginning." This early involvement translates into an open-door policy with the legislator for members of the organization.

Lobbying is not a dirty word but an important part of the legislative process bound by ethical rules of conduct. Lobbyists are registered, educated professionals hired by both state and federal organizations to influence decisions made by legislators. One approach to influence legislation is to ensure that the legislators have all the pertinent information prior to making a decision on a certain piece of legislation. For example, in the recent healthcare bill, a legislator who has a reputation of being "CRNA friendly" proposed an amendment for reimbursement for pain management services. However, the wording covered only physician services. After a discussion with the AANA lobbyist, the amendment was changed.

Because healthcare professional organizations are composed of members with full-time careers in the clinical arena, lobbyists are an integral part of influencing the healthcare agenda. Lobbyists are able to be continuously available during the legislative process. The lobbyists have cultivated relationships with legislative staff and understand the inner workings of Congress. Professional lobbying activities performed on behalf of an organization can include monitoring ongoing and proposed legislation, developing an agenda of legislative goals, advising on distribution of political action committee funds, communicating with the membership, and educating members during grassroots lobbying efforts. Lobbyists often assist in creating a voice for the professional organization in developing oral and written testimony. Professional lobbyists do not create the message. APRNs have the message; the lobbyist just knows how to get the message to the right people and in the correct manner.

Legislators are more likely to listen to the concerns of their constituents and to support the efforts of a group of constituents. APRNs must take on the professional responsibility of advocating for nursing and healthcare reform by contacting their representatives and senators in Congress.

APRNs have the ability to tell the story of their patients who cannot afford preventive health care, or the small-town hospital that is closing because of budget cuts, or the patient who does not have access to health care because of lack of providers. Personal stories told by a clinician in one of the most respected and trusted professions can be a powerful tool for influencing legislation. Also, storytelling can be the least intimidating entry into the world of grassroots lobbying. When APRN DNP students share their personal difficulties in obtaining funding for education and for research, it creates a more lasting impression than when a nonstudent discusses the challenges of financing education. APRN students can also share the real risk of a decline in the number of providers due to the high cost of education, especially at a time when the healthcare system may see a large influx of patients due to healthcare reform measures.

Professional organizations play a significant role in preparing the membership and alleviating some of the fears of grassroots lobbying. For example, the AANA's Federal Government Affairs Office creates "Action Alerts" to encourage members to contact their representatives or senators. A portion of the AANA website contains the information that members who are certified registered nurse anesthetists (CRNAs) can use to contact their legislators. At a yearly assembly held in Washington, D.C., the staff at the AANA's D.C. office educates CRNAs on the legislative process as a whole, on the current issues facing health care and healthcare reform, and on the issues specific to CRNAs. A portion of the assembly is spent practicing for lobbying, including the dos and don'ts of presenting the issues and very specific details on the agenda for lobbying visits to Capitol Hill. Attending these professional meetings can be a very empowering experience, creating an understanding of what one individual, as part of a larger organization, can do to advocate for the profession of nursing and for the health of the nation. **Table 5-2** lists examples of effective lobbying techniques.

Another essential aspect of lobbying is appreciating the roles and responsibilities of congressional staff. Each member of Congress has a chief of staff, also called an administrative assistant (AA), who is responsible for overseeing the overall management of the office, including managing the media and public relations and serving as a political advisor. Legislative directors are responsible for the "day-to-day legislative activities and may have more policy expertise" (Wakefield, 2008, p. 70). Legislative assistants (LAs), often post college interns or fellows participating in a fellowship program, have the most contact with special interest groups such as nursing professional organizations. LAs can be very influential because they advise the member of Congress on health policy issues. They control what information is presented to the member of Congress and what groups get face time

Table 5-2 Effective Lobbying

Lobby in person or on paper.

- Send letters to your member of Congress when necessary.
- Obtain face time with legislators early on and throughout their term(s).
- Make an appointment rather than just drop by (not just in Washington, but at home too).
- Be professional in appearance and demeanor.
- Be punctual.

Understand how the policy-making process works.

- Attend educational "boot camps."
- Maintain two-way communication with your professional organization regarding the organization's legislative agenda.

Use your professional organization's lobbyist.

Cultivate relationships with key legislative staff.

- Take the time and opportunity to educate staff on nursing issues.

Research your issues.

- Be knowledgeable, confident, and articulate.
- Know the number and status of the bill you are supporting or opposing (www.thomas. gov).

Research the legislator you will be lobbying.

- Build legislative profiles.
- Is there a healthcare provider in the legislator's family?
- Is the legislator on a committee with jurisdiction over healthcare issues? Is he or she the chair of the committee or a ranking member?

Drive the discussion.

- Tell your story.
- Provide credible, "at the bedside" information about the impact of policies on health care.
- Discuss the impact of proposed legislation on the individual in his or her district—on constituents, the healthcare consumer, and the overall health of the United States.
- Never bash or speak poorly of your adversaries' position on the legislation.
- If applicable, ask the legislator to sign on to cosponsor a bill you are supporting.

Stay in touch.

- Send a handwritten thank you note as follow-up.
- Include your business card and how to contact you for questions or assistance.
- Flaunt your credentials!

Exemplify professionalism.

- Focus on advocacy, trust, knowledge, and competency.
- Focus on the unique role, skills, and pivotal position of APRNs in the healthcare system.

with the senator or representative. LAs are assigned to a specific issue, such as health or veterans' affairs; this does not mean that the LA is an expert in that area, however! When meeting with an LA for the first time, it is crucial to determine what he or she knows about advanced practice nursing and nursing's stance on healthcare issues. It is important to spend time educating the LA, in a nondefensive, noncondescending manner, regarding APRN practice and the professional organization's legislative agenda. Even if the exact goal of the lobbying visit was not met, the LA will have obtained a greater understanding of APRNs, including those with doctoral education, which may increase the probability that a DNP may be sought out for advice on proposed legislation. An established relationship with the member of Congress's health LA will serve as a communication conduit for information regarding upcoming legislation and committee hearings.

Although the blend of money and politics may not always appear like a good combination, a strong political action committee (PAC) will increase access to and gain the attention of members of Congress. A PAC is a "group that is formed by an industry or an issue oriented organization to raise and contribute money to the campaign of political candidates who likely can advance their issue" (Twedell & Webb, 2007, p. 279). PACs have been involved in the campaign process over the last 60 years. Two types of PAC exist: separate segregated funds (SSFs) and nonconnected committees. SSFs are established and administered by organizations, whereas nonconnected committees are not sponsored by any organization (Federal Election Commission, 2009). Nursing PACs collect funds from their membership, pool the money, research the candidates, and distribute the money to legislators who are more likely to support the agenda of the nursing organization. PACs may contribute primarily to Democratic or Republican candidates, but often the PAC may be nonpartisan, supporting the candidate with similar priorities or the candidate who is influential on healthcare issues. Nurse anesthetists (NAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified nurse midwives (CNMs) have APRN-specific PACs. The American Nurses Association's PAC also contributes to candidates who support APRN issues.

As Congress addresses campaign reform, PACs have come under increased scrutiny and have been required to increase transparency in regard to sources of funding, donation amounts to candidates, and relationships with Congress. The Federal Election Campaign Act of 1971 prohibited organizations from using their general funds and membership dues to fund campaign contributions, and the Bipartisan Campaign Reform Act of 2002 placed further limits on contributions (Twedell & Webb, 2007). However, in 2010, Citizens United, a conservative nonprofit organization, successfully

used the First Amendment's prohibition on the government placing limits on political spending by corporations or unions as a mechanism to allow for financing political expenditures through a corporation's general treasury. This ruling by the United States Supreme Court allows for the creation of a "Super PAC" with access to significant amounts of money to spend on media campaigns for or against a certain candidate. All PACs must continue to be transparent as required from previous legislation related to campaign reform (*Citizens United v. Federal Election Commission*).

