CHAPTER 1

Informing Public Policy: An Important Role for Registered Nurses

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KEY TERMS

Advanced practice registered nurse (APRN): A registered nurse with an advanced degree in nursing, certified by a nationally recognized professional organization. The four types of APRNs are nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse–midwife (CNM), and certified registered nurse anesthetist (CRNA).

Canons: Rules of thumb, or guidelines, typically used by courts to interpret and rule on disagreements between policy and public law.

Healthcare provider professionals (HCPs): Registered nurses, advanced practice registered nurses, physicians, pharmacists, dentists, psychologists, occupational and physical therapists, dieticians, social workers, and physician assistants, and others who are licensed or authorized by a state or territory to provide health care.

Policy: A consciously chosen course of action: a law, regulation, rule, procedure, administrative action, incentive, or voluntary practice of governments and other institutions.

Policy process: A process that involves problem identification, agenda setting, policy design, government/organizational response, budgeting, implementation, and evaluation of the policy.

Political determinants of health (PDoH): Political forces, ideologies, processes, and decisions that determine the health of individuals and populations.

Political power: Political and social sciences refer to executive, legislative and judicial powers. For our purposes, common types of governmental powers exerted on health professionals and health programs are coercive power, blocking power, and purchasing power, which influence what nurses can and cannot do as well as the environments in which nurses work.

Politics: The process of influencing the allocation of scarce resources.

Public policy: A program, law, regulation, or other legal mandate provided by governmental agents; also includes actual legal documents, such as opinions, directives, and briefs, that record government decisions.

Rules and regulations: Instructions authorized by specific legislation detailing the actions to be taken to implement that legislation. They are developed by government agencies, often with the assistance of experts such as registered nurses.

Statutes: Written laws passed by a legislative body. They may be enacted by both federal and state governments and must adhere to the rules set in the U.S. Constitution. They differ from common law in that common law (also known as case law) is based on prior court decisions.

System: Spelled with a capital "S," the U.S. healthcare delivery and finance system (usage specific to this text).

system: Spelled with a lowercase "s," a group of hospitals and/or clinics that form a large healthcare delivery organization (usage specific to this text).

Introduction

In March 2020 the nursing profession was thrust into the national and global spotlight as the nature of "essential workers" gained momentum and meaning amid the COVID-19 pandemic (see **Figure 1-1**). Ironically, long before the emergence of the novel human coronavirus, 2020 had been designated as "The Year of the Nurse and Midwife" by the World Health Organization to honor Florence Nightingale's 200th birthday. The severity of the pandemic propelled nurses into high visibility as they invented new ways to use ventilating equipment, led public health efforts, found ways to preserve personal protective equipment (PPE), identified improvements in patient treatments (e.g., turning patients prone), and provided astounding examples of compassionate care day after day in the face of danger. Largely because of the 24-hour news cycle and social media, today nursing has momentum and a platform unlike any other time in its history. But is this really the case? Nurses have thought "Now is our time!" at other important moments in history.

The Politics of Clinical Practice

Looking back to the 2010 Institute of Medicine[1] (IOM) report, *The Future of Nursing: Advancing Health, Leading Change*, nursing seemed positioned to gain more authority (or at least shed some "supervision"). The report examined how nurses' roles, responsibilities, and education should change to meet the needs of an aging, increasingly diverse population and to respond to a complex, evolving healthcare system. In response to the IOM report, the Robert Wood Johnson Foundation (RWJF) and the American Association for Retired People (AARP) launched a joint *Campaign for Action* that was soon translated into state-level activities (AARP Public Policy Institute, 2021). The *Campaign for Action* was crafted as a prescription for nurses to facilitate the nation's shift

[1] Important to note: The name of the Institute of Medicine was changed to the National Academy of Medicine in 2016.

Figure 1-1 Health policy and politics determines who gets personal protective equipment.

from hospital-based services to a system focused on prevention and wellness in the community: nursing's time had arrived. It was a strong push that influenced nursing education and practice for a decade. The IOM report coupled with other evidence spurred changes in policy and practice, and in many ways positioned the profession to take advantage of its magnified voice in 2020.

A 10-year follow-up report card featuring two national nurse leaders, Drs. Sue Hassmiller and Mary Dickow, discussed significant gains in the nursing profession, including a dramatic increase in the number of registered nurses (RNs) with bachelor's degrees; the removal of many barriers to nurse practitioner (NP) practice in many states and the Veteran's Administration system; improvements in the percentage of minority students entering nursing, along with an emphasis on improving diversity and inclusivity; and success in placing more RNs on healthcare governance boards (Stringer, 2019).

This progress has spurred the RWJF to fund a second study focused on the future of nursing. This time the focus is on the nurse's role in addressing the social determinants of health and health equity. Dr. Hassmiller, who served as the National Academy of Medicine Senior Scholar in Residence and Adviser to the President on Nursing from 2019 to 2021, was tapped to lead the study. The RWJR report will be completed and distributed in 2021.

Nursing practice—that is, what we are allowed to do, required to perform, or prohibited from engaging in—is determined by **public policy**. Thus, nursing practice is a highly political activity. Policy is the end result of the process used to discover the best solution to an identified social problem. Politics is the process of this discovery—the dickering about values, ideology, and costs.

This text is framed around the **policy process** and is best read by progressing from beginning to end. Nurses and other **healthcare provider professionals (HCPs)** are ideally positioned to participate in the policy arena because of their history, education, practice, and organizational involvement. In this chapter, *policy* is an overarching term used to define both an entity and a process. The purpose of public policy is to direct problems to the government's attention and to secure the government's response. Not all health and healthcare issues require a government response: some are best resolved by volunteers, philanthropy, or professional organizations. In this text we will explore what rises to the level of public policy.

The definition of *public policy* is important because it clarifies common misconceptions about what constitutes policy. In this text, the terms *public policy* and *policy* are used interchangeably. The process of creating policy can be focused on many areas, most of which are interwoven. For example, environmental policy deals with determinants of health such as hazardous materials, particulate matter in the air or water, and safety standards in the workplace. Education policies are more than tangentially related to health—just ask school nurses. Regulations define who can administer medication; state laws dictate which type of sex education can be taught. Defense policy is related to health policy when developing, investigating, or testing biological and chemical weapons. There is a growing awareness of the need for a health-in-all-policies approach to strategic thinking about policy.

Health policy directly addresses health problems and is the specific focus of this text. In general, **policy** is a consciously chosen course of action: a law, regulation, rule, procedure, administrative action, incentive, or voluntary practice of governments and other institutions. By comparison, **politics** is the process of influencing the allocation of scarce resources. See **Table 1-1** for an explanation of the ideology and priorities of the five major political parties in the United States.

Policy Instruments

Official government policies reflect the beliefs and values of elected Members, the administration in power, and the will of the American people. Laws (or **statutes**) are one type of policy instrument that serve as legal directives for public and private behavior. Laws are made at the international, federal, state, and local levels and are considered the principal source in guiding conduct. Lawmaking usually is the purview of the legislative branch of government in the United States, although presidential vetoes, executive orders, and judicial interpretations of laws also have the force of law.

