EVIDENCE-INFORMED HEALTH POLICY

USING EBP TO TRANSFORM POLICY IN NURSING AND HEALTHCARE

JACQUELINE M. LOVERSIDGE & JOYCE ZURMEHLY

Praise for *Evidence-Informed Health Policy*

"Evidence-Informed Health Policy *is a significant and important book that needed to be written. The authors effectively integrate the policy process with evidence-based models and approaches. Each of the elements incorporated in this book is critical to understanding how policy evolves and why evidence is so important. While the policy process can be very messy, this book will greatly assist nurses and other healthcare providers in framing policy issues, formulating policy, influencing policymakers, and evaluating impact. As someone who teaches health policy, this book is an excellent asset for students who study health policy and the faculty who teach them."*

–Jean Johnson, PhD, RN, FAAN
Dean Emerita and Professor
School of Nursing
George Washington University

"Drs. Loversidge and Zurmehly masterfully combine the theoretical and practical aspects of policymaking using a tailored evidence-based framework that most nurses will find user-friendly and relatable. Examples of real-life policy issues are interspersed throughout, along with strategy tools and tables that further facilitate readers' understanding of key policy principles. Evidence-Informed Health Policy *is an important book that educators and students can use as a foundational guide for exploring the role of nurses in policymaking and professional advocacy."*

–Janice K. Lanier, JD, RN
Nurse Educator/Consultant
Meredith Enterprises

"Evidence-Informed Health Policy *is a must-have resource for teaching and learning how to translate the language of evidenced-based practice into health policymaking. Drs. Loversidge & Zurmehly provide an innovative model for applying EBP to health policymaking and artfully guide the reader through a study of healthcare policy and politics. This will be the preeminent guidebook for nurses who work in health policy and is a must-read for those seeking to become health policy advocates."*

–Robin M. Rosselet, DNP, APRN-CNP, AOCN
Director of Advanced Practice Providers
The James Cancer Hospital & Solove Research Institute

"The authors are accomplished nurse educators with extensive experience in health policy and promulgating administrative rules. This book skillfully adapts the Melnyk and Fineout-Overholt evidence-based practice (EBP) model to health policy. It includes a discussion of the evolution of policymaking, the use of evidence to inform health policy, the health policymaking process and models, and the adaptation of the EBP model to evidence-informed policymaking. This book is relevant for those serving in active policymaking roles, for health policy teachers, and especially for doctoral students."

–Candace Burns, PhD, APRN, FAAOHN
Colonel (USA Retired)
Professor and Director, Dual Degree Program AGPCNP/Occupational Health Nursing
Deputy Director, USF Sunshine Education and Research Center (SERC)
University of South Florida College of Nursing

"Evidence-Informed Health Policy, *by Drs. Jacqueline Loversidge and Joyce Zurmehly, delineates 'evidence-informed health policymaking,' a unique approach to advancing a health policy agenda. It is useful for teaching students because it also includes valuable information about how policymaking occurs in government and an extensive list of references at the end of each chapter. Organizations will find this evidence-informed method very helpful in developing their own positions and strategies for contributing to pertinent healthcare policy development."*

–Jane F. Mahowald, MA, RN, ANEF
Executive Director, Ohio League for Nursing

"Evidence-Informed Health Policy, *by Drs. Jacqueline Loversidge and Joyce Zurmehly, is a much-needed introduction to the development of evidence-based healthcare policies. The authors have provided an essential review of evidence-based practice models, healthcare policy, and policy development. The book concludes with a step-by-step guide to using the evidence-informed health policy model to address healthcare policy issues and to serve as a template for new policy development."*

–Evelyn Parrish, PhD, PMHNP-BC
Associate Professor and Director of Accreditation and Strategic Outcomes
University of Kentucky College of Nursing

EVIDENCE-INFORMED HEALTH POLICY

Using EBP to Transform Policy in Nursing and Healthcare

JACQUELINE M. LOVERSIDGE, PHD, RNC-AWHC
JOYCE ZURMEHLY, PHD, DNP, RN, NEA-BC, ANEF

Sigma
GLOBAL NURSING EXCELLENCE

The Sigma Theta Tau International Honor Society of Nursing (Sigma) is a nonprofit organization whose mission is advancing world health and celebrating nursing excellence in scholarship, leadership, and service. Founded in 1922, Sigma has more than 135,000 active members in over 90 countries and territories. Members include practicing nurses, instructors, researchers, policymakers, entrepreneurs, and others. Sigma's more than 530 chapters are located at more than 700 institutions of higher education throughout Armenia, Australia, Botswana, Brazil, Canada, Colombia, England, Ghana, Hong Kong, Ireland, Japan, Jordan, Kenya, Lebanon, Malawi, Mexico, the Netherlands, Nigeria, Pakistan, Philippines, Portugal, Puerto Rico, Singapore, South Africa, South Korea, Swaziland, Sweden, Taiwan, Tanzania, Thailand, the United States, and Wales. Learn more at www.sigmanursing.org.

Sigma Theta Tau International

550 West North Street

Indianapolis, IN, USA 46202

To order additional books, buy in bulk, or order for corporate use, contact Sigma Marketplace at 888.654.4968 (US and Canada) or +1.317.634.8171 (outside US and Canada).

To request a review copy for course adoption, email solutions@sigmamarketplace.org or call 888.654.4968 (US and Canada) or +1.317.634.8171 (outside US and Canada).

To request author information, or for speaker or other media requests, contact Sigma Marketing at 888.634.7575 (US and Canada) or +1.317.634.8171 (outside US and Canada).

ISBN: 9781948057202
EPUB ISBN: 9781948057219
PDF ISBN: 9781948057226
MOBI ISBN: 9781948057233

Library of Congress Cataloging-in-Publication data

Names: Loversidge, Jacqueline M., 1952- author. | Zurmehly, Joyce, 1957- author. | Sigma Theta Tau International, issuing body.
Title: Evidence-informed health policy : using EBP to transform policy in nursing and healthcare / Jacqueline M. Loversidge, Joyce Zurmehly.
Description: Indianapolis, IN : Sigma Theta Tau International, [2019] | Includes bibliographical references and index.
Identifiers: LCCN 2019001827| ISBN 9781948057202 (pbk.) | ISBN 9781948057219 (epub ebook) | ISBN 9781948057226 (pdf ebook) | ISBN 9781948057233 (mobi ebook)
Subjects: | MESH: Health Policy | Policy Making | Evidence-Based Practice
Classification: LCC RA427 | NLM WA 525 | DDC 362.1--dc23 LC record available at https://lccn.loc.gov/2019001827

First Printing, 2019

Publisher: Dustin Sullivan
Acquisitions Editor: Emily Hatch
Publications Specialist: Todd Lothery
Cover Designer: TNT Design
Interior Design/Page Layout: Rebecca Batchelor
Managing Editor: Carla Hall
Development and Project Editor: Kate Shoup
Copy Editor: Todd Lothery
Proofreader: Gill Editorial Services
Indexer: Joy Dean Lee

Table of Contents

Foreword

By Bernadette Mazurek Melnyk

Findings from a strong body of studies have shown that quality, safety, and patient outcomes can be substantially improved when healthcare is based on sound evidence from research. Yet, the translation of research into real-world clinical practice settings has been exceedingly slow, taking from multiple years to decades. Although many policymakers are starting to understand that they must base their decisions on the best evidence, the process of evidence-informed policymaking is also often painstakingly slow. Nurses, who are the largest healthcare workforce in the country, and other health professionals must understand the process of policymaking and how to best influence it with sound evidence from research.