Physician groups and pharmaceutical companies continue to have the top-spending PACs in health care, which often translates into greater political influence. During the 2008 election cycle, the only nursing PAC to break into the top 10 PACs was that of the American Association of Nurse Anesthetists. An interesting note is that the American Society of Anesthesiologists led PAC contributions from specialty physician groups (Center for Responsive Politics, 2009). According to the U.S. Department of Health and Human Services, in 2008 there were 250,527 APRNs (Health Resources and Services Administration, 2010). If each APRN donated $50 to his or her PAC, the resultant $12.5 million could move APRN PACs toward the top of the list of influential healthcare PACs. Information regarding individual PACs, including where the money comes from, how it is spent, and the overall worth of each PAC, can be found at www.opensecrets.org/index.php. With nursing's positive public image and a well-funded PAC, imagine the possibilities to influence legislation and advocate for improved quality and access to health care.

Coalition building is an effective approach to obtaining legislative and regulatory approval for an organization's policy agenda. Coalitions may last for the short term or long term, with the objective of combining resources to achieve a common goal. Nursing organizations can form coalitions either with other healthcare organizations or between APRN groups. For example, a coalition of over 30 nursing organizations created the Nursing Community Consensus Document (2008) requesting improved funding for doctoral education and calling for the removal of the rule that limits traineeship grants for doctoral education. Although the emphasis is on increasing nursing faculty, the importance of removing the cap on doctoral grants for entry-level doctoral students should not go unnoticed. According to Rice (2002, p. 122), the essential ingredients for strong coalitions include "leadership, membership, and serendipity." As in all organizations, it is important to have a leader who can organize the work of the coalition and a leader who can motivate the group to stay on target (Rice, 2002). This could be an important venue for a DNP. Membership is essential to increase the productivity and the visibility of the organization. Coalitions may be formed

by unforeseen opportunities. For example, proposed state legislation to remove the collaboration requirement for prescriptive authority may bring together the state nursing association and the state APRN organizations.

Just as there are benefits for organizations in coming together, there are also potential pitfalls and challenges to effective functioning of the group. When forming a coalition, it is essential to have all the right people: members who will work hard and people with a stake in the common goal (Rice, 2002). One of the challenges of working in a group of differing organizations is the presence of differing perspectives. Although the group may have one common goal, each member organization may have contradictory perspectives on other goals. When this occurs, it is essential to have a leader, potentially one with a DNP degree, who will seek out diverse opinions, allow members to agree to disagree, and "work toward achieving decisions which members can live with" (Rice, 2002, p. 128). Also, although opposing organizations may not agree on all topics, it is important to handle conflict effectively in order to maintain a working relationship if the need for collaboration does occur.

Coalitions may be created for the purpose of countering a threat to the ability of member organizations to practice to the full scope of their professional licensure. The Coalition for Patients' Rights (CPR) is composed of 35 organizations representing a variety of licensed healthcare professionals. With strength in numbers and a diverse group of providers, the aim of CPR is to offset the efforts of the American Medical Association's Scope of Practice Partnership (SOPP) initiative, which is designed to limit patients' choice of healthcare providers and ultimately patient access to health care (CPR, n.d.) Some coalitions may be formed without the express purpose of policy making. However, the data obtained by these nursing groups can be used to give a statistical significance to a proposed legislative agenda item. The Interagency Collaborative on Nursing Statistics (ICONS) "promotes the generation and utilization of data, information, and research about nurses, nursing education, and the nursing workforce" (ICONS, 2006).

Coalitions of like-minded organizations may join forces to ensure a seat at the table while the details of the composition of healthcare reform legislation are debated. The Patients' Access to Responsible Care Alliance (PARCA) is a coalition of nonphysician organizations that "aims to provide federal policymakers with access to information from all areas of the healthcare community . . . and is committed to quality cost-effective care and ensuring patients have options in the delivery of such care" (PARCA, n.d.). The inclusion of nondiscriminatory language for reimbursement for services provided by a nonphysician is critical for the future of APRNs and for equitable access to health care for all. This coalition was successful in

getting nondiscrimination language included in the Patient Protection and Affordable Care Act (ACA) of 2010. PARCA is composed of nursing APRN organizations, the American Academy of Audiology, the American Chiropractic Association, the American Optometric Association, the National Association of Social Workers, and others. As evidenced by the composition of PARCA, an important aspect to consider when building effective coalitions is the significance of connecting diverse groups, including both depth and breadth of professions.

Healthcare Reform

Because of increasing healthcare costs, "the insecurity resulting from basing healthcare insurance on employment," and the significant number of uninsured, the American public grew increasingly dissatisfied with the state of health care in the United States throughout the 1990s (Schroeder, 1993, p. 945). In 1993, the Clinton administration attempted to reform health care in the United States. The proposed national Health Security Act (HSA) of 1993 included guaranteed comprehensive benefits, limitations on health insurance premiums, and increased emphasis on quality, and mandated employers to provide insurance coverage through regulated health maintenance organizations (National Health Security Plan, 1993). The proposed plan, spearheaded by then first lady Hillary Clinton, had significant opposition from conservatives, small business owners, and the health insurance industry because of its cost and complexity, significant government oversight and control, and the potential to limit patient healthcare choices. In the end, legislation for healthcare reform was not passed.

Because of the difficulty in creating a coalition for support and the appearance of political shenanigans, the American public's interest in healthcare reform declined during the time that the HSA legislation was drafted. For the first time, nursing, the largest group of healthcare providers, had a significant presence during the debate over how to reform the U.S. healthcare system. This presence was due to the work of a small group of nurses who understood the importance of creating legislative relationships and of suggesting solutions to the problem, and who demonstrated a "willingness to compromise in the present to secure the greater gain in the future" (Milstead, 2008, p. 20).

In advance of the presidential and legislative impetus to restructure the healthcare system, the ANA created a task force in 1989 to begin work on an agenda to reform health care. Nursing's *Agenda for Healthcare Reform*, published in 1992, focused on the contribution that reforming health systems would have on improving access to care while controlling cost and

improving outcomes. The agenda called for a "federal standard of uniform basic benefits package for all US citizens and residents financed through public-private partnerships using a variety of healthcare providers including provisions for community health and quality measurement" (Trotter Betts, 1996, p. 4). Despite the failure of the HSA, the activism during this period allowed nurses to obtain increased visibility in the policy arena and develop skills in policy making. Nursing and the ANA came out better informed, with greater access to legislators, and better armed for the next legislative challenge (Rubotzky, 2000; Trotter Betts, 1996).

Blendon and Benson, in a 2001 review regarding American opinions on health policy over the last 50 years, found that "Americans may have expressed dissatisfaction with private health insurance and managed care but most don't trust the federal government to take over as a single-payer provider or are satisfied enough with their current medical payment arrangements" (cited in Jamelske, Johs-Artisensi, Taft, & German, 2009, p. 17). However, given the 2008 downturn in the economy, Americans and Congress are again concerned with enacting some variety of healthcare reform. With the rising cost of healthcare premiums and the increase in the number of Americans who are uninsured or underinsured, Americans have begun to realize that the potential to lose coverage in the future does exist. Policy lessons learned during the previous attempts at healthcare reform have set the stage for organized nursing to influence policy that will ensure improved health care for all Americans. An incremental healthcare reform policy would begin with small changes, allowing for the addressing of political dynamics at each stage. Influential policy makers exist on both sides of the plan for reform: creation of an immediate, all-encompassing change versus making small adjustments at regular intervals.