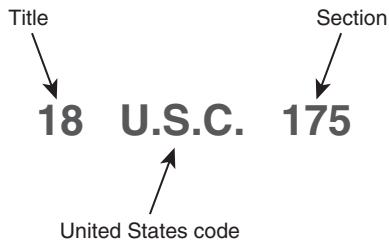
Policy instruments at the level of national governance include, but are not limited to, the following:

- *Bills*: A bill is proposed legislation under consideration by a legislative body (i.e., the U.S. Senate or the House of Representatives).
- *Act*: An act is legislation that has passed both houses of Congress and has been either approved by the president or has passed Congress over his veto, thus becoming law. Also known as a *statute*.

Table 1-1 Political Parties in the United States and Their Ideological Perspectives

Democratic	Republican	Libertarian	Green	Constitution
 © Matt Trommer/Shutterstock.	 © Hafakot/Shutterstock.			
■ Raise incomes and restore economic security for the middle class. ■ Create good-paying jobs. ■ Fight for economic freedom and against inequality. ■ End systemic racism. ■ Guarantee civil rights (especially for vulnerable groups). ■ Protect voting rights. ■ Secure environmental justice. ■ Ensure the health and safety of all Americans.	■ Preserve the U.S. Constitution. ■ Require a balanced budget for the federal government. ■ Repeal and replace the Affordable Care Act. ■ Maintain a strong military. ■ Make America energy independent. ■ Secure U.S. borders. ■ Promote hard work to end poverty. ■ Promote family. ■ Promote religious liberty.	■ Protect civil liberties. ■ Encourage noninterventionism. ■ Promote laissez-faire capitalism. ■ Abolish the welfare state. ■ Keep government to a minimum. ■ Ensure that the role of government is to protect the rights of every individual, including the rights to life, liberty, and property.	■ Ensure protection of the environment. ■ Promote nonviolence and antiwar positions. ■ Decentralize wealth and power to promote social justice. ■ Encourage grassroots democracy. ■ Promote feminism and gender equity. ■ Encourage respect for diversity and promote LGBT rights. ■ Focus on community-based economics. ■ Promote personal and global responsibility. ■ Encourage a future focus and sustainability. ■ Acknowledge ecological wisdom.	■ Restore honesty, integrity, and accountability to government. ■ Limit the federal government only to those roles outlined in the U.S. Constitution; the best government is local government. ■ Restore "true capitalist" principles to U.S. economic policies.

- *Executive orders*: An executive order is an instruction issued by the president that is used to direct the actions of the executive branch and has the effect of law. Executive orders are given numbers and are abbreviated as EO.###. Executive orders may amend earlier orders.
- *Presidential directive*: A presidential directive is a specific type of executive order that states the executive branch's national security policy and carries the force and effect of law that states requirements for the actions of the executive branch.
- *Rules and regulations*: **Rules and regulations** are the guidelines or instructions for doing something correctly and are the principles that govern the conduct or behavior of a person or organization. The primary difference between a rule and a regulation is that a rule is not legally binding, whereas a regulation is. These two terms are often erroneously used as synonyms.
- *Resolution*: A resolution is a form of legislative measure introduced and potentially acted upon by only one congressional chamber and is used for the regulation of business only within the chamber of origin. Depending on the chamber of origin, they begin with a designation of either H.Res. or S.Res.
- *U.S. Code*: All federal laws passed by the U.S. Congress are codified (included) into the U.S. Code for reference. The U.S. Code is divided by subject area into 50 sections called *titles*. Each title is then divided into chapters, subchapters, parts, sections, paragraphs, and clauses. U.S. Code references are written as follows:



Additional commonly used terms, such as *position statement*, *resolution*, *goal*, *objective*, *program*, *procedure*, *law*, and *regulation,* are not really interchangeable with the word *policy*. Rather, they are the formal expressions of policy decisions.

Several tools can be used to help determine the meaning of an ambiguous statute or to recognize the multiple plausible interpretations of a statute. These tools fall into the following four categories: (1) the text of the statute, (2) legal interpretations of the statute, (3) the context and structure of the statute, and (4) the purpose of the statute. Because laws are formatted and written in "legislative language," they are often difficult to read or understand. **Table 1-2** describes two commonly used **canons** of public law.

The agency assigned to interpret a particular law may have difficulty interpreting the law due to the speed with which some laws are passed and the nature of legislative language. Sometimes the interpretation of a law is legally challenged in the court system. Judicial interpretation of public law occurs in four ways: (1) through the court's interpretation of the meaning of broadly

written laws that are vague regarding details; (2) by the court determining how some laws are applied, that is, by resolving questions or settling controversies; or (3) by the court interpreting the Constitution and declaring a law unconstitutional, thereby nullifying the entire statute; and (4) by the court resolving conflicts between states and the federal government (Brannon, 2018). Judicial decisions about statutes are generally the final word on statutory meaning and will determine how a law is carried out—at least, unless Congress acts to amend the law. The legitimacy of any particular statutory interpretation is often judged by how well it carries out the will of the legislative body that generated it. For example, aspects of the Affordable Care Act (ACA) have been challenged many times in the judicial branch. Three of these challenges have been heard by the U.S. Supreme Court.

Table 1-2 Functions of Commonly Used Canons of Legislation Language

Terminology	Function Served
And versus **or**	"And" typically signifies a list, meaning that each condition in the list must be satisfied, whereas "or" typically signifies a disjunctive list, meaning that satisfying any one condition in the list is sufficient.
May versus **shall**	"Shall" indicates that a certain behavior is mandated by the statute, whereas "may" grants discretion to the agency charged with implementing the law.

Spotlight: The Patient Protection and Affordable Care Act of 2010 in the U.S. Supreme Court

***National Federation of Independent Business v. Sebelius (Sec. of HHS)* (2012).** In its 2012 ruling, the Court upheld the constitutionality of the ACA's individual mandate, which required most people to maintain a minimum level of health insurance coverage to begin in 2014. However, the Court found that the ACA's Medicaid expansion mandate was unconstitutionally coercive of states, and held that this issue was fully remedied by limiting the enforcement authority of the Health and Human Services Secretary. The ruling left the ACA's Medicaid expansion intact in the law, but the practical effect of the Court's decision made Medicaid expansion optional for individual states.

***King et al. v. Burwell (Sec. of HHS)* (2014).** David King did not want to buy health insurance. The 64-year-old Vietnam veteran worked as a limo driver and made $39,000 a year, and if it weren't for the subsidies (in the form of tax credits) afforded him by the ACA, King would not be able to, or have to, buy health insurance. King and three others filed a lawsuit against the government arguing that subsidies were supposed to be only for those purchasing health care through state-run health exchanges, not the federal one. The case focused on four words: "established by the State." Thirty-four states had

(continues)

opted against establishing exchanges under the Affordable Care Act, instead allowing residents to purchase health care through HealthCare.gov, the federal marketplace. The plaintiffs' suit argued that subsidies/tax credits were only for people purchasing health care on exchanges "established by the State." Although the legislative language of the ACA pertaining to the tax credits only referred to the exchanges established by the states, the Internal Revenue Service created a regulation that made the tax credits available to those enrolled in plans through federal as well as state exchanges.