This book by Drs. Loversidge and Zurmehly, two exceptional nurses and teachers who are seasoned in regulation, is a much needed and outstanding addition to the literature that fills a gap within health policy books because of the approach it takes with evidence as the essential foundation for policy. Masterfully organized, it starts with the origins of evidence-based practice so that readers can understand the basis and critical importance of evidence-informed policymaking. The content not only provides readers with the necessary knowledge of government structures, functions, and processes for the creation, passage, and dissemination of new bills but equips readers with the nuts and bolts of the seven-step evidence-based practice process applied to health policy, a pioneering first for the field.

This book should be a must-read in academic health professional programs and a staple in the library of every health professional. It is an exquisite masterpiece and a practical guide for how best to use evidence to influence health policy to ultimately improve the state of healthcare and population health outcomes across the nation.

–Bernadette Mazurek Melnyk, PhD, RN, APRN-CNP, FAANP, FNAP, FAAN
Vice President for Health Promotion
University Chief Wellness Officer
Dean and Professor, College of Nursing
Professor of Pediatrics and Psychiatry, College of Medicine
Executive Director, the Helene Fuld Health Trust National Institute for
Evidence-Based Practice in Nursing and Healthcare
The Ohio State University

Introduction

"Science and policy-making thrive on challenge and questioning; they are vital to the health of inquiry and democracy."

–Nicholas Stern

The source of this quote, Professor Lord Nicholas Stern, the IG Patel Chair of Economics and Government and Director of the India Observatory at the London School of Economics, may not be well known by most nurses and healthcare professionals. Nevertheless, the quote no doubt resonates with those of us in healthcare who believe strongly in evidence-based practice (EBP) as it applies to policymaking. Science and healthcare thrive on these same principles, so it should not be a leap to appreciate the importance of challenge, questioning, and science to health policymaking in a democracy.

Stern's observation is central to this book, which explores the world of evidence-informed policymaking in nursing and healthcare. Nurses have long been involved in healthcare as political activists. Indeed, our history is rich with examples, from Florence Nightingale's work at Scutari and Clara Barton's during the Civil War, to the policy agendas advanced by contemporary healthcare organizations. Nurses and other healthcare providers have spoken out for positive change in policy, either as citizens and constituents or as members of their professional associations. Nurses, often in partnership with other healthcare professionals, have influenced changes in reimbursement and scopes of practice for advanced practice nurses, the provision of affordable healthcare for underserved populations, improvements in workplace safety in healthcare environments, and many other issues dictated by state or federal policy. For years, nurses have shown up in force on The Hill in Washington, DC, and at statehouses across the nation to make their voices heard. We have been proponents for some pieces of legislation and opponents of others. Nurses and other healthcare professionals also serve diligently behind the scenes as active members of their associations and on their legislative and government relations committees.

Whether we are inclined to be activists or more quietly involved—not everyone is of activist fiber—every nurse and healthcare professional has a responsibility to understand the current health policymaking environment. What happens in health policy at the state or federal level affects the patients we care for, our practice, and ourselves. On a personal level, our livelihoods are at stake, as

well as our own health; at one time or another, we will all be patients, as will those we love. When that happens, we all hope that the best possible policy is driving the care we or our loved ones receive!

As healthcare has advanced to drive responsible change in clinical practice by a body of scientific evidence, nurses and other health professionals are continuing to gain competency in EBP. This movement has aligned with a parallel progression in the science of policymaking. This is not an oxymoron. Health services research and health policy scholars have long argued for the use of scientific evidence to drive sensible policy. Over the last decade, the language in that discipline has evolved from the term *evidence-based,* which is used for good reasons in healthcare, to the term *evidence-informed* to acknowledge the realities of policymaking. When evidence is used in the world of politics, the best one can hope for is that it will inform the dialogue and leverage the outcome.

As nurses and healthcare professionals are so passionately engaged in policymaking, it is time to bring their expertise in EBP into their work in policy. Nurses understand EBP; it works in the world of clinical practice. The models are clear and straightforward. But they are designed for clinical decision-making, not policymaking. This book was born out of the need to translate the language nurses know and use when applying EBP to clinical decision-making into a language for health policymaking.

Many descriptions and models of evidence-informed health policymaking appear in the literature, but the intended audience is largely health services research scholars. Therefore, the language is not as accessible to nurses and other healthcare professionals as is the language of EBP. One of the authors of this book, Jacqueline Loversidge, who has taught health policy to master's-level nursing students for a number of years (and who, along with co-author Joyce Zurmehly, also teaches doctor of nursing practice health policy), used the EBP model described by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt in her classes to help students understand how to incorporate evidence into policy. The EBP language and approach was not quite the right fit, however; it needed to be adapted from the clinical to the political. With Dean Melnyk's enthusiastic support, Loversidge adapted the model for health policy.

Loversidge's model, called the evidence-informed health policy (EIHP) model, was subsequently published in the *Journal of Nursing Regulation*. Its intended

audience in that publication consisted of nursing regulators and nursing educators—in no small part because of Loversidge's background in nursing regulation and her current role in academics. Since then, both Loversidge and Zurmehly have successfully used the model in their health policy classes to help students understand how to integrate evidence into the health policymaking process. A portion of this book describes the adapted model.

The goals of this book are threefold:

- To persuade readers that evidence-based or evidence-informed policymaking is not, after all, an oxymoron, and that perspectives on the use of evidence in policy are changing. To our knowledge, this is the first health policy text in nursing and healthcare in which evidence-based policymaking is the primary focus.
- To ground readers in policy and policymaking to a sufficient extent that it serves as a foundation for using the rest of the book.
- To present the EIHP model for nursing and healthcare, adapted from the Melnyk and Fineout-Overholt EBP model. This model can be used by nurses and other healthcare professionals serving in active policymaking roles, teaching health policy, or simply interested in the process.

The primary focus of this book is on policymaking in government, but principles and strategies presented can apply well in organizational settings. Mention of these applications is made throughout.