In March 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law despite a lack of bipartisan support. The ACA's wide-ranging provisions address many of the issues that were facing health care in the prior decades, including outmoded approaches to reimbursement, provider discrimination, lack of access to healthcare insurance at a reasonable cost, disparities in health care among all citizens, and rampant healthcare costs. Although many of the supporters of healthcare reform may have preferred a sweeping movement to publicly provided health care for all, many in Congress remembered the failures of the Clinton administration and supported incremental, narrower calculated initiatives. The ACA mandates individual health insurance but continues to preserve many aspects of the existing health insurance systems" (Gabel, 2011). It expands Medicare coverage and provides for increased federal support for the Children's Health Insurance Program. Of particular interest for

APRNs, it encourages the creation of new patient care models—Accountable Care Organizations—and provider nondiscrimination language in reimbursement for service. Other diverse components span from the linking of Medicare payments with quality indicators to increased access to preventive care and increased federal financial support for careers in nursing.

In this author's opinion, it remains to be seen whether the ACA will result in broad healthcare reform as it moves through the US judiciary, regulatory agencies, and state government. Also, according to Gable (2011), "the ultimate effects and significance of the ACA remain uncertain" (p. 340), and the same obstacles exist, including political opposition, concerns over constitutionality of mandates, and overall implementation of the legislation. Political influence developed by the ANA and nursing leaders in the 1980s and 1990s must be sustained throughout the upcoming legislative challenges during the anticipated long road to sustainable healthcare financing reform.

LONG-STANDING POLICY GOALS

Prior to advocating for improvements in health care, it is crucial to understand the issues that have been at the forefront of nursing policy and politics for over four decades and that continue to warrant nursing's legislative and regulatory involvement. According to Malone (2005, p. 139), "it is important to understand the recent history of any policy issue to better understand the obstacles and resources in play."

Nursing Workforce Development

As the demand for health care rises, the demographics of our population change, and the new Patient Protection and Affordable Care Act is implemented, the nursing profession continues to be challenged with an overall nursing workforce shortage. Although the primary factor behind the nursing workforce shortage changes over time, "consistent factors include unfavorable working conditions, relatively low income potential, more satisfying alternative job opportunities, and lack of nursing faculty" (McHugh, Aiken, Cooper, & Miller, 2008, p. 6). Doctorally prepared APRNs and nursing faculty are drawn from the relatively small pool of baccalaureate-prepared nurses; therefore, deficiencies in the number of registered nurses affect APRN vacancy rates and ultimately may limit patient access to care. Vacancy rates change over time relative to the changing economic times and healthcare market. Therefore, when advocating for legislative change concerning workforce development, it is necessary to have updated facts on past and current vacancy rates, the impact of past funding efforts on the shortage

of nurses, and the impact of vacancy rates on healthcare delivery. For example, data from the U.S. Bureau of Labor Statistics (BLS) has been used to support the need for educational funding due to a projected need for a 23% increase in registered nurses by 2016 (BLS, 2007). Additional information in the BLS *Occupational Outlook Handbook* reported that all four APRN specialties—CNS, CRNA, CNM, and NP—will be in "high demand particularly in medically underserved areas" and "relative to physicians, these RNs increasingly serve as lower-cost primary care providers."

According to McHugh et al. (2008), "The nursing shortage is not only of total numbers but also of the level of nursing education" (p. 7). Over the last decade, nursing organizations have continued to lobby for legislative support to increase funding for nursing education at both the baccalaureate and graduate level. One legislative mechanism for funding is through the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act). Title VIII programs have been the largest source of federal funding for nursing education over the last 45 years. In the 1960s, nursing leaders lobbied Congress to enact legislation that would alleviate the nation's nursing shortage by funding nursing education. In 1964, President Lyndon Johnson signed the Nurse Training Act of 1964. In the years since its inception, Title VIII has expanded to include funding for advanced practice nursing education, for the education of disadvantaged and minority students, for nurse faculty loan programs, and for nurse education, practice, and retention grants (Nursing Community Consensus Document, 2008). Title VIII grants are an essential component for increasing the number of APRN graduates and for ensuring that medically underserved areas receive access to healthcare services. However, the level of funding is not guaranteed, and, despite the increased costs of education and inflation, the relative level of funding has remained unchanged. It is through the continued action of involved nurses that Title VIII funding consistently remains in the national budget and on the legislative agenda.

Along with a greater demand for nurses, the changing complexity of health care and healthcare systems requires that a greater number of advanced practice nurses and nursing faculty be prepared at the graduate level. APRNs must continue to monitor and support legislative issues that alleviate the nursing shortage by expanding funding for nursing education, promoting a favorable work environment, and eliminating barriers to practice.

Reimbursement

Although the complexity and changing nature of regulation make a detailed discussion of APRN reimbursement impractical for this venue, it is

appropriate to discuss the fundamentals and historical background within the framework of advocating for APRN practice. It is imperative for the APRN provider to understand the challenges in achieving equality and to monitor for threats to APRN practice in the economic healthcare market within public policy. For over three decades, APRN groups have challenged our legislators to remove the financial barriers to practice (Sullivan-Marx, 2008).

For example, until 1989, all direct reimbursement for anesthesia services was limited to anesthesiologists. CRNAs were reimbursed from the money paid to the institution through Part A of Medicare. The disparity in the ability to directly bill for services created an inequality between providers delivering the same care. The Omnibus Reconciliation Act of 1987 required the federal Medicare program to create a separate payment plan for the anesthesia care delivered by a CRNA, which is now known as Medicare Part B. The change was budget neutral because responsibility for payment was moved from the Medicare Part A division to the Part B division (Broadston, 2001). The regulatory agency responsible for determining Medicare reimbursement was the Health Care Financing Administration (HCFA). When Medicare federal regulation changed, private insurance providers and state public health plans followed suit and opted to directly reimburse CRNAs for services provided (Broadston, 2001). It was essential during this time of legislative and regulatory change that CRNAs at all levels of the profession maintained close contact with Congress and the agencies responsible for transforming Medicare reimbursement.

During the 1970s and 1980s, as the number of nurse practitioners grew and diagnosis-related groups (DRGs) were created, nursing leaders in the American Nurses Association recognized the need for parity between physician and NP reimbursement. The ANA pressed for a mechanism to change Medicare rules through legislation (Sullivan-Marx, 2008). During this same period, three policy reports were released supporting the role of NPs and the removal of barriers to reimbursement: the Graduate Medical Education National Advisory Council's (GMENAC) report, the Office of Technology Assessment's report to Congress, and the Physician Payment Review Commission's report (Sullivan-Marx, 2008). The reports cited barriers, including the lack of NP Medicare reimbursement. The GMENAC report concluded that direct reimbursement by Medicare and Medicaid would be necessary to facilitate full use of nurse practitioners and clinical nurse specialists (Sullivan-Marx, 2008, p. 122). Finally, with the passage of the 1990 Omnibus Budget Reconciliation Act, nurse practitioners and clinical nurse specialists in rural health clinics and in nursing homes were allowed to directly bill Medicare at 85% of the physician rate. Certified nurse midwives were allowed to bill at 65% of the physician rate (Sullivan-Marx, 2008).

An additional seven years of encouraging legislators to act was required to include all NPs in direct reimbursement from Medicare. The Balanced Budget Act of 1997 granted NPs and CNSs the ability to bill Medicare in all geographic areas and settings, but still at only 85% of the prevailing physician rate (Abood & Franklin, 2000).