The Court held that Congress did not delegate the authority to determine whether the tax credits are available through both state-created and federally created exchanges to the Internal Revenue Service, but the language of the statute clearly indicates that Congress intended the tax credits to be available through both types of exchanges. When the plain language of the section in question is considered in the context of the statute as a whole, it is evident that the federally created exchanges are not meaningfully different from those created by the states, and therefore federally created exchanges are not excluded from the language referring to exchanges created by the states (Oyez, 2014).

California v. Texas (2020). In 2018 the Republican-controlled Congress enacted an amendment to the ACA that set the penalty for not buying health insurance at zero. Texas and several other states and individuals filed a lawsuit challenging the individual mandate to purchase insurance, arguing that because the penalty was zero, it could no longer be characterized as a tax, and was therefore unconstitutional. California and several other states joined the lawsuit to defend the individual mandate. Arguments were heard in November 2020, and the decision is expected to be released in summer 2021. Questions to be answered include: (1) Is the individual mandate of the ACA, which now has a penalty of zero for not buying health insurance, now unconstitutional? (2) If the individual mandate is unconstitutional, is it severable from the remainder of the ACA? The result of this case may overturn the ACA, in effect repealing it (Oyez, 2020).

Policy as a Process

For the purposes of understanding just what policy is, it is best to think in terms of policy as a process. Policymaking comprises six processes that are conducted within the context of stakeholder engagement and education (see **Figure 1-2**):

1. Problem identification and agenda setting
2. Policy analysis
3. Policy design
4. Policy enactment
5. Policy implementation
6. Evaluation of policy outcomes

This text discusses the six steps of the policy process. Note that the steps in the policy process are not necessarily sequential or logical. For example, the definition of a problem, which usually occurs in the agenda-setting phase, may change during fact-finding and debate. Program design may be altered significantly during implementation. Evaluation of a policy or program (often considered the last phase of the process) may propel onto the national agenda

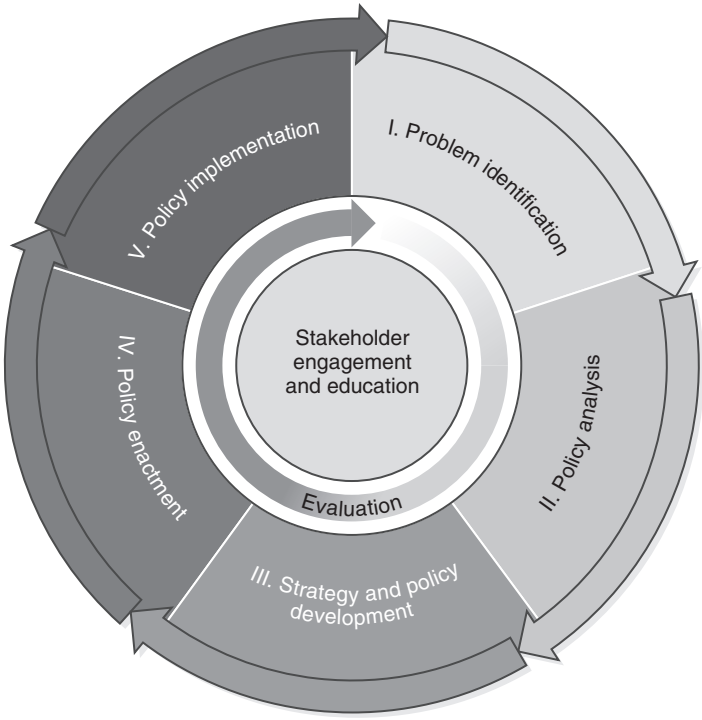


Figure 1-2 The policy process.

Centers for Disease Control and Prevention. (2012). Overview of CDC's Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/policy/analysis/process/

(often considered the first phase of the process) a problem that differs from the originally identified issue. For the purpose of organizing one's thoughts and conceptualizing the policy process, we will examine the policy process from a linear perspective in this text, but it is important to recognize that this path is not always strictly followed.

Opportunities for health professionals' input throughout the policy process are unlimited. Nurses are articulate experts who can address both the rational shaping of policy and the emotional aspects of the process. Nurses cannot afford to limit their actions to monitoring bills; they must seize the initiative and use their considerable collective and individual influence to ensure the health, welfare, and protection of the public and healthcare professionals.

Public Policy, Political Determinants of Health, and Clinical Practice

In our basic education as nurses and HCPs, we learned about the social determinants of health (SDoH) as the root causes of good or bad health. But what are the drivers of the SDoH? In general, the drivers of the SDoH are political decisions; therefore, the causes of health and of disease/illness are driven as

much by policy and politics as by any other cause. These political determinants of health do not get nearly the attention they deserve from the health professions. Yet, there is nothing radical in acknowledging the part played by political choices in affecting the nation's health; indeed, the premise of this text is that nurses affect the health of populations through their influence on the policy process. Think of areas as disparate as vaccines, air quality, seat belt safety, and smoking cessation—all cases where the public's health was better off for the legislative choices made by lawmakers, political appointees, and politicians at the state and federal levels (Mishori, 2019). See **Figure 1-3** for a depiction of the **political determinants of health (PDoH)** as envisioned by Ranit Mishori (2019).

Health is largely based on political choices, and politics is a continuous struggle for resources/power among myriad competing interests. Looking at health through the lens of political determinants means analyzing how different power constellations, institutions, processes, interests, and ideological positions affect health within different levels of governance. Health is political: health is unevenly distributed in our populations, many social determinants of health are dependent on political action, and health is a critical dimension of human rights, even though there is no "right" to health care guaranteed within the U.S. Constitution (Kickbusch, 2015).

"Lack of political will" is often cited as the main reason for failing to deal with political factors affecting health. How do nurses encourage a culture in which health-in-all-policies is a reality? How do nurses affect the political will of our nation? Nurses can engage in health policy analysis, health policy advocacy, and health policy research (often referred to as health services research). Sometimes it is difficult to discern any difference between advocacy

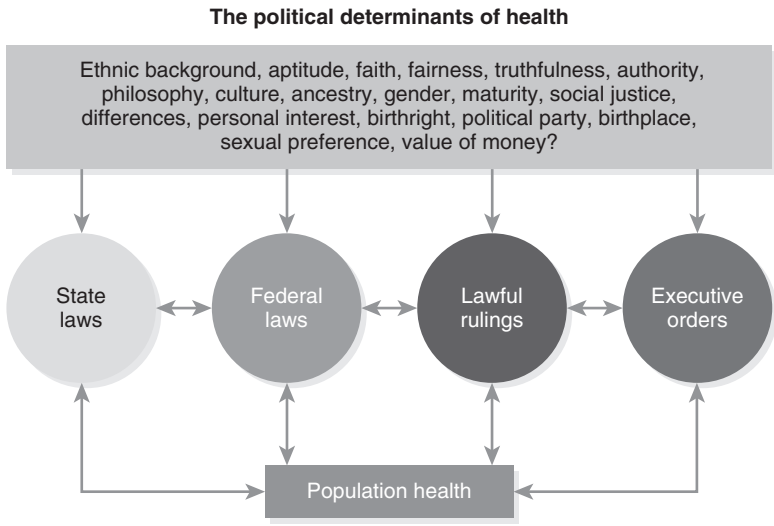


Figure 1-3 The political determinants of health.

