Policy Essentials

# Introduction

Every topic in nursing school has policy implications. Yet placing health policy in a curriculum can be challenging because it both ubiquitous and invisible. Policy influences almost every facet of the clinical encounter, yet its origin and intent can feel like a distant concern best left to someone else. As a local example, a nurse who is washing their hands before assessing a patient is likely aware of the hospital's policy on handwashing but may not realize how their actions are also guided by professional standards, regulations, and financial incentives. On a larger scale, equitable access to care, such as who is able to see a nurse practitioner, is also a policy issue. Therefore, it is imperative that nurses are competent to recognize, analyze, and act upon policies impacting their patients, community, and profession. The following prompts of Why, Who, What, When, Where, and How (the 5 Ws and H framework) are intended to help faculty surface health policy competencies and allow students to connect them with clinical learning and professional development.

**Why** – Policy is solving or preventing problems to optimize population health, equity, social welfare, and the nursing profession. The need for or impact of health policy is commonly assessed on:

* Quality – Including safety, effectiveness, efficient, equity, timeliness, and patient centeredness.[[1]](#endnote-1)
* Access – Including affordability, the capacity of the workforce to provide sufficient services, and whether patients can be seen by who they want, when they want, for the services they want.[[2]](#endnote-2)
* Cost – Including the price of services, the efficiency of services delivered, the administration of the system, waste and fraud, and unwarranted variation in allocation.[[3]](#endnote-3) (Cutler, 2018).

While there is a plethora of frameworks that combine or emphasize elements in different way, an important part of health policy competence is recognizing that patients – like consumers for all other goods and services – want services that are better, easier to get, and less expensive. These domains overlap in places and are influenced by social determinants of health, societal values, and history as well as policy. We encourage faculty to have their students assess how policies affect equity in quality, access, cost, and the nursing profession.

**Who** – Stakeholders are those influenced by and invested in health policies and include patients, families, nurses, healthcare facilities, insurance companies, and voters (depending on the circumstance). Analogous to a marketplace, policymakers are responding to a demand from stakeholders. Stakeholder groups may differ or align in terms of their interests, policy preferences, and strategies. For instance, nursing unions and hospitals share the goal of improving patient care but differ in their demand for staffing mandates. Policymakers include those who draft legislation, but also those who write regulations, implement programs, or write clinical protocols. They may be in government, healthcare facilities, or professional organizations. An important part of health policy competence is the ability to determine who the policymakers and stakeholders are; what interests they hold and how they align; and how much power and influence they have over policy.

**What** – “In all settings, *policies* are officially or authoritatively made decisions for guiding actions, decisions, and behaviors of others.”[[4]](#endnote-4) Policies can take the form of law, but also the rules and regulations needed to implement the law and judicial decisions about a law's constitutionality. Healthcare policy also takes the form of procedures and protocols within healthcare organizations and standards set by professional organizations. Policies can set requirements (e.g., you must hold a nursing license to practice nursing), establish programs to allocate resources (e.g., funding for nursing education), or create incentives (e.g., pay increases based on a clinical ladder). An important part of part of health policy competence is the ability to distinguish the form and characteristics of policy.

**When** –Current events open (or close) windows of opportunity for policy by increasing the number or volume of those demanding it or aligning the interests of stakeholders and/or policymakers.[[5]](#endnote-5) (Kingdon, 1984). For example, policy windows are opened in clinical settings when a sentinel event occurs or in schools of nursing when new curricular standards are released. Policies also have stages of formulation, implementation, and modification.4 An important part of health policy competence is the ability to analyze the changing interests of stakeholders and policymakers.

**Where** – Policy is made by the federal government, national professional organizations, states, municipalities, and healthcare organizations. Policies established at one level (e.g., federal law) often have echoes at other levels (e.g., protocols in healthcare organizations). For instance, at the macrosystem level, the American Association of Colleges of Nursing (AACN) writes *Essentials* which are guiding documents for national accreditation standards. At the microsystem level, schools of nursing adapt their curricula (i.e., educational policy) to meet the accreditation standards. An important part of health policy competence is assessing a policy's system-ness and the interplay between system levels.