These initial wins for parity in reimbursement demonstrated the importance of the political advocacy role for APRNs in influencing the structure of legislation and regulation that influences finance. The next step has been to remove the artificial barrier of supervision as a requirement for Medicare payment. In 2000, CRNAs lobbied extensively (and won) for a change at the federal level. Initial gains in removing the supervision requirement were lost with the change in presidential administration in 2001. However, the AANA and CRNAs fought to develop a compromise that would lead to the Medicare "opt-out" language that allowed states to decide whether to make physician supervision of CRNAs a requirement for reimbursement. As of January 2012, 16 states have opted out (www.aana.com). Although much of the fight for parity in reimbursement between APRNs and physicians has focused on Medicare/Medicaid, APRNs must stay vigilant to prevent limitations in reimbursement from other insurance providers.

According to Abood and Franklin (2000), the ability to document and bill for APRN services creates transparency regarding which provider is actually performing the patient care. This documentation allows for connecting patient outcomes to healthcare providers and gives APRNs an additional tool to demonstrate their value to both the institution and policy makers. As we move forward with healthcare reform, through the knowledge gained during doctoral education and practice, APRNs can provide the skills necessary to analyze and engage in the discussion of cost-effectiveness, pay for performance, and reimbursement.

State Nurse Practice Acts and Scope of Practice

The first board of nursing and the first nurse practice act (NPA) were created in 1903 in the state of North Carolina (Loversidge, 2008, p. 96). Initially, NPAs focused on protecting the use of the title RN rather than defining the delivery of nursing care (Tobin, 2001). Following the 1971 report of the Department of Health, Education, and Welfare's Committee to Study Extended Roles for Nurses, state NPAs began to change to include regulations governing APRN practice (Tobin, 2001). The NPA is an example of an enabling law and contains the laws and regulations that credential and govern a profession (Loversidge, 2008). As noted in a previous section, boards

of nursing and NPAs were created to protect the well-being of patients by ensuring consistent minimum standards of licensure and qualifications. Each state has a different NPA, which defines the scope of practice for all nurses within that state and delineates the officers, staff, and powers of the state regulatory board (e.g., the board of nursing).

NPAs include language that defines the roles and responsibilities of APRNs, including "accepting referrals from, consulting with, cooperating with, or referring to all other types of health care providers" and "must practice within a health care system that provides for consultation and collaborative management and referral as indicated by the health status of the patient" (Minnesota Board of Nursing, 2008). The evolution of the NPA is evident in the language regarding the roles of nurses. The initial ANA model definition of nursing practice in 1946 included the provision that the scope of practice for nursing is "not deemed to include acts of diagnosis or prescription of therapeutic or corrective measures" (Tobin, 2011, p. 98). The ANA amended the model definition to allow for nurses to perform specific tasks (diagnosis and treatment) "under emergency or special conditions as are recognized by the medical and nursing professions" (Tobin, 2011, p. 99). In 1996, the ANA revised the model practice definition to broaden the scope of practice of professional nursing, and a definition of APRN practice was explicitly included. The 2008 APRN Consensus Model grew out of the need for state NPAs to continue to evolve to meet the needs of the profession of nursing and the healthcare needs of the American public.

State NPAs vary widely in defining the scope of practice of APRNs. Some states have very few restrictions, whereas others limit the ability of the APRN to prescribe medications, independently administer chronic pain injections, admit patients, and conduct a pre-hospital history and physical. NPAs also include rules on delegation of duties to non-RN providers, continuing education requirements, and the administration of certain medications, such as propofol, a potent amnestic. NPAs include the rules for prescriptive authority for APRNs. The authorization for APRNs to prescribe with or without a written collaborative agreement with a physician must be expressly written into the agreement. States differ in the authority for APRNs to prescribe controlled substances. CRNAs may be exempt from some of the prescriptive language that requires written collaboration to administer anesthetic agents and their adjuncts during the perioperative period.

Historically, APRNs have had to be diligent in monitoring proposed changes to an NPA and to prevent other entities from attempting to supersede the power of the state board of nursing in defining APRN scope

of practice. In 2005, the American Medical Association created the Scope of Practice Partnership and stated, in the report of the board of trustees, "[AMA] agreed that it was necessary to concentrate the resources of organized medicine to oppose scope of practice expansions by allied health professionals that would threaten the health and safety of the public" (American Medical Association, 2005). The SOPP objective is to fund studies refuting claims that APRNs are necessary to improve access to care in rural states and to create studies comparing the educational, training, and licensure requirements of physician and nonphysician providers. Just as nursing organizations should have no role in defining the practice of medicine, physician groups are in no position to define APRN practice, licensure, certification, or education. According to the Coalition for Patients' Rights, rather than creating division among healthcare professionals, the AMA and the allied health members of CPR should be working together to find solutions to the current healthcare challenges.

Any time a state NPA is opened, whether the intent is to broaden scope of practice or not, the opportunity exists for language to be inserted that increases the need for supervision by a physician or removes prescriptive authority. State nursing organizations may be reluctant to open their NPA for just those reasons. Prior to any decision to open up a state NPA, nursing organizations should have a well-developed supportive relationship with legislators who serve the committee that reviews any proposed changes. APRNs are responsible for remaining knowledgeable about the current status of the NPA in their state and for practicing within the limits of their scope of practice.

DNP graduates will be expected not only to exhibit the skills of advanced clinical practice and systems thinking but also to be accountable for driving the discussion that sustains nursing workforce development, maintains parity in reimbursement, and removes barriers to the full scope of practice for APRNs.

INTEGRATION OF POLICY WITH ETHICS, RESEARCH, AND EDUCATION

Ethics and Policy Making

Just as a vital link exists between policy and practice, so too is the connection between policy and ethics strong. The 2001 *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association, 2001) includes the following statement: "The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for

maintaining the integrity of the profession and its practice, and for shaping social policy."

Policy decisions are ethical decisions on many different levels, from choices made by professional organizations, to prioritizing a legislative or regulatory agenda, to the allocation of scarce resources. A political ethical conflict "occurs when what one is told to do (either covertly or overtly) by those having more power in the organization or what one feels compelled to do by the organization is in conflict with one's ethical belief structure" (Silva, 2002, p. 180). It becomes more of a challenge when the policy initially appears to be at odds with one's values, but on further examination, the eventual outcome of policy implementation does support the needs of the profession and public. For example, APRNs may have the ethical dilemma of supporting a legislator through PAC contributions who does not have the same values as organized nursing but sits in a position of power to influence legislation. Kent and Liaschenko (2004) examined the connection between nursing values and ANA PAC donations. They encouraged the ANA PAC to continue to evaluate the donation process for successful outcomes that are important to nursing while maintaining a connection with legislative leadership—Democratic or Republican (Kent & Liaschenko, 2004). As nursing continues to become more influential in the policy arena, it is important to develop partnerships on both sides of the legislative aisle. Regardless of the occasional differences in political viewpoints, it is necessary to ensure equal access when issues important to nursing arise.

Clinical APRNs are often the central decision makers in the allocation of resources, including laboratory and invasive testing, time spent in the delivery of patient care, medical equipment, and referrals for additional interventions (Aroskar, Moldow, & Good, 2004). This array of patient care concerns has the potential for both policy and ethical implications. Aroskar et al. (2004) used focus groups to examine the clinical nurse's perspective on changes in healthcare policy that affect patient care. Changes in legislative policy influence institutional policy, which in turn influences patient care. The most frequently noted themes included the policy implications of cost containment, the effects of policy on quality of care and patient education, and the overall effect on nurses and nursing (Aroskar et al., 2004). Medicare regulations may dictate where patients may receive care and how much care will be reimbursed. Legislation may influence the appropriate allocation of healthcare resources, as well as the decision makers who define "appropriate." Regulation regarding APRN licensure may affect quality-of-life and end-of-life matters if patients do not have access to all providers who can provide pain management and palliative care. However, although the researchers found that all the focus groups stressed the importance

of nursing having a voice in policy development, the recognized need for "assertiveness does not always translate to advocacy for patients or participation in policy development" (Aroskar et al., 2004, p. 274).