Data from Mishori, R. (2019). The social determinants of health? Time to focus on the political determinants of health!. *Medical care*, 57(7), 491-493.

and analysis. This text will help you distinguish among advocacy, analysis, and research in health policy.

Legislation, along with rules and regulations, are the upstream causes that affect most aspects of our health, with the list being too exhaustive to include here. For example, downstream effects of reproductive health laws, such as the content of sex education in public schools, influence teen pregnancy as well as infant and maternal mortality rates; natural disaster planning and preparation results in downstream health effects of who lives and dies during a catastrophic event; the apportionment of parks and recreational spaces provides or disallows safe play spaces for children; the chemicals included in our water systems prevent dental caries or poison us; corporate oversight results in clean air or polluted air; a declaration of war determines what is spent on the military versus on schools and clinics; and so on. At this point, you may be wondering if there is anything related to health and health systems that is not affected by politics and policy. In a 2015 editorial in the *British Medical Journal*, Kickbusch wrote, "Health is a political choice and politics is a continuous struggle for power among competing interests." So why aren't these determinants of health taught broadly in health professionals' education? The main challenge for creating the field of "political epidemiology" lies in creating opportunities, either by design or in the analysis, to identify causal effects of political variables on population health. As stated by Mackenbach (2014):

> Overcoming this challenge will require ingenuity, as well as some stealing from other disciplines (such as comparative political science). Combining quantitative approaches, such as econometric techniques for evaluating natural experiments, with qualitative studies to reconstruct the causal pathways leading all the way from upstream politics to downstream health, is also likely to be useful. (p. 2)

Most of us have been educated and acculturated to believe that an individual's health is largely the result of personal choices and behaviors; however, during the COVID-19 pandemic we saw that government planning, preparation, funding, and policies had a huge effect on the health of individuals and populations, with some nations faring much better than others. **Case Study 1-1** provides the opportunity to further delve into the direct relationship between health policy and clinical practice.

CASE STUDY 1-1: Legislation to Address Health Professional License Portability During a Public Health Emergency: It's All in the Details!

Regulating the practice of nursing (and other health professions) is accomplished at the state level. In the early days of the COVID-19 pandemic, patients turned to telehealth to continue receiving care from the safety of their homes. At the same

time, states that were being hardest hit by the virus were beginning to experience provider shortages, especially nurses, forcing hospitals and health systems to seek assistance from professionals from other states. In August 2020, bills were introduced in Congress that were aimed at improving access to care through provider mobility and interstate telehealth by allowing providers to practice anywhere in the country with one state license—with some critical exceptions.

"The Nurse Licensure Compact (NLC) and other interstate compacts allow providers in many states to quickly relocate or reach patients using telehealth. However, the response during the COVID-19 pandemic was slow in states that had not already joined compacts, a complication that was at least partially due to lack of health provider license portability. In response to the growing COVID-19 crisis, governors across the country issued executive orders waiving state licensing requirements for healthcare providers, allowing providers to deliver in-person and telehealth services outside of their states of licensure in order to improve patient access to care. However, many stakeholders argued that these changes were happening too slowly and were inconsistent from state to state, complicating telehealth responses to patients from out of state. A number of healthcare advocates began to urge the federal government to intervene and pre-empt state licensing laws, allowing providers to practice across state lines as long as they had one state license. However, as many discovered for the first time, the federal government does not currently possess the legal authority to do so" (NCSBN, August 21, 2020).

In response to this problem, Members of Congress introduced a number of bills that would temporarily allow providers to practice across state lines when a Public Health Emergency has been declared:

- *Equal Access to Care Act (S.3993)*: This bill was introduced in the U.S. Senate on June 17, 2020, to allow healthcare providers to deliver telehealth services in any U.S. jurisdiction with only one license. If this bill had become law, it would have legally pre-empted the Nurse Licensure Compact and other compacts with regard to the location of care during telehealth interactions. The National Council of State Boards of Nursing (NCSBN) opposed the bill.
- *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S.421).* The TREAT Act was introduced in the Senate on August 4, 2020. A companion bill (H.R.8283) was introduced in the House of Representatives on September 17, 2020. These bills provided for the temporary licensing authority for healthcare professionals to practice in-person or via telehealth anywhere in the United States with a license in good standing in only one jurisdiction during a period where both a Public Health Emergency has been declared by the secretary of Health and Human Services (HHS) and a national emergency has been declared by the president. The temporary licensing would remain in effect for up to 180 days after the emergency period concluded. When practicing telehealth, healthcare professionals would be required to follow the practice laws and regulations in their jurisdiction of licensure, not the jurisdiction where the patient is located.

  Unlike the Equal Access to Care Act, the TREAT Act addressed concerns related to state-based licensure, discipline, and the NLC through the addition of three critical provisions in Section 4 of the bill:

  - *Subsection (f): Investigative and Disciplinary Authority.* This provision would allow jurisdictions to investigate and take disciplinary action against a provider by preventing them from practicing in their jurisdiction, and then require such as preclusion to be reported to the licensing authority in the provider's state of licensure.

- *Subsection (g): Multiple Jurisdiction Licensure.* This provision would require a provider to follow the practice laws and regulations in the jurisdiction where the patient is located if the provider holds a license in that jurisdiction, alleviating legal confusion about which license would apply in these situations.
- *Subsection (h): Interstate Licensure Compacts*. This provision would exempt providers who hold a multistate license or privilege to practice in multiple jurisdictions through an interstate compact from being subject to this bill.

The inclusion of these provisions better preserves state-based public protection regulatory models and addressed federal legislation's inherent legal conflicts with the NLC and other compacts. In response to the provisions included, the NCSBN remained neutral on the TREAT legislation.

This case study reminds us of the need for constant vigilance to ensure that nursing avoids the unintended consequences of well-intended public policies.

Why You Are the Right Person to Influence Health Policy

When we think of **political power**, we may think of how people, governments, and powerful groups may compel us to do things or even to think a certain way. This sort of power is known as *coercive power*. Coercive power is typically exercised by parents over children. It is also exercised by laws such as those establishing a minimum drinking age for purchasing alcohol or tobacco products or permitting underage marriage only with the consent of a parent or guardian. The second type of power important for nurses to understand is *blocking power*. This type of power has also been referred to as *negative decision power*. Blocking power is used to prevent issues from rising to legislative attention either by limiting an issue from getting on the agenda or by relegating it to a low priority on the agenda. Impeding or limiting policy and social choices has been studied much less than coercion. Examples of blocking power include the political gridlock we typically see around the annual federal budget process based on the use of congressional rules to create a stalemate and control of information flow. Google has been said to be the world's largest censor by blocking access to millions of websites (Epstein, 2016). A third type of power affecting health programs and systems is *purchasing power*. The best example of this in the healthcare arena is the purchasing power of the federal Medicare program, which determines reimbursement rates for healthcare providers.

Influence and power may also be gained from the strategic use of social media or from the 24-hour news cycle (**Figure 1-4**). The COVID-19 pandemic catapulted nurses and other essential workers into the limelight, providing the nursing profession with a voice that is not usually available.

Nursing's education requirements, communication skills, rich history, leadership, and trade association involvement, as well as our practice venues, uniquely qualify nurses to influence thought leaders and policymakers. Nursing and nurses have an ongoing impact on health and social policies.