Audiences who can best benefit from this book include the following:

- Nurse leaders
- Nurses who are members or staff of professional associations and organizations
- Healthcare regulatory agency members or staff
- Other healthcare professionals

These audiences can use this book to familiarize themselves with strategies for making the best use of evidence to leverage dialogue and influence policymakers to advance health policy agendas or as a tool to navigate governmental or

organizational policymaking environments. It can also be used as a textbook for nurse educators and for nursing students enrolled in health policy courses. For educators and students, we anticipate this book will be particularly useful for guiding health policy-related DNP projects, which are an emerging interest and focus in DNP programs.

Chapters 1 and 2 of this book focus on the use of evidence in health policymaking and its evolution. They begin with foundations in evidence-based medicine and its extension beyond medicine to EBP. They then describe some of the most often used EBP models before segueing to an explanation of how evidence can be used in policymaking. Finally, they describe how the landscape in policymaking is changing to become more aware of and open to the use of evidence.

Chapters 3 through 5 provide a foundation in policy and government. These chapters focus on health policy basics and how policymaking works. They answer the question, what is health policy? They then describe government structures and functions that drive processes, followed by the processes themselves, using the US Congress and federal regulatory agencies as models. Theoretical models that are useful to understanding processes are also presented, including several that the authors find most useful in practice. These chapters end with a discussion of the influence of stakeholders and partisan politics on the policymaking process.

Chapters 6 through 9 describe the EIHP model. Chapter 6 provides an overview of the model as a whole. Chapter 7 describes its foundation, which consists of the first four steps: cultivating a spirit of inquiry; asking the policy question in the PICOT format; searching for and collecting the most relevant best evidence; and critically appraising that evidence. Chapter 8 addresses the next two steps: integrating the best evidence with issue expertise and stakeholder values and ethics, and contributing to the health policy development and implementation process, respectively. Finally, Chapter 9 describes the last two steps: framing the policy change for dissemination to the affected parties, and evaluating the effectiveness of the policy change and disseminating findings. Strategy tools are suggested for each of these steps.

Finally, Chapter 10 provides a discussion of challenges that may be encountered when engaging in evidence-informed policymaking and strategies for addressing those challenges.

Readers may note two tendencies in this book:

- At first, this book refers to evidence-*based* policymaking. But as you read, this term quickly evolves into evidence-*informed* policymaking. This is not intended as a bait and switch but rather reflects the evolution in thinking about how evidence is used in different environments. We must base clinical care on evidence, but in policymaking, the reality is that evidence merely informs.
- When we describe governmental policymaking, we primarily use the federal model as the basis for explanation. This is because it is the model for government in the US. However, much of what is accomplished in health policy actually happens at the state level—either in state legislatures or state regulatory agencies (state boards). So, those of you working at the state level, take note: You are at the epicenter of health policymaking!

It is our hope that all our readers will come away with a stronger understanding of how government works, what the policymaking process is, and how they may be able to influence policymakers to make the best use of evidence as health policies change or new health policies are introduced. Whether this influence happens at the federal or state level, in legislatures or during agency rule-making, is irrelevant; any positive influence can have an impact. For educators and students, we hope this book will help you bridge EBP and health policymaking. For those of you who are working on DNP health policy projects, we hope this book, and the EIHP model, provide process guidance. And if this book intrigues you enough to look more closely as a constituent at your own policymakers and their voting records on health policy issues, the more the better; you'll be using evidence of your own to become a more informed voter!

–Jacqueline M. Loversidge and Joyce Zurmehly

"Pretending that politics and science do not coexist is foolish, and cleanly separating science from politics is probably neither feasible nor recommended."

–Madelon Lubin Finkel

1

EXTENDING THE USE OF EVIDENCE-BASED PRACTICE TO HEALTH POLICYMAKING

–JACQUELINE M. LOVERSIDGE, PHD, RNC-AWHC

KEY CONTENT IN THIS CHAPTER

- The use of evidence in policymaking
- The evolution of evidence-based practice (EBP)
- Adapting EBP for use in health policy
- Why now is the time: reaching critical mass
- The use of research and evidence in policymaking in other countries
- The imperative for using evidence in health policymaking
- Evidence-based versus evidence-informed
- Definitions of evidence-informed policymaking

The Use of Evidence in Policymaking

Healthcare providers and consumers expect that the policies that drive, guide, and underpin healthcare will be safe and effective. Strong governmental health policy forms the foundation for healthcare funding, sustains programs for special needs groups who might otherwise find it challenging to access adequate care, and, at the state level, establishes the parameters for health professionals' scopes and standards of practice.

Nurses and other healthcare professionals involved in various professional organizations work tirelessly to advance health policy initiatives and have long mentored newcomers to their organizations who desire to do this work. Time, experience, and trial and error make for great teachers, and much of policymaking is informed by those factors. However, today's healthcare environment is so complex that trial, error, and opinion are insufficient for developing informed policy. It is therefore incumbent upon educated health professionals to press for the judicious use of science and evidence in policymaking. To do that, we must arm ourselves not only with the best evidence but with a full and realistic understanding of the political processes that are part and parcel of policymaking.

This chapter reviews the evolution of the use of evidence in the practice of medicine, in nursing and healthcare, and to inform policymaking. It presents some of the most-used evidence-based practice (EBP) models and discusses the rationale for adapting clinical practice-focused models—that is, EBP models—so they can be useful in the policymaking environment. Finally, it addresses controversies surrounding the terms *evidence-based* and *evidence-informed* and defines evidence-based policymaking.

The Evolution of Evidence-Based Practice

Historically, good conventional medical practice was based on tradition, and clinical measures considered to be successful were passed on from mentor to student. This unquestioned practice of treating patients based on an oral tradition of unknown or forgotten origin began to change in the late Middle Ages, when physician-scholars—often men of the cloth—took on the practice of medicine. These healers focused on gaining a new understanding of past

thought and practice through the exploration of natural science and experimentation and the search for medical truth (Daly & Brater, 2000). Historians believe the early foundations of evidence-based medicine were laid in the 17th and 18th centuries—a positive effect of the Enlightenment, as medicine turned toward the evaluation and interpretation of scientific evidence (Gerber, Lungen, & Lauterbach, 2005). The use of EBP, as we have come to know it, grew out of this long, slow evolution toward EBM.

Evidence-Based Medicine to Evidence-Based Practice

As the conduct of research in medicine evolved, practice developed and changed in response, keeping pace with the available science. But as this conduct of research became more sophisticated and the practice of medicine matured, physicians realized that findings from a single study—no matter how robust—were insufficient to ethically justify sweeping change in practice. Accordingly, practitioners sought to integrate a body of work culled from the best research findings into their practice.

In addition to the problems associated with insufficient evidence, the time it takes to conduct research and the lag between publication of research and adoption of the knowledge gleaned by that research into practice also became apparent. Incredibly, the average time lag in the health research translation process is 17 years (Morris, Wooding, & Grant, 2011). To improve this process, the field of translation science developed. Titler (2014) defines *translation science* as "a field of research that focuses on testing implementation interventions to improve uptake and use of evidence to improve patient outcomes and population health, and to explicate what implementation strategies work for whom, in what settings, and why" (p. 270).