APRNs educated and experienced in policy will have the ability to comprehend the ethical implications of policy development and implementation and be able to integrate both while achieving the ultimate goals of improving health and supporting the profession of nursing. According to Silva (2002), the solution to successful resolution of an ethical conflict between values and politics involves either integration or compromise. Integration includes the incorporation of all points of view into the policy, whereas compromise encourages all parties to forfeit something for the overall common good (Silva, 2002). Just as APRNs have a professional responsibility to be involved in policy, as noted by the ANA's Code of Ethics, they also have an ethical responsibility to the public to be engaged in healthcare policy.

Research and Policy Making

The initial link between nursing policy, practice, and research may have begun in the 1960s as nurse researchers sought federal funding and an equal playing field with medicine for research dollars (Milstead, 2008). Research and policy are connected in two interrelated ways: there is nursing research and policy research. Nursing research is used to supply the data and background information for creating policy. Policy research is the "analysis of a social problem to provide policy makers with alternative recommendations for future initiatives aimed at alleviating problems" (Nagelkerk & Henry, 1991, p. 20). During the process of restructuring health care in the United States, both types of research will be essential for creating an evidence-based plan that includes an examination of the alternatives. Nurse researchers have begun to realize that when using research to create policy, the largest challenge may originate from the inherent potential for ambiguous data to produce different interpretations and then different policies. In these situations, the successful APRN leader must shape the policy agenda such that the issue becomes defined as a problem, backed by research, that requires legislative or regulatory action. Often nursing research is "published by nurse academicians in the nursing literature but policymakers do not access their work" (Short, 2008, p. 266). APRNs can be the experts who bring the data to the legislator and discuss the outcomes and how they can be applied to public policy. Short (2008) encourages nurses to submit their research studies to journals outside of nursing and to include the potential policy implications of nursing research.

The media can be used to open a window of opportunity on an issue important to nursing. When the media started reporting the childhood obesity epidemic, nurse researchers were the content experts who used supporting data to influence public policy. Because of their favorable public impression, nurses have the ability to convey health-related information in a manner that is considered fact without a particular bias or slant. An institution or organization's public relations staff can be used as a tool to stimulate public and legislator interest in nursing health policy research (Diers, 2002). Because research can be uninteresting or overwhelming to the lay public, the ability to translate research into powerful stories or anecdotes can serve as a catalyst for legislative activity.

Although the value of evidence-based research outcomes is not disputed, the ability of evidence to influence policy in the manner and to the degree expected by the researcher is still debated. Policy decisions are political decisions, and thus the rational, correct decision is not always made; instead, the decision may be a compromise between competing interests. The majority of citizens, who may have competing values at odds with the best policy evidence, must also support policy decisions. The quality of the research or the research design may be less important than an understanding of the current political agenda or the agenda of special interest groups. In that case, the research may even be called into question despite solid methodology, or politicians and healthcare providers may use researched outcomes selectively to back an alternative course of action. APRNs educated in healthcare policy will be able to anticipate political trends, discover areas lacking in data, and design studies to seek out the answers.

Evidence-based practice data may be used to influence healthcare financing policy. Rather than focus on an outmoded "this is the way we do it here" approach, the impetus should instead focus on whether current evidence supports the need for a procedure or a medication that incurs an increase in healthcare cost without a proven clinical benefit. According to P. R Orszag (2009), former director of the Congressional Budget Office and of the Office of Management and Budget, when looking at the correlation between cost and quality, "the higher cost providers, the higher cost hospitals, the higher cost regions are not generating better health outcomes than the lower cost, more efficient providers" (p. 74). Outcome-based research may be assisted by the use of information technology. With the increased emphasis on the use of electronic health records (EHRs), APRNs must be involved in the development of data entry points to support further research of outcomes relative to nursing care, including cost versus quality. Program evaluation is an integral part of policy research. Doctorally prepared APRNs are experts in program evaluation. As experts, APRNs must continue to use feedback

to ensure that "old problems are being addressed, new problems are being identified and appropriate solutions are being considered" (Milstead, 2008, p. 21).

The political agenda is often shaped by cost, quality, and access to care. Research designed with that in mind can be used to a professional organization's benefit. In a May 2009 letter to the Senate Finance Committee answering a request for input into financing healthcare reform, Jackie Rowles, past president of AANA, used data from a Government Accountability Office study (2007, p. 15) to communicate the financial incentive for including CRNAs in the blueprint for healthcare financing reform. Then-president Rowles stated, "CRNAs predominate where there are more Medicare patients than average. CRNAs also predominate where private payment is lower than average, which is also where the gap between Medicare and private payment is less. Where anesthesiologists predominate, private payments are higher than average and the gap between Medicare and private payment is greater" (Rowles, 2009). Recognizing that the current anesthesia staffing patterns may become unsustainable in an age of cost containment and healthcare reform, the AANA funded a study conducted by non-CRNA economists who analyzed a variety of staffing approaches. Hogan, Seifert, Moore, and Simonson (2010) were able to use economic modeling to prove that CRNAs working independently were more cost-effective to hospitals. These data can prove powerful when discussing implementation of healthcare reform legislation.

The IOM *Future of Nursing* Report (2011) stressed the importance of better data collection on workforce planning and transforming the clinical practice environment. Outcomes research data continue to become more important as pressures to reduce cost and improve quality become a critical part of the conversation when APRNs meet with legislators and discuss removing barriers to practice. In recent years, professional nursing organizations and individuals have begun to take a more proactive role in gathering and publishing these important data. For example, Newhouse et al. (2011) conducted an extensive systematic review and found positive patient outcomes when APRNs were involved in the care of a variety of patients. Dulisse and Cromwell (2010) examined the impact of removal of the CRNA Medicare supervision rule on patient outcomes and found no increased risk to patients in states that had opted out. An important facet of the Dulisse-Cromwell research was its inclusion in a non-nursing journal, *Health Affairs*.

Clinical systems research, inherent in the final scholarly or capstone project of the DNP degree, is a useful means to provide an evidence-based approach to making policy changes within local, state, or federal health systems. Challenges within health care can often be traced back to a

systems problem. APRNs with the clinical background and the education in evidence-based practice and policy will be able to frame the questions to search for the solutions. Is there a need to create policies that providers must follow to ensure delivery of evidence-based diabetes care or guarantee on-time immunizations? Why are some medical centers more efficient than others, and should their processes be emulated? How do we ensure access to care with a sustainable health policy?

Education, Practice, and Policy Making

According to Malone (2005), too often policy is not consistently emphasized as a part of nursing education even though policy can influence many aspects of patient care. When policy development has been included as part of nursing education, the primary focus has been on identifying and using an institution's policy manual (Malone, 2005). Policy-making skills are an integral part of doctoral education. Just as nurses learn the clinical skills necessary to care for patients, they are also compelled to learn the skills necessary for influencing policy. When new graduates have a sense of competency obtained through education and practical experience, they are more likely to become involved in the process. In the past, opportunities for formal policy education within nursing were limited. Most skills were learned on the job through mentoring or self-directed education. With the increased complexity of health care and an increased need for nurses to become politically involved, the education process should now include a focused, systematic, consistent approach.

One approach to educating APRNs in how to influence public policy is to apply the nursing process—assess, diagnose, plan, implement, and evaluate. For example, the nursing process can be applied to addressing the challenges in delivering health care in the United States in the context of the Affordable Care Act of 2010.