Figure 1-4 Frontline nurses catapulted into the 24-hour news cycle in 2020.
Tom Stiglich at Creators.com.

Figure 1-5 illustrates some aspects of nurses' impact on the health and well-being of populations.

Advanced studies build on education and experience and broaden the arena in which nurses work to a systems perspective, including both regional health **systems** and the overall U.S. **System** of healthcare delivery and finance. Nurses not only are well prepared to provide direct care to persons and families, but also act as change agents in the work environments in which they practice and the states/nations where they reside.

Nurses have developed theories to explain and predict phenomena they encounter in the course of providing care. In their practice, nurses also incorporate theory from other disciplines such as psychology, anthropology, education, biomedical science, and information technology. Integration of all this information reflects the complexity of nursing care and its provision within an extremely convoluted healthcare System. Nurses understand that partnerships are valued over competition, and that the old rules of business that rewarded power and ownership have given way to accountability and shared risk.

Communication skills are integral to the education of nurses, who often must interpret complex medical situations and terms into common, understandable, pragmatic language. Nurse education programs have formalized a greater focus on communications than is present in any other professional education program. From baccalaureate curricula through all upper levels of nurse education, major segments of nursing courses focus on individual communications and group processes. Skills include active listening, reflection, clarification,

1852	**Florence Nightingale** used statistics to advocate for improved education for nurses, sanitation, and equality.
1861	**Clarissa "Clara" Barton** was a hospital nurse in the American Civil War. She founded the American Red Cross.
1879	**Mary Mahoney** was the first African American nurse in the United States and a major advocate for equal opportunities for minorities.
1903	North Carolina creates first Board of Nursing in the nation and licenses the first registered nurse.
1906	**Lillian D. Wald**, nurse, humanitarian, and author, made many contributions to human rights and was the founder of American Community Nursing. She helped found the NAACP.
1909	The University of Minnesota bestows the first bachelor's degree in nursing.
1916	**Margaret Higgins Sanger** was an American birth control activist, sex educator, writer, and nurse. Sanger popularized the term "birth control" and opened the first birth control clinic in the United States (later evolved into Planned Parenthood).
1925	The Frontier Nursing Service was established in Kentucky with advanced practice nurses (midwives).
1955	**RADM Jessie M. Scott, DSc**, served as assistant surgeon general in the U.S. Public Health Service; led the Division of Nursing for 15 years; and provided testimony before Congress on the need for better nursing training that led to the 1964 Nurse Training Act, the first major legislation to provide federal support for nurse education during peacetime.
1966	The nurse practitioner (NP) role is created by **Henry Silver, MD**, and **Loretta Ford, RN**.
1967	**Luther Christman, PhD**, became the first male dean of a School of Nursing (at Vanderbilt University). Earlier in his career, he had been refused admission to the U.S. Army Nurse Corps because of his gender. He was the founder of the American Association for Men in Nursing, as well as a founder of the National Student Nurses Association.
1971	Idaho statutorily recognizes advanced practice nursing.
1978	**Faye Wattleton, CNM**, was elected president of the Planned Parenthood Federation of America—the first African American and youngest person ever to hold that office. She was the first African American woman honored by the Congressional Black Caucus.
1987	**Ada S. Hinshaw, PhD**, became the first permanent leader at the National Institute of Nursing Research at the National Institutes of Health.
1989	**Geraldine "Polly" Bednash, PhD**, headed the American Association of Colleges of Nursing's legislative and regulatory advocacy programs as director of government affairs. She became CEO of AACN in 1989 and coauthored AACN's landmark study of the financial costs to students and clinical agencies of baccalaureate and graduate nursing education.
1992	**Eddie Bernice Johnson, BSN**, was the first nurse elected to the U.S. Congress (D-TX), where she was a strong voice for African Americans and pro-nursing policies.

Figure 1-5 Prominent nurses who have influenced policy. *(continues)*

1996 **Beverly Malone, PhD**, was elected president of the American Nurses Association; President Clinton appointed her to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry and to the post of deputy assistant secretary for health within the Department of Health and Human Services.

1998 **Lois G. Capps, BSN**, was a U.S. Representative from California from 1998–2017, where she founded the Congressional Nursing Caucus.

2001 **Major General Irene Trowell-Harris, EdD, RN, USAF (Ret.)**, served as director of the Department of Veterans Affairs, Center for Women Veterans. She was instrumental in establishing fellowship for military nurses in the office of Senator Daniel K. Inouye (D-HI).

2009 **Mary Wakefield, PhD**, became the first nurse appointed as director of the Health Resources and Services Administration. In 2015, she became the acting deputy secretary for the Department of Health and Human Services. She also served as chief of staff for U.S. Senators Quentin Burdick (D-ND) and Kent Conrad (D-ND).

2010 **Mary D. Naylor, PhD**, was included as a member of the Medicare Payment Advisory Commission, which influences health policy, and she also holds memberships on the RAND Health Board and the National Quality Forum Board of Directors, as well as serving as past-chair of the board of the Long-Term Quality Alliance.

2011 **LTG Patricia Horoho, MSN, RN**, became the first female and nurse to command the U.S. Army's Medical Command and serve as the surgeon general of a military department over the 239-year history of the Department of Defense. She was honored by Time Life Publications for her actions at the Pentagon on September 11, 2001.

2013 **Marilyn Tavenner, MHA, RN**, became the first nurse confirmed as administrator of the Centers for Medicare and Medicaid Services, serving during the rollout of the Affordable Care Act of 2010.

2013 **Joanne Disch, PhD**, became an influential voice for health policy as chair of the national board of directors for the American Association of Retired Persons and the American Academy of Nursing.

2019 **Ernest Grant, PhD**, became the first male elected as the American Nurses Association's president, championing the plight of immigrants and refugees to the United States.

2020 **Sheila P. Burke, MSN**, chaired Baker Donelson's influential Government Relations and Public Policy Group, following a distinguished career in government. In 1995, she was elected secretary of the Senate, the chief administrative officer of the U.S. Senate. She served from 2000 to 2007 as a member of the Medicare Payment Advisory Commission. She worked for 19 years on Capitol Hill on the staff of the Senate Majority Leader Bob Dole. She then served as the deputy secretary and chief operating officer of the Smithsonian Institution.

Figure 1-5 Continued.

assertiveness, role playing, and other techniques that build nurse competence levels. These same skills are useful when talking with policymakers.

Nursing care is not only a form of altruism, it also incorporates intentional action (or inaction) that focuses on a person or group with actual or potential health problems. The education of nurses puts them in the position of

discovering and acknowledging health problems and health System problems that may demand intervention by public policymakers. For these reasons, accrediting agencies require policy content within nurse education programs.

Practice and Policy

Evidence and theory provide the foundation for nursing as a practice profession. Nurses stand tall in their multiple roles—provider of care, educator, administrator, consultant, researcher, political activist, and policymaker. In their daily practice, nurses spot healthcare problems that may need government intervention, although not all problems nurses and their patients face in the healthcare System are amenable to solutions by government. Corporations, philanthropy, or collective action by individuals may best solve some problems. Most nurses are employees (as are most physicians today) and must navigate the organizations in which they work. By being attuned to systems issues, nurses have developed the ability to direct questions and identify solutions. This ability is reflected in the relationships that nurses can develop with policymakers.