Time and experience yielded valuable lessons about how to translate findings from research into practice. But science, isolated from the realities of practice, could not serve the needs of both practitioners and patients. Human factors needed to be considered, including clinician experience and judgment, as well as the patient's lived experience, values, and healthcare objectives. As a result, a process that integrated scientific findings, the patient's needs, and the practitioner's expertise was developed by physicians for use in medicine. It was, and is still, called *evidence-based medicine* (EBM).

As EBM evolved, its definition included reference to the conscientious use of current best evidence for making decisions about patient care (Sackett, Straus,

Richardson, Rosenberg, & Haynes, 2000). An updated and well-accepted definition is: "Evidence-based medicine (EBM) requires the integration of the best research evidence with our clinical expertise and our patient's unique values and circumstances" (Straus, Richardson, Glasziou, & Haynes, 2011, p. 1).

The term *EBM* is self-limited because it refers only to the practice of medicine. Consequently, other health professions sought to broaden the definition and embraced the more inclusive term *practice*. The term *evidence-based practice* is now widely used among non-physician healthcare providers. More than 50 models of EBP have emerged in the literature to address the needs of nursing practice, education, and science; one EBP model is transdisciplinary (Satterfield et al., 2009; Stevens, 2013).

Evidence-Based Practice Models

EBP models share a common purpose, regardless of the differences in their processes and structures: They establish a systematic method for the user to ask clinical questions, search for and synthesize evidence, and translate what is found in the research to be serviceable in practice settings. All EBP models are process models. They largely aim to assist the process of clinical decision-making to improve patient-care quality and outcomes (Mitchell, Fisher, Hastings, Silverman, & Wallen, 2010).

Definitions of EBP are model-dependent but generally take a three-pronged or three-legged stool approach. An established definition of EBP is:

> a paradigm and lifelong problem-solving approach to clinical decision making that involves the conscientious use of the best available evidence . . . with one's own clinical expertise and patient values and preferences to improve outcomes for individuals, groups, communities, and systems. (Melnyk & Fineout-Overholt, 2015, p. 604)

Although there are numerous types of EBP models, six nursing EBP models are selected for description here, as they are some of the most frequently discussed in the literature. These models are as follows:

- The Academic Center for Evidence-Based Practice (ACE) Star Model of Knowledge Transformation

- The Advancing Research and Clinical Practice Through Close Collaboration (ARCC) Model
- The Iowa Model
- The Johns Hopkins Nursing EBP (JHNEBP) Model
- The Promoting Action on Research Implementation in Health Services (PARIHS) Framework
- The Stetler Model

These EBP models demonstrate commonalities in their purpose, but their unique attributes make them more or less useful for organizations or individual healthcare providers, with some models being useful for both. Organizations, individual healthcare providers, and healthcare educators can choose which model to use based on the intended purpose and best fit. Summaries and overviews of the predominant EBP models have been published (Dang et. al., 2015; Schaffer, Sandau, & Diedrick, 2013); brief overviews of model and framework elements are provided here.

The Academic Center for Evidence-Based Practice (ACE) Star Model of Knowledge Transformation

This model is designed for use by either organizations or individual providers. It focuses on locating nursing evidence for practice at the bedside and addresses ways to effect the adoption of innovation. Key steps of the model are as follows (Kring, 2008; Stevens, 2013; The University of Texas Health Science Center School of Nursing, 2015):

1. Discovery
2. Evidence summary
3. Translation
4. Integration
5. Evaluation

The Advancing Research and Clinical Practice Through Close Collaboration (ARCC) Model

This model, developed by Melnyk, Fineout-Overholt, Gallagher-Ford, & Stillwell (2011), takes organizational culture and readiness into account and is an

ideal fit for use in large organizations (Schaffer et al., 2013). The ARCC Model is based on the following assumptions:

- Healthcare systems have both barriers to and facilitators for EBP implementation.
- For individuals or systems to implement EBP, barriers must be removed or minimized, and facilitators mounted or strengthened.
- Clinicians must develop belief in EBP and confidence in their ability to carry out EBP.
- Successful advancement of a systemic EBP culture requires mentors.

Steps in the ARCC Model begin with an assessment of organizational culture and readiness for the implementation of EBP system-wide, proceed to an identification of the strengths of and barriers to EBP, and move to the development and use of EBP mentors in the organization (Melnyk et al., 2011). The ARCC Model has been widely used and tested, and valid, reliable instruments are available for measuring its key constructs (Dang et al., 2015).

The Iowa Model

The emphasis of the Iowa Model is on its use in an organization. It is particularly applicable in interdisciplinary settings. This model features a team approach and focuses on the identification of practice questions, the search for and critique or synthesis of evidence, and problem-solving steps including pilot testing of selected EBP changes. A flowchart guides organizational decision-making, and feedback loops are helpful for determining when a change in direction is needed. For example, is there sufficient research to pilot a practice change? If not, then one should base practice on other types of evidence or conduct additional research. Essential steps in the model are as follows (Schaffer et al., 2013; Titler et al., 2001):

1. Identify practice questions.
2. Determine whether the topic is an organizational priority.
3. Form a team to search for, critique, and synthesize evidence.
4. Determine evidence sufficiency.
5. Pilot the change if evidence is sufficient.
6. Evaluate the pilot, disseminate results, and, if successful, implement the program into practice.

The Johns Hopkins Nursing EBP (JHNEBP) Model

The Johns Hopkins Nursing EBP (JHNEBP) Model is a practical model designed for use by bedside nurses. The model emphasizes the identification of the practice question and the skilled evaluation of evidence. Attention is given to the translation of research to practice. The construction of an implementation plan is also an important model element. The three-step model is called PET, short for practice question, evidence, and translation. These steps are summarized as follows (Dang et al., 2015; Johns Hopkins Medicine, n.d.; Schaffer et al., 2013):

1. Identify the practice question (the EBP question) using a team approach.
2. Search for, critique, and summarize the evidence, and develop strong, feasible recommendations accordingly.
3. Translate the recommendations by moving them into an actionable practice change that is implemented, evaluated, and communicated.

The Promoting Action on Research Implementation in Health Services (PARIHS) Framework

The Promoting Action on Research Implementation in Health Services (PARIHS) Framework includes core elements of evidence, context, and facilitation as a framework for the practice change process. The framework highlights the impact of context on EBP success—for example, leadership support (Schaffer et al., 2013). The framework has been developed and refined, applied in a variety of settings, and complements other EBP models. It has also been developed to recognize and make best use of organizational complexity. The model uses a dynamic framework consisting of elements and multiple sub-elements. The major elements are evidence, context, and facilitation (Dang et al., 2015). Revisions to the framework, with accompanying tools for implementation, have been made available (Dang et al., 2015; Stetler, Damschroder, Helfrich, & Hagedorn, 2011).