Begin with an assessment of the situation. A bipartisan report released by the U.S. Senate Finance Committee on May 18, 2009, noted that "46 million Americans lack health insurance coverage, employer-sponsored health care premiums have increased 117 percent between 1999–2008, and annual health care spending is expected to outpace annual growth in the overall economy by 2.1 percent in the next ten years. Also, in 2009, health spending will increase 5.5 percent while gross domestic product is expected to decrease 0.2 percent" (Senate Finance Committee, 2009). It is important to include both a financial and social perspective; for example, "The United States ranks last among industrialized nations in mortality from conditions preventable with timely and effective care" (Gable, 2011, p. 342).

The next step in the process is to identify or diagnose the problem. Armed with data from government sources, including the Department of Health and Human Services, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services, APRNs can recognize many of the problems in healthcare systems, including a healthcare delivery system that does not provide access to all Americans, the uncontrolled rise in healthcare cost, and the lack of preventive health care.

Following a diagnosis of the problem, the biggest challenge then becomes how to plan for resolution of the crisis while anticipating potential obstacles. According to Malone (2005), obstacles to policy intervention include "lack of media attention, ideological opposition from those in decision-making positions, lack of money, advocacy leadership struggles and efforts from those actively opposed" (p. 141). The doctorally prepared advanced practice nurse will be prepared, informed, and empowered to challenge any Congress or presidential administration to support a healthcare policy that meets the six aims of the IOM: safe, effective, patient centered, timely, efficient, and equitable (IOM, 2001). The search for innovative solutions while using the resources at hand may prove to be more difficult than anticipated, as evidenced by the failure of the Clinton plan. How can the United States ensure equal access to high-quality care for all Americans while controlling cost? Is the U.S. nursing workforce substantial enough to handle the potential influx of patients into the healthcare system? APRNs may be asked to provide expert testimony, serve as content experts, and garner support from legislators during this stage of the process.

While the legislation is being implemented, APRNs must continue their political activism with vigilance and a skeptical eye regarding any drafts, testimony, or regulations that do not support the intent of the reform legislation. The last step of the process—which should actually occur throughout the progression of legislation—is to evaluate whether the legislation works. Formative evaluation of the policy process should occur from the beginning. Did APRNs become involved, and how effective were they? What were the obstacles to policy legislation and implementation? Were the obstacles recognized early in the process? Does the legislation meet the six aims of the IOM? Does the legislation provide for equal access to providers and for patients? How will outcomes be measured, and will they be measured equitably for all providers? Will this plan be sustainable?

Maynard (1999) described a four-dimensional intersecting model for teaching healthcare policy that consists of information, commitment, initiative, and involvement. The first step is the responsibility that nurses have to remain informed and up to date about the health policy agenda. The second step is the commitment to act on an issue. Initiative, the third step,

is the "power, ability, or instinct to begin or follow through with a plan or task" (p. 193). Although the model is not intended to be linear, the final step is involvement in the process of influencing policy. As the content of policy education is formalized within the curriculum of DNP programs, educators will need to be able to demonstrate the relevance of policy to practice. One approach to accomplish this is to instruct APRNs how to determine the basis of proposed policy changes.

An awareness of where legislation and regulation originate may be critical to understanding and influencing policy. Taft and Nanna (2008) stressed the importance of educating nurses on the sources of healthcare policies that affect practice, including organizational, public, and professional sources. Examples of organizational sources are consumers of health care (patients), the media, and insurers. Patients who have experienced difficulties in the healthcare system are frequently an impetus for legislative change, for example, changes in insurance coverage for preventive exams. Public sources include the government at all levels and all branches, economic and demographic trends, and special interest groups (Taft & Nanna, 2008). Healthcare disciplines, including nursing, universities, and research-generating organizations, comprise the final type of source: professional sources. Professional APRN associations have played an integral role in proposing legislation that influences health care and have been involved in the regulatory role.

Nursing educators at all levels of preparation, from the baccalaureate to doctoral degree, must serve as mentors by becoming role models for political activism, risk taking, and health policy advocacy. Experienced nurses can successfully communicate the connection between professional commitment and political responsibility. Rather than merely encouraging nurses to be politically involved, nursing faculty should equip students with the knowledge and skills to feel confident in their ability to influence policy. According to Rains and Carroll (2000), "Health policy education at the graduate level has the potential to increase the political skills, involvement, and competence of nursing's future leaders" (p. 37). It is crucial during doctoral education that APRN students become actively involved in the process by lobbying on Capitol Hill, by serving as student representatives on professional organization committees, and by successfully demonstrating the ability to articulate the legislative and regulatory process. Policy-educated APRN clinicians should serve as role models to the next generations of baccalaureate- and graduate-prepared nurses. APRNs will be able to create a teaching environment that synthesizes didactic knowledge with the practice and work environments (Short, 2008). J. A. Milstead proposed that hospitals consider developing a health policy/researcher position to combine advanced clinical

skills with the research skills necessary to influence health policy decisions within the organization and on a larger scale (Peters, 2002, p. 7).

Although all APRNs must participate in healthcare policy at some level, it is unrealistic to assume that all APRNs should become policy experts in addition to their roles in providing direct patient care. The extensive commitment of time and energy necessary to effectively perform all the duties of both roles may not be achievable. Instead, the future of advanced practice nursing may include the specialty of health policy APRN. As nurses become more adept and interested in policy, especially after doctoral education, they may choose to focus their career on influencing legislation and serving as a health policy expert. Nurses can gain practical experience by applying for policy fellowships in Washington, D.C. Perhaps the most well-known fellowship is the Robert Wood Johnson Foundation (RWJF) Health Policy Fellowship. Historically, nurses have not taken advantage of these opportunities. In the RWJF Fellowship's 37 years, over 230 fellowships have been awarded, but only 27 nurses have been fellows (RWJF Health Policy Fellowships Program, n.d.). Health policy fellowships offer nurses an opportunity to brief legislators on healthcare issues, develop proposals, and staff conferences and hearings.

Although the relationship between policy and practice has focused on clinical care, nurse executives with a doctoral education foundation can play a critical role in influencing the policies that have a direct impact on patient care. Peters (2002) compared influencing policy to teaching an elephant to dance: difficult to do, but it can be accomplished if approached methodically. Administrators must be "committed to political activism; stay informed through formal and informal channels; challenge the status quo; identify a base of support; and get the issues on the agenda" (Peters, 2002, pp. 5–7).

PHASES OF POLICY INVOLVEMENT

All APRNs have the responsibility to their patients to become involved in the political process at some level. Various authors have described levels of political involvement and emphasized that the focus is on finding a level at which the individual can be engaged and that is compatible with where the individual may be in his or her career. Boswell, Cannon, and Miller (2005) identified "three primary levels of commitment: survival, success, and significance" (p. 6). As APRNs become more engaged in the process, they may move through the levels, or they may choose to stay at the level at which they are comfortable. At the survival level, the individual takes part

in the voting process or may serve on a community board. At the next level, success, the individual "chooses to become influential in the policy arena" by becoming involved on the state or national level (Boswell et al., 2005, p. 6). Significance is the final level of involvement, whereby the individual is intensely involved in all aspects of healthcare policy, assuming leadership positions in influencing legislation at the state and national level.