Nurses bring the power of numbers when they enter the policy arena. According to a 2018 report from the National Council of State Boards of Nursing (NCSBN), there were 4,096,607 registered nurses (RNs) and 920,655 licensed practical nurses/licensed vocational nurses (LPN/LVNs) in the United States as of October 2019 (NCSBN, 2020). Collectively, nurses represent the largest group of healthcare workers in the nation.

Nurses have many personal stories that illustrate health problems and patients' responses to them. These stories have a powerful effect when a nurse brings an issue to the attention of policymakers. Anecdotes often make a problem more understandable at a personal level, and nurses are credible storytellers. By applying evidence to a specific patient situation, nurses may also bring research to legislators in ways that can be understood and can have a positive effect.

Nurses live in neighborhoods where health problems often surface and can often rally friends to publicize a local issue. Nurses are constituents of electoral districts and can make contacts with policymakers in their districts. Nurses vote. It is not unusual for a nurse to become the point person for a policymaker who is seeking information about healthcare issues. A nurse does not have to be knowledgeable about every health problem, but a nurse often has knowledge of a specific patient population as well as a vast network of colleagues and resources to tap into when a policymaker seeks facts. The practice of nursing prepares the practitioner to work in the policy arena. Note that the public policy process depicted in Figure 1-2 involves the application of a decision-making model in the public sector.

All facets of nursing practice and patient care are highly regulated by political bodies. State boards of nursing and other professional regulatory boards exert much influence in interpreting the statutes that govern nursing. Scope of practice is legislated by elected members but then defined in the rules and regulations by boards. Because each state and jurisdiction defines the practice

of nursing differently, nursing scope of practice varies widely across the specific states. A fear expressed by many boards is that their decisions may interfere with Federal Trade Commission (FTC) rules that restrict monopoly practices. In 2014, the FTC published a policy paper addressing the regulation of the **advanced practice registered nurse (APRN)** that includes five key findings with important implications for policymakers:

1. APRNs provide care that is safe and effective.
2. Physicians' mandatory supervision of and collaboration with advanced nurse practice is not justified by any concern for patient health or safety.
3. Supervision and collaborative agreements required by statute or regulation lead to increased costs, decreased quality of care, fewer innovative practices, and reduced access to services.
4. APRNs collaborate effectively with all healthcare professionals without inflexible rules and laws.
5. APRN practice is "good for competition and consumers" ("FTC Policy Paper," 2014, p. 11).

Professional nurses who are knowledgeable about the regulatory process can more readily spot opportunities to contribute or intervene prior to final rule making.

Organizational Involvement

Professional organizations bring their influence to the policy process in ways that a single person may not. There are myriad nurse-focused organizations, including those in specialty areas, education-related organizations, and leadership-related organizations. For example, the American Nurses Association, the National League for Nursing, and Sigma Theta Tau International state a commitment to advancing health and health care in the United States and/or on a global scale, as noted in their mission statements and goals, and offer nurses opportunities to develop personal leadership skills. The Oncology Nurses Society, the American Association of Critical Care Nurses, the American Association of Nurse Anesthetists, the Emergency Nurses Association, and many other specialty organizations focus on policies specific to certain patient populations and provide continuing education. Participating on committees within trade associations provides opportunities to learn about the organization, its mission, and its outreach efforts in more depth.

Professional associations afford their members experiences to become knowledgeable about issues pertinent to the organization or the profession. These groups can expand a nurse's perspective toward a broader view of health and professional issues, such as at the state, national, or global level. This kind of change in viewpoint often encourages a member's foray into the process of public policy. Some nurses are experienced in their political activity. They serve as chairs of legislative committees for professional organizations, work as campaign managers for elected officials, or present testimony at congressional, state, or local hearings; a few have run for office or hold office.

Political activism is a major expectation of most professional organizations. Many organizations employ professional lobbyists who carry those organizations' issues and concerns forward to policymakers. These sophisticated activists are skilled in the process of getting the attention of government and obtaining a response. Nurses also have an opportunity to voice their own opinions and provide information from their own practices through active participation in organizations. This give-and-take builds knowledge and confidence when nurses help legislators and others interpret issues.

Taking Action

Nurses cannot afford to limit their actions in relation to policy. Instead, nurses need to share their unique perspectives with bureaucrats, agency staff, legislators, and others in public service regarding what nurses do, what nurses and their patients need, and how their cost-effectiveness has long-term impacts on health care in the United States.

Many nurses are embracing the whole range of options available in the various parts of the policy process. They are seizing opportunities to engage in ongoing, meaningful dialogues with those who represent the districts and states and those who administer public programs. Nurses are becoming indispensable sources of information for elected and appointed officials, and they are demonstrating leadership by becoming those officials and by participating with others in planning and decision making. By working with colleagues in other health professions, nurses often succeed in moving an issue forward owing to their well-recognized credibility and the relatively fewer barriers they must overcome.

A Professional Nursing Workforce

Nurses can bring research and creativity to efforts geared toward solving public policy issues such as high drug prices, patient readmission rates, deployment of screening tools, and the most efficacious use of RN and APRNs. Aiken and colleagues have reported repeatedly that hospitals with higher proportions of baccalaureate-prepared nurses demonstrate decreased patient morbidity and mortality (Aiken et al., 2003, 2012, 2014; Van den Heede et al., 2009; Wiltse-Nicely, Sloane, & Aiken, 2013; You et al., 2013). Aiken's research includes studies in the United States and in nine European countries. Although the NCSBN has stated that it is not ready to support legislation or regulation that requires a bachelor of science in nursing (BSN) as the entry level into practice as a registered nurse, the marketplace is moving in a different direction (**Figure 1-6**). Many healthcare agencies limit new hires to those with a BSN and have policies that require RNs with associate's degrees or diplomas to complete a BSN within 5 years of employment. Academic institutions have expanded or created RN-to-BSN programs in response to the demand from the accrediting agency for Magnet status, the American Nurses Credentialing Center.

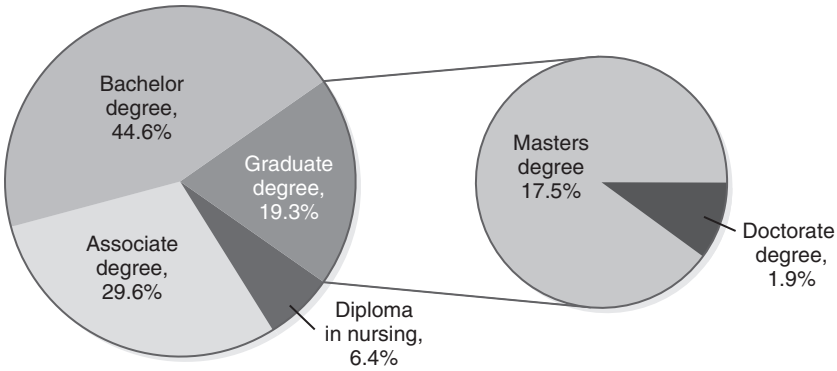


Figure 1-6 Highest nursing and nursing-related educational attainment.