**How** – Advocacy and analysis are used by both stakeholders and policymakers to shape policy. Advocacy requires an understanding of the audience, tailoring of the message and delivery, and the ability to judge influence on stakeholders and policymakers. Analysis requires knowledge of theories or frameworks to guide the selection of measures and methodologies, judgement to discern patterns of evidence, and openness to unintended consequences. An important part of health policy competence is the ability to conduct rigorous analysis and effectively communicate evidence in advocacy. Enacting and implementing policy is also essential in advancing policy changes.

# Vignettes

We have provided two vignettes of policy issues as exemplars of how faculty can use this toolkit. The first vignette examines the clinical practice guidelines that call for the use of a Black coefficient in the determination of glomerular filtration rate. This vignette highlights a policy that is influenced by unconscious bias by affecting the eligibility for kidney transplants for Black patients with end stage renal disease. The second vignette illustrates the policy and resultant supply chain changes to make enteral tube connectors safer for patients.

## Vignette 1: Black Coefficient in Glomerular Filtration Rates and Kidney Transplant Eligibility

*Cliff is a 59-year-old Black man with diabetes, hypertension, and kidney failure. He is not eligible to be on the kidney transplant waiting list because his estimate glomerular filtration rate (eGFR) was most recently calculated to be 21 mL/min/1.73 m2 and patients are eligible for transplant evaluation when their eGFR falls below 20 mL/min/1.73 m2. However, if Cliff had been White his eGFR rate would have been calculated as 19 mL/min/1.73 m2 and he would have been eligible for evaluation and listing.*

The management of kidney failure is guided by monitoring estimated GFR because direct measurement with a filtration marker is difficult to administer, burdensome for the patient, and expensive. The estimation is done by a laboratory using equations that include values for creatinine, age, sex, body size, and race. In these equations, Black race is multiplied by a coefficient making the estimated GFR 16-18% higher than Whites. The justification for the Black coefficient is based on an association between self-reported Black race and higher directly measured GFR.[[6]](#endnote-6) While self-reported race may accurately convey the patient's lived experience, the proportion of African American genetic ancestry among self-reported African Americans ranged from 1% to 98% and from 0% to 11% among those who reported European ancestry.[[7]](#endnote-7) Using a binary categorization of self-reported race in the estimation of GFR is akin to substituting age in years for the patient's opinion of whether they feel old or young. There may be some association, but the construct is wrong (perception vs chronology), and the measurement scale is unnecessarily imprecise (binary vs continuous).

How GFR is determined represents a *healthcare policy issue* because it impacts access to resources and equity of outcomes. Racism, in the form of unconscious bias, allowed race to be biologized in science. Race is a social construct that carries biological consequences and not a genetic marker with biologic expressions. Policy, in the form of a clinical practice guideline, made this racism structural. The policy implications are detailed below:

**Why** – The use of race in the calculation of GFR impacts the quality, cost, and access to healthcare.

* ***Quality*** – Of the six domains of quality, Equity, Effectiveness, and Timeliness are the three domains most clearly impacted. Equitable healthcare is "Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status" and Black patients are less likely to be evaluated for transplant, entered onto the transplant wait list, and ultimately receive a transplant.[[8]](#endnote-8),[[9]](#endnote-9) Compared with those on dialysis, patients who received a transplant had a 68% lower risk of death after 18 months.[[10]](#endnote-10) Effective healthcare is "Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit." Race is used in the calculation of GFR as a proxy for biologic factors such as muscle mass that can impact creatinine clearance. However, self-reported race is a less effective variable than several alternatives including measurement of muscle mass or genetic ancestry because (1.) continuous variables contain more information than categorical variables and (2.) self-reported race is confounded with social experiences of racism. Moreover, recent research has found that calculating estimated GFR without the race coefficient was more closely associated with directly observed GFR than when calculated with the race coefficient (r=0.75 vs r=0.61, respectively). Timely healthcare is "Reducing waits and sometimes harmful delays for both those who receive and those who give care." Use of the Black coefficient is associated with a 1.9 year longer wait for transplantation among Black patients as compared with Whites.[[11]](#endnote-11)
* ***Cost*** – Delays in transplant are associated with higher healthcare costs. Jassal and colleagues[[12]](#endnote-12) found that increasing the waitlist time from two to four years was associated with a tripling of the cost for a quality adjusted life year. The use of the Black coefficient may also increase costs for patients because eligibility for the End-Stage Renal Disease Medicaid and Medicare coverage is dependent upon GFR.