The Stetler Model

The Stetler Model was originally developed with a focus on research utilization but has been updated to merge conceptually with the EBP paradigm. The model is individual provider-focused but can be useful for promoting organizational change toward the use of EBP in that it gives explicit support

for individuals working in groups responsible for advancing practice change (Stetler, 2001). Its emphasis is on critical thinking. Like the PARIHS Framework, it also acknowledges the importance of context for advancing EBP (Schaffer et al., 2013).

Applying EBP Models to Practice

Each of the EBP models described provides effective processes for addressing complex clinical problems. Whether the model is designed for use by individual providers or organizations, each model requires that the user do each of the following:

1. Ask a clinical question.
2. Search the literature to identify a body of evidence.
3. Use a systematic process to critique and synthesize the evidence.
4. Take logical steps to determine whether the body of evidence is sufficient to support a practice change.

Healthcare systems are urged to integrate EBP into their organizational cultures as a means to improve patient outcomes and reduce cost. To do so, registered nurses (RNs) and advance practice registered nurses (APRNs) alike have been called upon to develop expertise in EBP. To achieve this, EBP competencies specific for RNs and APRNs have been developed; it is now imperative that healthcare systems commit to a plan that integrates these competencies into the practice culture so that an EBP-competent nursing workforce becomes the standard. Leadership support and EBP mentorship are essential components of any system meant to promote EBP in an organization (Melnyk, Fineout-Overholt, Giggleman, & Choy, 2017; Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014).

Adapting EBP for Use in Health Policy

Policy-related frameworks and models are useful for strategizing to advance a health policy agenda and for analyzing existing or pending health policy. These are addressed in detail in Chapter 5, "Policymaking Processes and Models." However, as nurses and other health professionals are gaining competency in EBP, it is a natural extension for them to draw upon their understanding of EBP models to address health policy problems.

Clearly, a number of excellent EBP models exist. All these models use evidence to solve problems and are designed to be useful in complex environments. Because of these attributes, EBP models lend themselves to use in the health policy milieu, if they are modified. There are two primary reasons why EBP models are particularly adaptable to health policymaking:

- Although EBP models are designed to address clinical issues, they are predominantly process models. As such, the approaches suggested in EBP models for identifying and describing problems, searching the literature, appraising and synthesizing evidence, and taking steps to determine the best path to accomplish a practice change are similar to those needed to address health policy issues (Loversidge, 2016a).
- In addition to research evidence, EBP models consider factors such as internal evidence, clinician expertise, patient values and preferences, and mentor or organizational support and facilitation (Melnyk & Fineout-Overholt, 2015; Schaffer et al., 2013). The consideration of these additional factors enables EBP models to adapt particularly well to complex policy environments (Loversidge, 2016a).

There are, however, significant differences between clinical organization environments and the policymaking environment, which necessitate the adaptation of EBP models for this alternate use. Most notably, in most clinical environments, providers from across clinical disciplines and leadership agree on the mission: to serve the patient's health and safety needs, improve outcomes, and lower costs. This kind of singular focus is rarely seen in policymaking, however. Government policy priorities are established by a commander-in-chief—that is, the president of the United States or the state governor—as well as by the majority party. Therefore, partisan politics necessarily become a part of the agenda-setting formula.

In addition, priority timelines shift according to the time of year and the legislative cycle. For example, during the budget cycle, attention is focused on the budget bill. Similarly, at the end of a two-year congressional or legislative session, bills that are favored politically and considered a priority will be pushed to passage, while bills that aren't are likely to languish and die.

Add to that the fact that stakeholders—and their interests in legislation—are numerous and varied. Lobbyists representing professional associations or business organizations, private citizens or consumers, individual professionals, and

a host of others seek to influence the outcome of the policymaking process. Some factors and relationships are flexible, in which case the potential to sway opposition by building relationships, reaching compromise, or influencing a legislator's vote may or may not present itself. Other factors are immovable, such as the timing of budget cycles, legislative sessions, and election seasons.

Because of these factors, the direct application of clinical EBP models to the policymaking process would be, at best, difficult and awkward. The language of EBP is not a direct fit for policymaking, the stakeholders are different and more varied, and the policymaking processes do not occur in an orderly fashion. Policymaking is necessarily a messy and nonlinear process; it's often a case of two steps forward and three steps back. Therefore, although EBP models and frameworks provide, in concept, an ideal foundation for preparing nurses and healthcare providers to use evidence in policymaking, these models must be adapted to be useful in the policymaking process.

Why Now Is the Time: Reaching Critical Mass

One persuasive reason to advance the utilization of EBP in health policymaking is that nurses are becoming increasingly familiar with, and gaining competency in, EBP. Although there is much room for the growth of competency in this area, more nurses are EBP-competent now than ever before (Melnyk & Fineout-Overholt, 2015; Melnyk et al., 2014). Other healthcare providers are also becoming more familiar with EBP processes.

Nurses and other healthcare providers are less accustomed to health policymaking, so the use of a recognizable model to approach policy problems can provide both a sense of comfort and a sense of mastery. Nurses across the practice and leadership spectrum—RNs, APRNs, nurse managers and chief nursing officers, nurses in leadership and advocacy positions in professional associations, and so on—are becoming familiar with the use of EBP as a process to resolve clinical problems. In addition, nursing educators are called on to teach EBP to students at both the undergraduate and the graduate levels (American Association of Colleges of Nursing [AACN], 2006; AACN, 2008; AACN, 2011), providing a measure of assurance that the next cadre of nursing professionals will have a level of EBP competency.

The nursing profession is approaching a critical mass of EBP-competent nurses who will be able to advance the use of EBP in health policymaking (Loversidge, 2016a). Concurrently, the nursing profession has put out the call for nurses to advance the health of the nation by serving on boards and making changes at the policy level (Institute of Medicine [IOM], 2010). A nonexhaustive list of national nursing policy and advocacy priorities that could be facilitated by an evidence-based approach includes the following (AACN, 2018; American Association of Nurse Practitioners, 2018; American Nurses Association, 2018; National League for Nursing, 2017):

- Safe staffing
- Workplace health and safety
- Supporting operable information technology
- Protecting and improving provisions of the Affordable Care Act
- Accessibility, affordability, diversity, excellence, and efficiency in higher education for nurses
- Improved funding, efficiency, and safety for biomedical and healthcare research
- Focus on value-based models of person-centered, prevention-focused care
- Licensure/state practice environments and access to care

The Use of Research and Evidence in Policymaking in Other Countries

The US has trailed European countries and Canada in its use of evidence in policymaking. The United Kingdom, the Netherlands, and Canada were early adopters, having used evidence in the development of health policy for almost 20 years (Dobrow, Goel, & Upshur, 2004; Elliott & Popay, 2000; Niessen, Grijseels, & Rutten, 2000). The literature is rich with examples from other countries.