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2019. Brief Summary Results from the 2018 National Sample Survey of Registered Nurses, Rockville, Maryland.

Spotlight: Title VIII of the Affordable Care Act: Community Living Assistance Services and Supports (CLASS) Act

The CLASS Act was intended to allow Americans who are or who become disabled to receive a $50 daily payment to put toward assisted living. The amount was to be spent on home health care, adult daycare, and other services to allow those with disabilities to stay in their homes when possible. The amount could also go toward care provided by assisted living facilities, nursing homes, and group homes. The program was intended to be self-funded and would have reduced the deficit by $70.2 billion over 10 years by allowing people to remain employed and stay out of nursing homes and hospitals. The CLASS Act entered into force on January 1, 2011, but by October 1 it was determined to be unworkable. It could not compete with private-sector plans that offered better benefits.

Innovation in Health Care: Reform or Incrementalism?

Starting with the Truman administration in the 1940s, every U.S. president's administration has struggled to reform the healthcare System to meet the needs of all U.S. residents. President Barack Obama declared early in his administration that a major priority would be health care for all, and in 2010 the Patient Protection and Affordable Care Act (commonly known as the ACA and "Obamacare") was established. More than a decade later, some aspects of the ACA continue to be controversial. The ACA includes 10 legislative titles; some of the titles were found to be unworkable or unsustainable during the implementation phase. The ACA is an example of sweeping reform, and its passage into law was a political feat. Most changes in health policy are incremental rather than sweeping.

During the 115th and 116th Congresses, the Trump administration, together with a Republican majority in the Senate, took steps to weaken the ACA, including the following:

- Eliminating of the mandate that all Americans purchase health insurance (Supreme Court case).
- Sharply reducing support for marketing the state-level health insurance exchanges as well as for the exchange navigators who could help guide those who need this insurance.
- Reducing the number of days of the annual enrollment period by one-half.
- Reneging on financial commitments to health insurers (the ACA provided for various subsidies to insurance companies to reduce their risks of losing money if they participated on the exchanges).
- Expanding access to cheaper insurance coverage that does not meet the quality standards for health insurance required by the ACA. (The ACA was originally intended to bolster the quality of health insurance through such measures as requiring insurers in the individual and small-group markets to cover 10 essential benefits, guaranteeing coverage of those with preexisting conditions at premium rates similar to heathier enrollees, and reducing risks of medical bankruptcy by prohibiting insurers from imposing certain spending caps on health care for an enrollee).

These and other actions to reduce the effectiveness and scope of the ACA did not require full legislative repeal. Instead, there has been a chipping away and erosion of the ACA's intended reforms to improve the U.S. healthcare System, reduce costs, and improve access to care for millions of Americans.

The 2020 elections did not provide a clear mandate to either a conservative or liberal point of view regarding the future of healthcare legislation. President Biden will need to work with a slim Democratic majority in the 117th Congress to amend, strengthen, and improve the ACA—or replace it. Former Senate Majority Leader Mitch McConnell, reelected in 2020 to his seventh 6-year term, will lead the Republican minority to possibly obstruct and delay much of the Biden administration's agenda (as he promised to do during the Obama administration). No party has a clear pathway to the super-majority (two-thirds of the Senate) needed to control specific types of votes. Based on recent history, the election cycle may return the congressional majority to the Republicans in 2022.

Divided government allows more points of view to be considered when designing policies; however, it can also cripple a government's ability to get anything done. As this text goes to press, Biden's cabinet appointments as well as other advisory positions are unknown; hopefully, nurses will be included. One of Biden's first actions as president-elect was to create a White House Coronavirus Task Force; the original appointees did not include any nurses.

Nurses must speak out as articulate, knowledgeable, caring professionals who contribute to the whole health agenda and who advocate for their patients and the community. All healthcare professions have expanded the boundaries of practice from their beginnings. Practice inevitably reflects societal needs and conditions; homeostasis is not an option if the provision of health care is to be relevant.

Spotlight: Voting in the Senate

Most issues in the Senate are decided by a simple majority vote: one-half plus one of the senators voting, assuming the presence of a quorum. For instance, if all 100 senators vote, the winning margin is at least 51. Under Senate precedents, a tie vote on a bill defeats it. Some super-majority votes (also known as extraordinary majority) are explicitly specified in the Constitution; implicitly, they also exist in authority granted in Article I, Section 5, which says, "Each chamber may determine the Rules of Its Proceedings." Under this constitutional power, the Senate has imposed on itself a number of additional super-majority requirements. These include invoking cloture, suspending the rules, postponing treaty consideration indefinitely, making a bill a special order (antiquated), and waiving the Congressional Budget Act of 1974, Senate Rule XXVIII, Senate Rule XLIV, and the Statutory Pay-As-You-Go Act of 2010 (also known as "pay-go").

What is cloture? A three-fifths vote of all senators (60 of 100) is required to invoke cloture—the closure of debate—on most bills. However, a two-thirds vote of the senators present and voting is required to invoke cloture on measures or motions to amend Senate rules. Once cloture has been invoked, the 30 hours of debate available during postcloture consideration may be extended by a three-fifths vote of all senators duly chosen and sworn.

Developing a More Sophisticated Political Role for Nurses

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

Nurses have learned that by using nursing knowledge and skill, they can gain the confidence of government actors. Personal stories drawn from professional nurses' experience anchor conversations with legislators and their staffs, creating an important emotional link that can influence policy design. Nurses' vast network of clinical experts produces nurses in direct care who provide persuasive, articulate arguments with people "on the Hill" (i.e., U.S. congressional Members and senators who work on Capitol Hill).

Working With the Political System

Many professional nurses and APRNs develop contacts with legislators, appointed officials, and their staffs. Groups that offer nurse interaction include the U.S. House Nursing Caucus and the Senate Nursing Caucus (membership shifts with the election cycle). Members hold briefings on nurse workforce planning, patient and nurse safety issues, vaccinations, school health, reauthorization of

legislation (e.g., the Emergency Medical System Act, the Ryan White Act), preparedness for bioterrorism, and other relevant and pertinent issues and concerns.

Nurses must stay alert to issues and be assertive in bringing problems to the attention of policymakers. It is important to bring success stories to legislators and officials—they need to hear what good nurses do and how well they practice. Sharing positive information will keep the image of nurses positioned within an affirmative and constructive picture.

Conclusion

Healthcare professionals must have expert knowledge and skills in change management, conflict resolution, active listening, assertiveness, communication, negotiation, and group processes to function appropriately in the policy arena. Professional autonomy and collaborative interdependence are possible within a political system in which consumers can choose access to quality health care that is provided by competent practitioners at a reasonable cost. Professional nurses have a strong, persistent voice in designing such a healthcare system for today and for the future.

The policy process is much broader and more comprehensive than the legislative process. Although individual components can be identified for analytical study, the policy process is fluid, nonlinear, and dynamic. There are many opportunities for nurses in advanced practice to participate throughout the policy process. The question is not *whether* nurses should become involved in the political system, but *to what extent*. Across the policy arena, nurses must be involved with every aspect of this process. By knowing all the components and issues that must be addressed in each phase, the nurse in advanced practice will find many opportunities for providing expert advice. APRNs can use the policy process, individual components, and models as a framework to analyze issues and participate in alternative solutions.