Hewison (2008) described nursing involvement in policy as a continuum from policy literacy, to policy acumen, to policy competence, and, finally, to policy influence (p. 292). Rather than finding a level of engagement, Hewison (2008) applied the strategy to where individuals are in their careers, from novice to expert. Policy literacy may only involve reviewing the literature, defining the issues, and analysis of health policy research. This early stage provides a framework for the more experienced nurse to develop policy acumen. Policy acumen is "an awareness and understanding distilled from a policy analysis" that allows nurses to influence the manner in which health care is organized and delivered (Hewison, 2008, p. 293). APRNs who have come to understand the issues and can analyze policy that translates into action would be able to persuade policy leaders to make healthcare decisions that are favorable to nursing and to their patient population. They can make the transition from the introspective realm of acumen to the action of competence (Hewison, 2008). The final level of policy influence brings together all the elements of the previous levels. The APRN who has achieved this level integrates the issues with health policy research, formulates the agenda, and influences policy on the national and international scale.

Most authors agree that all nurses have the responsibility of becoming involved in the policy process (Boswell et al., 2005; Hewison, 2008; Peters, 2002). Although it may be an intimidating task for both the novice and the experienced APRN, there are opportunities for involvement at all levels and in all areas of interest to nursing, including legislation and regulation, research, ethics, and practice.

CONCLUSION

According to Peters (2002), nurses should start to look at policy as not just the legislative process but also a comprehensive method of identifying healthcare issues and then bringing those issues to the legislature and the American public. "Nurses will not be effective in politics or policy-making until they value their voices, develop policy agendas that embrace their core values, and learn the skills of policy making and influencing" (Mason et al., 2002, p. 12). Political expertise is essential for success. Nursing practice and

health care must no longer be shaped by other dominant interest groups but instead by the inclusion of nurses using their education in policy combined with their unique understanding of the patient perspective.

Nurses must take advantage of positive public opinion and their pivotal position in the healthcare system as the largest group of providers. Patient advocacy should include policy advocacy, with APRNs increasing their knowledge of the issues and increasing political involvement. APRNs can be a crucial part of reforming health care by offering guidance and support to elected leaders. In the United States, APRNs have never been in a better position to influence health care as a whole, but it will require a group of "policy initiators who are willing to work toward eliminating the inequality of healthcare resources" (Peters, 2002, p. 5). This statement has been borne out in the last few years as nurses are increasingly involved at the state and federal level and as their expertise is recognized as a crucial part of ensuring that healthcare reform is implemented in a manner that is cost effective, accessible, and based on the evidence.

According to health policy expert Mary Wakefield (2008), "If nurses want to be sought out as health care resources and to have their views reflected in health policy, nurses have to get off the porch to run with the big dogs" (p. 86). It has been argued that clinically engaged APRNs already have a full daily agenda, so how can they take on the additional responsibility of influencing policy? A more vital question should be, How can we not? Political activism provides nurses with the means to promote overall health through passing supportive health policy legislation, using evidence-based policy to transform institutional and national health systems, and employing policy language that prevents discrimination in reimbursement and patient access to providers. The doctorally prepared advanced practice nurse is in the position to become this political advocate.

ACKNOWLEDGMENTS

A special acknowledgment and thank you go out to my policy mentors: Laura Cohen, CRNA, and Brian R. Bullard, MBA, MPH, MA.

REFERENCES

Abood, S., & Franklin, P. (2000). Why care about Medicare reimbursement? *American Journal of Nursing, 100*(6), 69–70, 72.

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from http://www.aacn.nche.edu/DNP/pdf/essentials.pdf

American Medical Association. (2005). *Scope of practice partnership*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/471/bot24A06.doc

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Retrieved from http://www.nursingworld.org/codeofethics

APRN Consensus Work Group & National Council of State Boards of Nursing. (2008, May 7). *Consensus model for APRN regulation: Licensure, accreditation, certification and education*. Retrieved from https://www.ncsbn.org/APRNJoint_Dia_report_May_08.pdf

Aroskar, M. A., Moldow, D. G., & Good, C. M. (2004). Nurses' voices: Policy, practice and ethics. *Nursing Ethics, 11*(3), 266–276.

Bankart, M. (1993). *Watchful care: A history of America's nurse anesthetists*. New York, NY: Continuum.

Boswell, C., Cannon, S., & Miller, J. (2005). Nurses' political involvement: Responsibility versus privilege. *Journal of Professional Nursing, 21*(1), 5–8.

Broadston, L. S. (2001). Reimbursement for anesthesia services. In S. Foster & M. Faut-Callahan (Eds.), *A professional study and resource guide for the CRNA* (pp. 287–311). Park Ridge, IL: AANA Publishing.

Bureau of Labor Statistics. (2007). Registered nurses. In *Occupational outlook handbook* (2008–09 edition). Retrieved from http://www.bls.gov/oco/ocos083.htm

Center for Responsive Politics. (2009). *Health professionals' PAC contributions to federal candidates, 2006–2008*. Retrieved from http://www.opensecrets.org/pacs/industry.php?txt=HO1&cycle2008

Coalition for Patients' Rights. (n.d.). *About us*. Retrieved from http://www.patientsrightscoalition.org/about-us.aspx

Diers, D. (2002). Research as a political and policy tool. In D. J. Mason, J. K. Leavitt, & M. W. Chaffee (Eds.), *Policy and politics in nursing and healthcare* (pp. 141–156). St. Louis, MO: Saunders.

Dulisse, B., & Cromwell, J. (2010) No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs, 29*(8), 1469-1475.

Ennen, K. A. (2001). Shaping the future of practice through political activity: How nurses can influence health care policy. *Journal of the American Association of Occupational Health Nurses, 49*(12), 557–569.

Federal Election Commission. (2009). *Quick answers to PAC questions*. Retrieved from http://www.fec.gov/ans/answers_pac.shtml

Gable, L. (2011). The Patient Protection and Affordable Care Act, public health, and the elusive target of human rights. *Journal of Law, Medicine, and Ethics, 39*(3), 340–354.

Government Accountability Office. (2007, July 27). *Medicare physician payments: Medicare and private payment differences for anesthesia services*. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (GAO Report GAO-07-463). Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCIQFjAA&url=http%3A%2F%2Fwww.gao.gov%2Fnew.items%2Fd07463.pdf&ei=cghFUK7dM4XW9QSQy4DgBQ&usg=AFQjCNFqVaFzAeLi3YbdA1G-T1pCqxNCQg&sig2=yJPg4O4L7xzTAhXEkbzaQQ

Hamric, A. B., Spross, J. A., & Hanson, C. M. (2000). *Advanced practice nursing: An integrative approach* (3rd ed.). St. Louis, MO: Elsevier Saunders.

Health Resources and Services Administration. (2010). *The registered nurse population: Findings from the 2008 National Sample Survey of Registered Nurses*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurvey2008.html

Hewison, A. (1999). The new public management and the new nursing: Related by rhetoric? Some reflections on the policy process and nursing. *Journal of Advanced Nursing, 29*(6), 1377–1384.

Hewison, A. (2008). Evidence-based policy: Implications for nursing and policy involvement. *Policy, Politics, and Nursing Practice, 9*(4), 288–298.

Hogan, P. F., Seifert R. F., Moore, C. S., & Simonson, B. E. (2010). Cost effectiveness analysis of anesthesia providers. *Nursing Ecomonic$, 28*(3), 159–169.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

Interagency Collaborative on Nursing Statistics. (2006). Retrieved from http://www.iconsdata.org/index.htm

Jamelske, E. M., Johs-Artisensi, J. L., Taft, L. B., & German, K. A. (2009). A descriptive analysis of healthcare coverage and concerns in west central Wisconsin. *Policy, Politics, and Nursing Practice, 10*(1), 16–27.

Kent, R. L., & Liaschenko, J. (2004). Operationalizing professional values through PAC donations. *Policy, Politics, and Nursing Practice, 5*(4), 243–249.