**What**

* The clinical practice guideline functions as a policy to allocate a scarce resource – kidney transplants. The guideline recommends the use of the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) estimating equation. Recommendation 1.4.3.3 reads, "We recommend that clinicians use a GFR estimating equation to derive GFR from serum creatinine (eGFRcreat) rather than relying on the serum creatinine concentration alone." [[13]](#endnote-13)This policy interacts with many others. For instance, the Organ Procurement and Transplantation Network's policy 8.3 states that the date GFR fell below 20 mL/min/1.73 m2 determines a patient's place on the wait list.[[14]](#endnote-14) As the primary marker of kidney failure, GFR is also used to guide prescribing and determine insurance eligibility.

**Who**

* The policymakers in this vignette are the International Society of Nephrology who wrote the clinical practice guidelines. The stakeholders are patients with end stage renal disease and their families. Stakeholders also include the clinical laboratories that adopted the standards recommended in the guidelines, clinicians who based decisions upon the guideline's criteria, and insurers whose coverage is impacted by a patient's clinical course.

**Where**

* The clinical practice guideline is from an international professional society. By itself, it carries no enforcement mechanism, offers no incentives, and provides no accreditation or credential. However, clinical practice guidelines from professional organizations inform government policy and healthcare organizations use them to establish protocols. Thus, an international professional organization can change the practice of a hospital's laboratory.

**When**

* The flaws in using race as a biologic construct were known long before the development of GFR estimating equations.[[15]](#endnote-15) Additionally, racial disparities in access to transplantation have been documented for decades.[[16]](#endnote-16) In 2015, Udler and colleagues[[17]](#endnote-17) published research demonstrating how genetic ancestry and polymorphisms better predicted renal function than self-reported ancestry. In the three years following publication, it was cited 18 times. The murders of Ahmaud Arbery, Breonna Taylor, George Floyd, and others changed the politics and public discourse of structural racism.[[18]](#endnote-18) In this context, the publication of the opinion piece, "Reconsidering the Consequences of Using Race to Estimate Kidney Function" by Eneanya and colleagues[[19]](#endnote-19) aligned problem recognition, an altered politics, and a policy solution thereby opening Kingdon's policy window. In the three years after Eneanya's article opened the policy window, Udler's article was cited 47 times. More importantly, laboratories across the country stopped using the Black coefficient when reporting GFR.

**How**

* As described above, analysis on the impact of the black coefficient has demonstrated that Black patients wait longer for kidney transplantation than White patients and have worse outcomes.
* Advocacy regarding this issue reached the national news.[[20]](#endnote-20) It has also prompted the American Society of Nephrology (ASN) and the National Kidney Foundation (NKF) to form a joint task force to re-examine the use of race in the calculation of GFR. On 9/23/21 the task force released their recommendation that laboratories across the country estimate GFR without the race coefficient.[[21]](#endnote-21)

## Vignette 2: Enteral Feeding Tube Connectors and Patient Safety

As a result of many deaths and medical errors, the California Hospital Association and other healthcare and patient advocacy groups collaborated with the California legislature to introduce Senate Bill 158 authored by California State Senator Dean Florez in 2008.[[22]](#endnote-22) The bill was successfully signed into law by the Governor of California. The law prohibited health facilities from using an intravenous connection, epidural connection, or enteral feeding connection that would fit into a connection port other than the type it was intended for. Yet enteral feeding tube connections were manufactured with Leur lock connection, which were the connections also for IV and epidural connections. Therefore, health facilities could not use enteral-specific connectors if they did not exist.[[23]](#endnote-23) The passage of this law was one of the major impetuses to have the device manufacturing companies to develop an alternative connector for enteral feeding tubes and syringes. Subsequent laws were required to extend the deadline to allow for the manufacturers to design and manufacture appropriate tubing and syringes.[[24]](#endnote-24)

In 2009, AdvaMed, the manufacturers’ trade association successfully pushed legislation (Assembly Bill 444, 2016) to delay the bill’s effects until 2013 or 2014 or until an international standards group reached a decision on appropriate standards for enteral feeding tube connection design.[[25]](#endnote-25)

A New York Times article published in 2010 written by Gardiner Harris profiled multiple people who died as a result of tubing misconnections and identified opportunities within the manufacturer trade associations and the Food and Drug Administration (FDA) bureaucracy that caused delays in improving patient safety.