At the turn of the millennium, a group of researchers from the Netherlands explored and reported on evidence-based approaches in health policy and healthcare delivery at three levels of impact (Niessen et al., 2000):

- Intersectoral assessment with or without collaboration of the health sector
- National healthcare policy
- Evidence-based medicine

Their analysis predicted a growing demand for *intersectoral assessment*, which is assessment undertaken by actors outside the health sector. Additionally, they found that governments were largely increasing their support for and use of evidence in health policymaking and that EBP and treatment guidelines published by independent professional organizations were gaining prominence.

Concurrently, researchers from the UK conducted a qualitative study to better understand the influence of evidence on policymakers within the UK's National Health Service (NHS) after a period of NHS reform. Whereas in medicine and in the health science professions, the effect of evidence on quality improvement is fairly direct, these policy researchers found that the effect of evidence on policymakers was more indirect. They discovered that research was more likely to affect and mediate the policy debate or to be used in dialogue between stakeholders. They also found that when policymakers made decisions, their knowledge and experience, budget limitations, and time constraints countered even the strongest evidence. The researchers noted, however, that sustained dialogue between policymakers and researchers improved utilization of evidence in the policymaking process (Elliott & Popay, 2000).

The importance of separating individual clinical decision-making from evidence-based decision-making at a population-policy level was studied by collaborating researchers from the UK and Canada. They noted that decision-making at the policy level is rife with uncertainty, variability, and complexity. They also observed that in health policymaking, the use of evidence may be more important than how it is defined. From this research they developed an evidence-utilization process model as a basis for a context-based conceptual framework of evidence-based decision-making in health policy (Dobrow et al., 2004).

The US has gained momentum in its use of evidence in policymaking. This is in part a result of the groundswell of health policy experts and healthcare professionals who have interest and expertise in compiling relevant evidence to help policymakers with their work. However, an additional force for change was initiated during the Obama administration: Public Law 114-140, which was passed by the US Congress to create the Commission on Evidence-Based Policymaking. The commission's report was released September 7, 2017, and its recommendations heard during a meeting of the full House Committee on Oversight and Government Reform on September 26, 2017. Chapter 2, "Using Evidence: The Changing Landscape in Health Policymaking," provides a summary of that report and a discussion of two companion bills subsequently introduced in the US House and Senate.

The Imperative for Using Evidence in Health Policymaking

Some say that the term *evidence-based policymaking* is an oxymoron. Even though the social and economic realities that account for many of our nation's negative health outcomes are amenable to improvement through health policy reform, policy changes are driven largely by ideology and bias instead of evidence (Fishbeyn, 2015). Still, the potential for positive change in the nation's policy through the use of evidence is promising, as long as the complexity of the policymaking process is understood, appreciated, and leveraged.

Leaders in nursing, nursing education, and nursing regulation have made significant contributions to the advancement of evidence-based policymaking. Numerous nursing health policy textbooks include the role of research and EBP applications in health policymaking. The National Council of State Boards of Nursing and leaders from state boards of nursing tirelessly advance evidence-based policymaking in regulation (Damgaard & Young, 2017; National Council of State Boards of Nursing Practice, Regulation and Education Committee, 2006; Ridenour, 2009; Spector, 2010). And our nation's nursing leaders have long advocated for change in how nurses contribute to health policymaking (IOM, 2010).

EBP models, adapted for use in health policymaking, are useful tools for actors who intend to influence policymakers. They are especially important, however, for individuals who serve in leadership positions in nursing and other health

profession associations or health-related government agencies. Those who work in government agencies have a more formal role in policymaking, so using a solid evidence base to influence policymakers and stakeholders is essential. Using an evidence-based health policy model that considers context and stakeholders in addition to evidence allows for a more logical and complete analysis of the policymaking environment and permits a more realistic strategy to emerge.

Nurse educators can use an evidence-based health policymaking model to teach students about health policy. Using the steps of an evidence-based policymaking process can help students gain an understanding of the overall health policymaking process, analyze and understand health policy issues more completely, and formulate strategies to effect change. Students can apply the steps of the process to pending or existing policy or use the process to strategically plan their own policy response to a known health policy problem.

Evidence-Based Versus Evidence-Informed

At the turn of the millennium, health policy scientists became familiar with the use of research to inform policymaking. They had become accustomed to the use of both single studies and systematic reviews as sources of evidence but were coming around to the idea that these sources alone were insufficient for informing policy discussions with legislators. They reached consensus that a more extensive body of evidence was required. As a result, the term *evidence-based* came into use in policymaking (Dobrow et al., 2004; Niessen et al., 2000; Pawson, 2006).

Around the same time that EBP emerged as a complement to EBM in the health professions, the term *evidence-based* was established as the norm in policymaking. However, policy leaders and scientists noted that there is often a considerable gap between the scientific evidence presented to policymakers and a policy as it is enacted (Brownson, Chriqui, & Stamatakis, 2009). Consequently, these leaders and scientists began to lean toward the term *evidence-informed* rather than *evidence-based* because it is a more accurate reflection of the realities and complexities of the policy environment.

The term *evidence-informed* is useful and important in policymaking for several reasons:

- **It acknowledges the boundaries of the use of evidence in policymaking:** As discussed, in policymaking, the use of evidence has been found to be indirect. Its best uses are to inform, mediate, or influence dialogue between stakeholders (Campbell et al., 2009; Elliott & Popay, 2000; Lavis et al., 2009; Morgan, 2010). Stakeholders may consist of individuals or groups including lawmakers, lobbyists, service providers, consumers, and other professionals.
- **It recognizes the rapidly changing, politically charged policy environment:** Limited budgets, budget cycles, and the timing of congressional or legislative sessions are inflexible and affect both priorities and stakeholder relationships (Bowen & Zwi, 2005; Jewell & Bero, 2008).
- **It acknowledges a global standard that has emerged for health policy over the past decade:** The term *evidence-informed* pressed itself into use when the World Health Organization (WHO) EVIPNet Knowledge Translation Platform (KTP) was established in 2005. The WHO EVIPNet KTP has advanced the systematic use of evidence in health policymaking since that time and is known as the *Evidence-Informed Policy Network* (WHO, 2018). In 2009, the journal *Health Research Policy and Systems* solidified use of the term by publishing a supplemental issue that provided support tools for evidence-informed health policymaking (Lavis et al., 2009).

Definitions of Evidence-Informed Policymaking

A variety of definitions of evidence-informed policymaking exist. There are common themes among them; what distinguishes the definitions is their source and purpose.

This section provides five definitions of evidence-informed policymaking. The first two originate from health policy-focused sources. The next two are not directly health-focused but are helpful in that one is in plain language, while the other shows the level of detail necessitated by government policy reports.