Loversidge, J. M. (2008). Government regulation: Parallel and powerful. In J. A. Milstead (Ed.), *Health policy and politics: A nurse's guide* (pp. 91–127). Sudbury, MA: Jones and Bartlett.

Malone, R. E. (2005). Assessing the policy environment. *Policy, Politics, and Nursing, 6*(2), 135–143.

Mason, D. J., Leavitt, J. K., & Chaffee, M. W. (2002). *Policy and politics in nursing and healthcare* (4th ed.). St. Louis, MO: Saunders.

Maynard, C. A. (1999). Political influence: A model for advanced nursing education. *Clinical Nurse Specialist, 13*(4), 191–195.

McHugh, M. D., Aiken, L. H., Cooper, R. A., & Miller, P. (2008). The U.S. presidential election and health care workforce policy. *Policy, Politics, and Nursing, 9*(1), 6–14.

Milstead, J. A. (2008). *Health policy and politics: A nurse's guide* (3rd ed.). Sudbury, MA: Jones and Bartlett.

Minnesota Board of Nursing. (2008). *Nurse Practice Act*. Retrieved from http://www.state.mn.us/mn/externalDocs/Nursing/Entire_Nurse_Practice_Act_042303011528_Nurse%20Practice%20Act.pdf

Nagelkerk, J. M., & Henry, B. (1991). Leadership through policy research. *Journal of Nursing Administration, 21*(5), 20–24.

National Council of State Boards of Nursing. (n.d.). *About NCSBN*. Retrieved from http://www.ncsbn.org/about.htm

National Health Security Plan. (1993). *Table of contents*. Retrieved from http://www.ibiblio.org/nhs/NHS-T-o-C.html

Newhouse, R. P., Bass, E. B., Steinwachs, D. M., Stanik-Hutt, J., Zangaro, G., Heindel, L., . . . Fountain, L. (2011). Advanced practice nurse outcomes 1990-2008: A systematic review. *Nursing Economic$, 29*(5), 1–21.

Nursing Community Consensus Document. (2008). *Reauthorization priorities for Title VIII Public Health Service Act (42U.S.C. 296 et seq.)*. Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCIQFjAA&url=http%3A%2F%2Fwww.apha.org%2FNR%2Frdonlyres%2F657AD8DE-1281-4DF7-A9D1-7C2E3A053434%2F0%2FNursingConsensusDocument.pdf&ei=pwdFUM2GDYzW8gSi3oCACw&usg=AFQjCNEiVNoy5EOLdSBGAXdaHVuP6zcB6Q&sig2=S6XVVS4HiqTD1UQTRzZGbA

Orszag, P. R. (2009). Beyond Economics 101: Insights into healthcare reform from the Congressional Budget Office. *Healthcare Financial Management, 63*(1), 70–75.

Patients' Access to Responsible Care Alliance. (n.d.). Retrieved from http://www.accessparca.com/home.html

Peters, R. M. (2002). Nurse administrators' role in health policy: Teaching the elephant to dance. *Nursing Administration Quarterly, 26*(4), 1–8.

Rains, J. W., & Carroll, K. L. (2000). The effect of health policy education on self-perceived political competence of graduate nursing students. *Journal of Nursing Education, 39*(1), 37–40.

Rice, R. (2002). Coalitions: A powerful political strategy. In D. J. Mason, J. K. Leavitt, & M. W. Chaffee (Eds.), *Policy and politics in nursing and healthcare* (pp. 121–140). St. Louis, MO: Saunders.

Robert Wood Johnson Foundation Health Policy Fellowships Program. (n.d.). *Alumni directory*. Retrieved from http://www.healthpolicyfellows.org/secure/alumni-search.php

Rowles, J. (2009). *Comments of the American Association of Nurse Anesthetists on financing healthcare reform to the Senate Finance Committee*. Park Ridge, IL: American Association of Nurse Anesthetists.

Rubotzky, A. M. (2000). Nursing participation in healthcare reform efforts 1993–1994: Advocating for the national community. *Advances in Nursing Science, 23*(2), 12–33.

Schroeder, S. A. (1993). The Clinton health care plan: Fundamental or incremental reform? *Annals of Internal Medicine, 119*(9), 945–947.

Senate Finance Committee. (2009). *Financing comprehensive health care reform: Proposed health system savings and revenue options*. Retrieved from http://www.finance.senate.gov/newsroom/ranking/release/?id=24d07772-b4b8-414d-811d-24cc1c75c2a8

Short, N. M. (2008). Influencing health policy: Strategies for nursing education to partner with nursing practice. *Journal of Professional Nursing, 24*(5), 264–269.

Silva, M. C. (2002). Ethical issues in health care, public policy, and politics. In D. J. Mason, J. K. Leavitt, & M. W. Chaffee (Eds.), *Policy and politics in nursing and healthcare* (pp. 177–184). St. Louis, MO: Saunders.

Sudduth, A. L. (2008). Program evaluation. In J. A. Milstead (Ed.), *Health policy and politics: A nurse's guide* (pp. 171–196). Sudbury, MA: Jones and Bartlett.

Sullivan-Marx, E. M. (2008). Lessons learned from advanced practice nursing payment. *Policy, Politics, and Nursing Practice, 9*(2), 121–126.

Taft, S. H., & Nanna, K. M. (2008). What are the sources of health policy that influence nursing practice? *Policy, Politics and Nursing Practice, 9*(4), 274–287.

Tobin, M. (2011). State government regulation of nurse anesthesia practice. In S. Foster & M. Faut-Callahan (Eds.), *A professional study and resource guide for the CRNA*, 2nd ed. (pp. 93-118). Park Ridge, IL: AANA Publishing.

Trotter Betts, V. (1996). Nursing's agenda for healthcare reform: Policy politics and power through professional leadership. *Nursing Administration Quarterly, 20*(3), 1–8.

Twedell, D. M., & Webb, J. A. (2007). The value of the political action committee: Dollars and influence for nurse leaders. *Nursing Administration Quarterly, 31*(4), 279–283.

Wakefield, M. K. (2008). Government response: Legislation. In J. A. Milstead (Ed.), *Health policy and politics: A nurse's guide* (pp. 65–90). Sudbury, MA: Jones and Bartlett.

Appendix 5-1

Glossary

Caucus: A group of members of Congress or a political party created to support a defined political ideology or interest; in Congress, often votes en bloc.

Continuing resolution: A type of appropriations legislation that financially supports the government until a formal appropriations bill can be passed by Congress and signed into law.

Drop: Submitting the committee report concerning proposed legislation to the appropriate desk in the Senate or the House of Representatives.

Final rule: A regulation that has been published in the *Federal Register*. Includes the date on which the regulation goes into effect.

Grassroots lobbying: Occurs when nonpaid individuals contact their legislators to influence policy. May be very effective when coming from a legislator's constituency.

Hearing: A public meeting of a legislative committee or regulatory body held for the purpose of taking testimony concerning proposed legislation or regulation.

Jurisdiction: The authority or power granted to a legislative or regulatory body to allocate resources and approve, execute, and enforce laws. Typically has defined areas of responsibility.

Legislative assistant (LA): An employee of a senator or representative who keeps the legislator informed, meets with constituents, drafts reports, and so forth.

Mark up: A committee process that amends, debates, and rewrites proposed legislation.

Omnibus legislation: A single bill that is voted on once but contains diverse amendments to a variety of other laws. Notably used in spending bills.

Regulation: A principle, rule, or law designed to control or govern conduct.

Report out: The proposed legislation, along with the committee report, is sent out of committee to the floor of the House or Senate to be acted on.

Special interest group: A group of individuals who coordinate lobbying efforts around a common interest (e.g., nursing) and seek to influence policy makers.