A research study was published in 2011 by Debora Simmons and colleagues titled, Tubing Misconnections: Normalization of Deviance in the journal, Nutrition in Clinical Practice.[[26]](#endnote-26) The authors reviewed 116 published cases of nutrition tubing misconnections with IV and other inappropriate tubing and devices. Of the 116 cases, 21 patients died and 95 survived. Out of the 95 survivors, 84 had at least 1 diagnosis reported. Diagnoses included respiratory conditions including cardiopulmonary arrest (n=37, 44%) sepsis (n=16, 19%), neurological harm (n=11, 13%), renal impairment (n=8, 9.5%). Additionally, ECRI, an independent nonprofit organization dedicated to improving the safety, quality, and cost-effectiveness of healthcare and is the only organization worldwide that conducts independent medical device evaluations, identified enteral feeding tube misconnections as one of the top 10 technology hazards in 2012.

In 2015, the new international design standard for enteral feeding tube devices was released. The initiative by the Global Enteral Device Supplier Association (GEDSA) titled, “Stay Connected,” unveiled ENFit®, the enteral feeding tube connection.[[27]](#endnote-27) The healthcare industry was then able to order appropriate supplies, train staff, and improve safety in patient care.

**Why**

* Enteral feeding tubes and syringes across the world were being connected to IV and epidural lines causing severe morbidity and mortality in multiple practice settings and in multiple patient populations in the inpatient settings and long-term care. These errors can lead to secondary trauma to the healthcare providers involved in the situations and can also create significant financial costs to the healthcare system, patients, and families.

**Who**

* Patients and families provided the stories of morbidity and death due to medical device errors served as the catalyst for policy makers, researchers, legislators, and accreditation agencies (i.e., the Joint Commission) to notice and take action.
* Researchers, Simmons, and colleagues studied the incidence and prevalence of medical errors and the impact on health and the costs of care.
* Policymakers, such as ECRI and the California Hospital Association and other healthcare and patient associations, listened to the stories, read the research, advocated for regulatory and statutory changes.
* The manufacturer trade association, AdvaMed, set standards for device design and manufacturing. They also needed to advocate for the manufacturers and revise standards.
* Legislators, such as California State Senator Dean Florez, worked with all stakeholders to enact policy into law.

**What**

* The policy focused on Russell & Fawcett’s Level 2. The change in enteral feeding connectors improved quality of patient care within health care delivery systems initially in California but spread to other states and internationally.
* When examining this exemplar in light of the CDC POLARIS framework, it is interesting that implementation of the policy and the law needed to be delayed (introduction and passage of California Assembly Bill 444[[28]](#endnote-28)) due to the industry not being ready with the safety tested devices.

**When**

* The policy window per Kingdon’s Policy Streams Theory was opened when research, policy makers, non-profit agencies, and clinicians identified a quality and patient safety gap. Legislation, a national press article, nursing and trade associations continued to push for policy changes.

**Where**

* Engaging in policy work happened at multiple levels. The beginning policy work occurred in California with introduction of legislation to change the enteral feeding tube connectors. The bill, Senate Bill 158, passed through the bicameral California legislature and was signed into law by the Governor. While the bill was signed into law, the manufacturers did not have Luer lock alternatives and so needed to design, test, get approval from the FDA, and then manufacture the new devices. So, continued policy work needed to occur at the national and international levels to ensure that the policy could be implemented to improve safe patient care.

**How**

* Once the policy was enacted into law and the manufacturers had approval to manufacture the new product, ENFit®, the industry and nursing community created the “Stay Connected” initiative to educate healthcare personnel, conduct research, write position statements, and advocate for patient safety.

# Policy Resources

This partial list of various resources is provided to help faculty with teaching policy and to advance student learning.