Chapter Discussion Points

1. What is the number (or designation) of your voting district? Obtain your voting record from the board of elections and describe your citizenship in regard to voting in elections.
2. Identify a health- or healthcare-related problem you have encountered in your community or in practice (e.g., "My patients all have dental problems and have no means of paying for dental care"). Discuss how the diagram of the policy process (Figure 1-2) can help inform how you approach finding a solution to this problem. Reflect on which level of government might address this problem and why. Identify the stakeholders in this issue.
3. Read fact-based (not opinion) books or journalistic articles or listen to podcasts about the changing paradigm in healthcare delivery and payment systems. Suggestions for reading include *Priced Out* (2019) by Uwe Reinhardt,

Being Mortal (2014) by Atul Gawande, articles/blog postings in *The Atlantic* and *Health Affairs*, and *Which Country Has the Best Health Care* (2020) by Ezekiel Emanuel.
   a. List three questions you have after reading this material.
   b. List three new ideas you have gained.
   c. Commit to three actions that you will take as a result of being informed by this material.
4. Consider a thesis, graduate project, or dissertation on a specific topic (e.g., clinical problems, healthcare issues). Use the policy process as a framework.
5. Use a search engine to explore a policy related to a health or healthcare topic such as Supplemental Nutrition Assistance Program (SNAP) benefits, the nursing workforce, or the National Practitioner Database (NPDB). Which government agencies are responsible for developing the policy? For enforcing the policy? How has the policy changed over time? What are the consequences of not complying with the policy? What is needed to change the policy?
6. Identify nurses and healthcare professionals who are elected officials at the local, state, or national level. Follow them on Twitter and Facebook to determine how they became policy experts, what their objectives are, and to what extent they use their clinical knowledge in their official capacities. Ask the officials if they tapped into nurses' groups during their campaigns. If so, what did the nurses and HCPs contribute?
7. Watch a health- or healthcare-related hearing in the U.S. House of Representatives or the Senate. These are accessible online at www.congress.gov. The House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions Committee are good choices. Discuss three things you learned from the hearing. Was there testimony by nurses or other clinicians? Would nursing/HCP testimony be valuable at this hearing? How are witnesses chosen? What topics could you testify about (think of the patient population you work with)?
8. Discover how to get notifications (and agendas) of upcoming health-related committees in your state government. Who are the chairs of these committees?

CASE STUDY 1-2: The Addiction Epidemic

You are an acute care nurse practitioner who works in an urban emergency room (ER). You see many people who come to the ER who have overdosed on heroin. Emergency medical services (EMS) personnel may administer a drug that might reverse the overdose such as naloxone (Narcan). You may see three overdoses during each 12-hour shift; some of these patients are admitted to the hospital, and others are sent home with a consultation for psychiatric follow-up. You are becoming hardened to the issue and have begun to question what you can do to address this epidemic.

Case Study Discussion Questions

1. You hear that the state health director is convening a task force. List four actions you can take to be invited to participate in this task force.
2. Which other healthcare professionals should be included on the task force?
3. Which state agencies and regulatory boards could add value to the discussion?
4. Which information/experience could the APRN use to lead a discussion about widespread addiction?
5. Identify three issues that might be brought up at a meeting that could derail a focus on public safety. Which tactics can the nurse use to bring the discussion back to the issue of safety?

References

AARP Public Policy Institute. (2021). *The future of nursing: Campaign for action*. Center to Champion Nursing. https://campaignforaction.org/about/leadership-staff/the-rwjf-and-aarp-partnership/.

Aiken, L. H., Clarke, S. R., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association*, 290(12), 1617–1623.

Aiken, L. H., Cimotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. E. (2012). Effects of nurse staffing and nursing education on patient deaths in hospitals with different work environments. *Medical Care, 49*(12), 1047–1053.

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kózka, M., Lesaffre, E., McHugh, M. D., Moreno-Casbas, M. T., Rafferty, A. M., Schwendimann, R., Scott, P. A., Tishelman, C., van Achterberg, T., & Sermeus, W. for the RN4CAST consortium. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *Lancet, 383*(9931), 1824–1830.

Brannon, V. (2018). Statutory interpretation: Theories, tools and trends. Congressional Research Service Report 45153. https://crsreports.congress.gov/product/pdf/R/R45153

Centers for Disease Control and Prevention. (2020). Overview of CDC's policy process. U.S. Department of Health and Human Services. https://www.cdc.gov/policy /analysis/process/docs /cdcpolicyprocess.pdf

Epstein, R. (2016, June 22). How did Google become the Internet's censor and master manipulator, blocking access to millions of websites? *U.S. New and World Report.* https://www.usnews.com /opinion/articles/2016-06-22/google-is-the-worlds-biggest-censor-and-its-power-must-be-regulated

FTC policy paper examines competition and the regulation of APRNs. (2014). *American Nurse*, *46*(3), 11.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. National Academies Press.

Kickbusch, I. (2015). The political determinants of health—10 years on. *British Medical Journal,* 2015;350:h81.

Mackenbach, J. P. (2014). Political determinants of health. *European Journal of Public Health, 24*(1), 2.

Mishori, R. (2019). The social determinants of health? Time to focus on the political determinants of health. *Medical Care*, *57*(7), 491–493.

National Council of State Boards of Nursing. (2020, August 21). *Policy briefing: Members of Congress introduce legislation to address health professional license portability during a public health emergency.* https://www.ncsbn.org/14954.htm

National Council of State Boards of Nursing. (2020). NCSBN's environmental scan: A portrait of nursing and healthcare in 2020 and beyond. *Journal of Nursing Regulation*, *10*(4), S1–S36.

Oyez. (2014). *King v. Burwell*. https://www.oyez.org/cases/2014/14-114

Oyez. (2020). *California v. Texas*. https://www.oyez.org/cases/2020/19-840

Patient Protection and Affordable Care Act of 2010. (2010). Pub. L. No. 111-148, 124 Stat. 119.

Stringer, H. (2019, July 1). *IOM Future of Nursing report card: Progress after 10 years with Sue Hassmiller and Mary Dickow*. Nurse.com blog. https://www.nurse.com/blog/2019/07/01/iom-future-of-nursing-report-card-progress-after-10-years/

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2019). *Brief summary results from the 2018 National Sample Survey of Registered Nurses*. Author.

Van den Heede, K., Lesaffre, E., Diya, L., Vleugels, A., Clarke, S. P., Aiken, L. H., & Sermeus, W. (2009). The relationship between inpatient cardiac surgery mortality and nurse numbers and educational level: Analysis of administrative data. *International Journal of Nursing Studies*, *46*, 796–803.

Wiltse-Nicely, K. L., Sloane, D. M., & Aiken, L. H. (2013, June). Lower mortality for abdominal aorta aneurysm repair in high volume hospitals contingent on nurse staffing. *Health Systems Research*, *48*(3), 972–991.

You, L.-M., Aiken, L. H., Sloane, D. M., Liu, K., He, G-P, Hu, Y., . . . Sermeus, W. (2013). Hospital nursing, care quality, and patient satisfaction: Cross-sectional survey of nurses and patients in hospitals in China and Europe. *International Journal of Nursing Studies, 50*(2), 154–161.