The fifth is a definition for evidence-informed health policy for use in nursing education and regulation, which may be extended to general healthcare policymaking.

The first definition underpins the SUPPORT tools for evidence-informed health policymaking (Oxman, Lavis, Lewin, & Fretheim, 2009). The SUPPORT project, initiated by the European Commission, generated a series of articles for individuals responsible for making health policy and program decisions. The SUPPORT definition follows:

> Evidence-informed health policymaking is an approach to policy decisions that aims to ensure that decision making is well-informed by the best available research evidence. It is characterized by the systematic and transparent access to, and appraisal of, evidence as an input into the policymaking process. (Oxman et al., 2009, p. 1)

The second definition comes from the WHO EVIPNet, which speaks to "promot[ing] the systematic use of research evidence in health policymaking in order to strengthen health systems and get the right programs, services and drugs to those who need them" (2018).

The Overseas Development Institute (ODI) is the source of the third definition. The ODI is an independent think tank that promotes global progress by focusing on research and analysis to develop sustainable solutions for significant problems. Its definition of evidence-informed policymaking is "when policymakers use the best available evidence to help make policy decisions . . . [this includes] scientific research . . . [and also] statistical data, citizen voice, and evaluation evidence" (Ball, 2018).

The fourth definition comes from the Commission on Evidence-Based Policymaking (2017). Its definition focuses on the meanings of the word *evidence* rather than on a process:

> "Evidence" can be defined broadly as information that aids the generation of a conclusion . . . this report uses the shorthand "evidence" to refer to information produced by "statistical activities" with a "statistical purpose" that is potentially useful when evaluating government programs and policies . . . we define "statistical activities" as "the collection, compilation, processing, analysis, or dissemination of data for the purpose of describing or making

> estimates concerning the whole, or relevant groups or components within, the economy, society, or the natural environment, including the development of methods or resources that support those activities, such as measurement of methods, statistical classifications, or sampling frames." A "statistical purpose" is defined as "the description, estimation, or analysis of the characteristics of groups . . . and includes the development, implementation, or maintenance of methods, technical or administrative procedures, or information resources that support such purposes." (pp. 8–11)

The last definition comes from the evidence-informed health policy (EIHP) model used throughout much of this text. It is an adaptation of the Melnyk and Fineout-Overholt definition of EBP (2015). In the EIHP model, evidence-informed health policy "combines the use of the best available evidence and issue expertise with stakeholder values and ethics to inform and leverage dialogue toward the best possible health policy agenda and improvements" (Loversidge, 2016b).

Summary

This chapter discussed why evidence should be considered in health policymaking. It began by explaining how EBP evolved from EBM. EBP is a process that addresses clinical problems and improves the quality of healthcare and patient outcomes. A number of nursing-specific EBP models exist; this chapter offered a non-exhaustive list of those models and described them in brief. All of these are process models and therefore may be adapted to non-clinical, health-related problems, including health policy problems.

The chapter went on to note that evidence-based policymaking has been advanced in other countries, particularly in Western Europe and Canada, and is now gaining traction in the US. It explained why nurses and other health professionals who have competency in EBP are positioned to adapt these skills. Finally, it discussed how evidence-based or evidence-informed policymaking can address health policy problems and help nurses and other healthcare providers influence, inform, and advance positive change in health policy.

References

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf

American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education for professional nursing practice*. Retrieved from https://www.aacnnursing.org/Portals/42/Publications/BaccEssentials08.pdf

American Association of Colleges of Nursing. (2011). *The essentials of master's education in nursing*. Retrieved from https://www.aacnnursing.org/Portals/42/Publications/MastersEssentials11.pdf

American Association of Colleges of Nursing. (2018). Federal policy agenda 2017–2018. Retrieved from https://www.aacnnursing.org/Policy-Advocacy/About-Government-Affairs-and-Policy/Federal-Policy-Agenda

American Association of Nurse Practitioners. (2018). Legislation/regulation. Retrieved from https://www.aanp.org/legislation-regulation

American Nurses Association (2018). Legislative and regulatory priorities for the 115th Congress. Retrieved from https://www.nursingworld.org/practice-policy/advocacy/federal/115-congress-legislative-and-regulatory-priorities/

Ball, Louise. (2018, Jan. 2). Explainer: What is evidence-informed policymaking? *Overseas Development Institute*. Retrieved from https://www.odi.org/comment/10592-explainer-what-evidence-informed-policy-making

Bowen, S., & Zwi, A. B. (2005). Pathways to "evidence-informed" policy and practice: A framework for action. *PLoS Medicine, 2*(7), e166.

Brownson, R. C., Chriqui, J. F., & Stamatakis, K. A. (2009). Understanding evidence-based public health policy. *American Journal of Public Health, 99*(9), 1576–1583. doi:10.2105/AJPH.2008.156224

Campbell, D. M., Redman, S., Jorm, L., Cooke, M., Zwi, A. B., & Rychetnik, L. (2009). Increasing the use of evidence in health policy: Practice and views of policy makers and researchers. *Australia & New Zealand Health Policy, 6,* 21. doi:10.1186/1743-8462-6-21

Commission on Evidence-Based Policymaking. (2017). *The promise of evidence-based policymaking*. Retrieved from https://www.cep.gov/content/dam/cep/report/cep-final-report.pdf

Daly, W. J., and Brater, D. C. (2000). Medieval contributions to the search for truth in clinical medicine. *Perspectives in Biology and Medicine, 43*(4), 530–540.

Damgaard, G., & Young, L. (2017) Application of an evidence-informed health policy model for the decision to delegate insulin administration. *Journal of Nursing Regulation, 7*(4), 33–40.

Dang, D., Melnyk, B. M., Fineout-Overhold, E., Ciliska, D., DiCenso, A., Cullen, L., . . . Stevens, K. R. (2015). Models to guide implementation and sustainability of evidence-based practice. In B. M. Melnyk & E. Fineout-Overholt (Eds.), *Evidence-based practice in nursing & healthcare: A guide to practice* (3rd ed., pp. 274–315). Philadelphia, PA: Lippincott Williams & Wilkins.

Dobrow, M. J., Goel, V., & Upshur, R. E. (2004). Evidence-based health policy: Context and utilisation. *Social Science & Medicine, 58*(1), 207–217.

Elliott, H., & Popay, J. (2000). How are policy makers using evidence? Models of research utilisation and local NHS policy making. *Journal of Epidemiology & Community Health, 54*(6), 461–468.

Fishbeyn, B. (2015). When ideology trumps: A case for evidence-based health policies. *The American Journal of Bioethics, 15*(3), 1–2. doi:10:10.1080/15265161.2015.1019781

Gerber, A., Lungen, M., & Lauterbach, K. W. (2005). Evidence-based medicine is rooted in the Protestant exegesis. *Medical Hypotheses, 64*(5), 1034–1038.