## Policy curriculum guides and related articles

## Teach Population Health [Component 4-2015 Health Systems and Health Policy in CLINICAL PREVENTION & POPULATION HEALTH CURRICULUM FRAMEWORK (teachpopulationhealth.org)](http://www.teachpopulationhealth.org/component-4-2015.html) [Educating nurses for leadership roles.](https://pubmed.ncbi.nlm.nih.gov/15481400/)

 Turale, S., & Kunaviktikul, W. (2019) [The contribution of nurses to health policy and advocacy requires leaders to provide training and mentorship.](https://pubmed.ncbi.nlm.nih.gov/31429074/)   *International Nursing Review*, *66*(3), 302–304. <https://doi.org/10.1111/inr.12550>

Ellenbecker C, Fawcett J, Jones E, Mahoney D, Rowlands B & Waddell A (2017). A staged approach to educating nurses in health policy Policy Polit Nurs Pract Feb;18(1):44-56.: DOI: [10.1177/1527154417709254](https://doi.org/10.1177/1527154417709254)

Anders R. L. (2021). Engaging nurses in health policy in the era of COVID-19. *Nursing forum*, *56*(1), 89–94. <https://doi.org/10.1111/nuf.12514>

Scott, J., Johnson, R., & Ibemere, S. (2021). Addressing health inequities re-illuminated by the COVID-19 pandemic: How can nursing respond? *Nursing Forum*, *56*(1), 217–221. <https://doi.org/10.1111/nuf.12509>

Heiman, H. J., Smith, L. L., Respress, E., & Bayer, C. R. (2019). Health Policy Training for Health Equity Leaders. *Ethnicity & Disease*, *29*(Suppl 2), 405–412. <https://doi.org/10.18865/ed.29.S2.405>

## Policy-related organizations

[Kaiser Family Foundation](http://www.kff.org/)

[Health Systems: Transforming Healthcare in the U.S. - RWJF](https://www.rwjf.org/en/our-focus-areas/focus-areas/health-systems.html)     <https://www.rwjf.org/en/our-focus-areas/focus-areas/health-systems.html>

[Commonwealth Fund](https://www.commonwealthfund.org/)   <https://www.commonwealthfund.org/>

[Advocacy (nursingworld.org)](https://www.nursingworld.org/practice-policy/advocacy/) American Nurses Association policy issues

[The National Academy for State Health Policy (nashp.org)](https://www.nashp.org/)

[UCLA Center for Health Policy Research](https://healthpolicy.ucla.edu/publications/latest/Pages/default.aspx)

[Health Policy Analysis and Evidence | AD for Policy and Strategy | CDC](https://www.cdc.gov/policy/analysis/index.html)  <https://www.cdc.gov/policy/analysis/index.html>

## Policy case studies

[Healthy People eLearning Lessons | Healthy People 2020](https://www.healthypeople.gov/2020/tools-and-resources/healthy-people-eLearning/Healthy-People-eLearning-Lessons)

[Laws, Policies, and Legal Review Tools | NCHHSTP | CDC](https://www.cdc.gov/nchhstp/legal-review.html)

## Legislative process

[Flow Chart - How a Bill Becomes a Law in the USA (happyschools.com)](https://www.happyschools.com/how-a-bill-becomes-a-law-in-usa/)

[How a Bill Becomes a Law - GovTrack.us](https://www.govtrack.us/how-a-bill-becomes-a-law)

[How Laws Are Made | USAGov](https://www.usa.gov/how-laws-are-made)

[The Legislative Process | house.gov](https://www.house.gov/the-house-explained/the-legislative-process)

## Health Policy textbooks

Goudreau, K. & Smolenski, M. (2018). [Health policy and advanced practice nursing: impact and implications](https://bobcat.library.nyu.edu/primo-explore/fulldisplay?docid=nyu_aleph007555484&context=L&vid=NYU&lang=en_US&search_scope=all&adaptor=Local%20Search%20Engine&isFrbr=true&tab=all&query=any%2Ccontains%2Cpolicy%20and%20nursing&sortby=date&facet=frbrgroupid%2Cinclude%2C653556132&offset=0). New York, NY: Springer Publishing, LLC.

Loversridge, J. (2019). Evidence-Informed Health Policy 1st Edition. Indianapolis, IN: SIGMA Theta Tau International.

Mason D, Perez A, McLemore M & Dickson E (2021) Policy & Politics in Nursing and Health Care (Policy and Politics in Nursing and Health) 8th Edition, Elsevier.

Nickitas D, Middaugh D, Feeg V (2020) Policy and Politics for Nurses and Other Health Professionals, Third Edition, Jones, and Bartlett Learning.

Rambur B (2022) [Health Care Finance, Economics, and Policy for Nurses, Second Edition: A Foundational Guide](https://www.amazon.com/Health-Finance-Economics-Policy-Nurses/dp/0826152538/ref=sr_1_1?qid=1638376172&refinements=p_27%3ABetty+Rambur+PhD++RN++FAAN&s=books&sr=1-1&text=Betty+Rambur+PhD++RN++FAAN), Springer.

Shi, L. (2019). Introduction to Health Policy, Second Edition. Health Administration Press.

## Journals

Policy, Politics, & Nursing Practice

Health Affairs

Milbank Quarterly

## Nurse Organization Websites

American Academy of Nursing

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American Nurses Association

American Association of Nurse Practitioners

National Council of State Boards of Nursing

National Forum of Nursing Workforce Centers

National Education Progression In Nursing

National League for Nursing

## 

**The 5 Ws and the H of Teaching Policy** The 5 Ws and H Framework (Why, Who, What, When, Where, and How) provided below is intended to help faculty and students understand the various aspects of policy. Faculty can use the 5Ws and H Framework to both analyze and set up the lesson activities related to any policy issue.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5 W’s and How | Recommended content | Resources | Learning strategies | Assessment |
| Why | * Why do we need to influence or make a change within a system, population, group, or community? | * CDC Policy Process (POLARIS) webpage[[29]](#endnote-29) | * Conduct an overview of the policy process |  |
| * Identify the policy problem | * CDC POLARIS Problem Identification[[30]](#endnote-30) | * Conduct an environmental scan * Conduct a literature review (academic and lay presses) |  |
| What | * Understanding the levels of policy | * Russell & Fawcett | * Analyze at what Russell & Fawcett levels different policy initiatives have been or can be initiated related to the problem. * Describe the effect of how a policy change at one level has an effect on the other levels. What can or should be done as a result, if any? |  |
| * Understand overview of policy strategy | * CDC POLARIS Strategy and Policy Development[[31]](#endnote-31) | * Review the CDC Policy Process |  |
| Where | * Understanding the appropriate level of policy intervention such as the local, regional, statewide, national, federal, international levels. | * Russell & Fawcett Policy Levels | * Describe the need at all Russell & Fawcett levels to understand the full extent of a change in policy, and then determine at which level should be the first step in changing policy |  |
| When | * Understanding opening policy windows | * Kingdon Policy Streams | * Using Kindon’s Policy Streams theory, describe the concept of timing from a temporal, current events, and other window opportunities to have the most successful change of changing or implementing a new policy |  |
| Who | * Identifying the “pro” and “con” stakeholders and the public. |  | * Environmental scan * Brainstorming who would be positively and negatively affected |  |
| * Who has the formal and informal power, authority, and influence that can help drive or block policy development? | * Lewin’s Force Field Analysis | * Use Lewin’s Force Field Analysis to understand the driving and restraining forces and identify sources of power, authority, and influence |  |
| * Understanding all perspectives and rationales. | * CDC Policy Analysis[[32]](#endnote-32) webpage | * Debates * Policy analysis |  |
| * Methods of communicating with stakeholders and the public. |  | * Policy briefs, policy analyses, editorials, position papers, media sound bites, social media, press conferences, public speaking |  |
| How | * Enact the policy * Implement the policy | * CDC POLARIS Policy Enactment[[33]](#endnote-33) * CDC POLARIS Policy Implementation[[34]](#endnote-34) * Rogers’ Diffusion of Innovation Theory | * Using the POLARIS strategies and Rogers’ Diffusion of Innovation theory, describe how policy will be enacted and implemented |  |

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