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

Jewell, C. J., & Bero, L. A. (2008). "Developing good taste in evidence": Facilitators of and hindrances to evidence-informed health policymaking in state government. *The Milbank Quarterly, 86*(2), 177–208.

Johns Hopkins Medicine. (n.d.). Center for Evidence-Based Practice. Retrieved from https://www.hopkinsmedicine.org/evidence-based-practice/ijhn_2017_ebp.html

Kring, D. L. (2008). Clinical nurse specialist practice domains and evidence-based practice competencies: A matrix of influence. *Clinical Nurse Specialist, 22*(4), 179–183.

Lavis, J. N., Oxman, A. D., Souza, N. M., Lewin, S., Gruen, R. L., & Fretheim, A. (2009). SUPPORT tools for evidence-informed health policymaking (STP) 9: Assessing the applicability of the findings of a systematic review. *Health Research Policy and Systems, 7* (Suppl. 1), 1–7.

Loversidge, J. M. (2016a). A call for extending the utility of evidence-based practice: Adapting EBP for health policy impact. *Worldviews on Evidence-Based Nursing, 13*(6), 399–401. doi:10.1111/wvn.12183

Loversidge, J. M. (2016b). An evidence-informed health policy model: Adapting evidence-based practice for nursing education and regulation. *Journal of Nursing Regulation, 7*(2), 27–33.

Melnyk, B. M., & Fineout-Overholt, E. (2015). *Evidence-based practice in nursing and healthcare: A guide to best practice* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Melnyk, B. M., Fineout-Overholt, E., Gallagher-Ford, L., & Stillwell, S. B. (2011). Evidence-based practice, step by step: Sustaining evidence-based practice through organizational policies and an innovative model. *American Journal of Nursing, 111*(9), 57–60.

Melnyk, B. M., Fineout-Overholt, E., Giggleman, M., & Choy, K. (2017). A test of the ARCC model improves implementation of evidence-based practice, healthcare culture, and patient outcomes. *Worldviews on Evidence-Based Nursing, 14*(1), 5–9.

Melnyk, B. M., Gallagher-Ford, L., Long, L. E., & Fineout-Overholt, E. (2014). The establishment of evidence-based practice competencies for practicing nurses and advanced practice nurses in real-world clinical settings: Proficiencies to improve healthcare quality, reliability, patient outcomes, and costs. *Worldviews on Evidence-Based Nursing, 11*(1), 5–15.

Mitchell, S. A., Fisher, C. A., Hastings, C. E., Silverman, L. B., & Wallen, G. R. (2010). A thematic analysis of theoretical models for translational science in nursing: Mapping the field. *Nursing Outlook, 58*(6), 287–300. doi:10.1016/j.outlook.2010.07.001

Morgan, G. (2010). Evidence-based health policy: A preliminary systematic review. *Health Education Journal, 69*(1), 43–47. doi:10.1177/0017896910363328

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine, 104*(12), 510–520. doi:10.1258/jrsm.2011.110180

National Council of State Boards of Nursing Practice, Regulation and Education Committee. (2006). Evidence-based nursing education for regulation (EBNER). Retrieved from https://www.ncsbn.org/Final_06_EBNER_Report.pdf

National League for Nursing. (2017). *Public policy agenda 2017–2018*. Retrieved from http://www.nln.org/docs/default-source/advocacy-public-policy/public-policy-agenda-pdf.pdf?sfvrsn=2

Niessen, L. W., Grijseels, E. W., & Rutten, F. F. (2000). The evidence-based approach in health policy and health care delivery. *Social Science & Medicine, 51*(6), 859–869.

Oxman, A. D., Lavis, J. N., Lewin, S., & Fretheim, A. (2009). SUPPORT tools for evidence-informed health policymaking (STP) 1: What is evidence-informed policymaking? *Health Research Policy and Systems, 7*(Suppl. 1), S1. doi:10.1 186/1478-4505-7-S1-S1

Pawson, R. (2006). Evidence-based policy: The promise of a systematic review. In R. Pawson (Ed.), *Evidence-based policy: A realist perspective* (pp. 2–17). London, UK: Sage Publications Ltd. doi:10.4135/9781849209120.n1

Ridenour, J. (2009). Evidence-based regulation: Emerging knowledge management to inform policy. In K. Malloch & T. Porter-O'Grady (Eds.), *Introduction to evidence-based practice in nursing and health care*. (pp. 275–299). Sudbury, MA: Jones and Bartlett Learning.

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM* (2nd ed.). London, UK: Churchill Livingstone Elsevier.

Satterfield, J. M., Spring, B., Brownson, R. C., Mullen, E. J., Newhouse, R. P., Walker, B. B., & Whitlock, E. P. (2009). Toward a transdisciplinary model of evidence-based practice. *The Milbank Quarterly, 87*(2), 368–390.

Schaffer, M. A., Sandau, K. E., & Diedrick, L. (2013). Evidence-based practice models for organizational change: Overview and practical applications. *Journal of Advanced Nursing, 69*(5), 1197–1209. doi:10.1111/j.1365-2648.2012.06122.x

Spector, N. (2010). Evidence-based nursing regulation: A challenge for regulators. *Journal of Nursing Regulation, 1*(1), 30–36.

Stetler, C. B. (2001). Updating the Stetler Model of research utilization to facilitate evidence-based practice. *Nursing Outlook, 49*(6), 272–279.

Stetler, C. B., Damschroder, L. J., Helfrich, C. D., and Hagedorn, H. J. (2011). A guide for applying a revised version of the PARIHS framework for implementation. *Implementation Science, 6*, 99–109.

Stevens, K. R. (2013). The impact of evidence-based practice in nursing and the next big ideas. *Online Journal of Issues in Nursing, 18*(2), Manuscript 4. doi:10.3912/OJIN.Vol18No02Man04

Straus, S. E., Richardson, W. S., Glasziou, P., & Haynes, R. B. (2011). *Evidence-based medicine: How to practice and teach it* (4th ed.). London, UK: Churchill Livingstone Elsevier.

Titler, M. G. (2014). Overview of evidence-based practice and translation science. *The Nursing Clinics of North America, 49*(3), 269–274.

Titler, M. G., Kleiber, C., Steelman, V., Rakel, B. A., Budreau, G., Everett, L. Q., . . . Goode, C. (2001). The Iowa Model of evidence-based practice to promote quality care. *Critical Care Nursing Clinics of North America, 13*(4), 497–509.

The University of Texas Health Science Center School of Nursing. (2015). Star Model. Retrieved from http://nursing.uthscsa.edu/onrs/starmodel/star-model.asp

World Health Organization. (2018). Evidence-Informed Policy Network: What is EVIPNet? Retrieved from http://www.who.int/evidence/about/en/

INDEX

A

B

C

D

E

F

G

H

J

K

L

M

N

O

P

R

S

T

U

V

W