

Charting Nursing's Future

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Reports on Policies That
Can Transform Patient Care

Strengthening Public Health Nursing—Part II How Nurse Leaders in Policymaking Positions Are Transforming Public Health

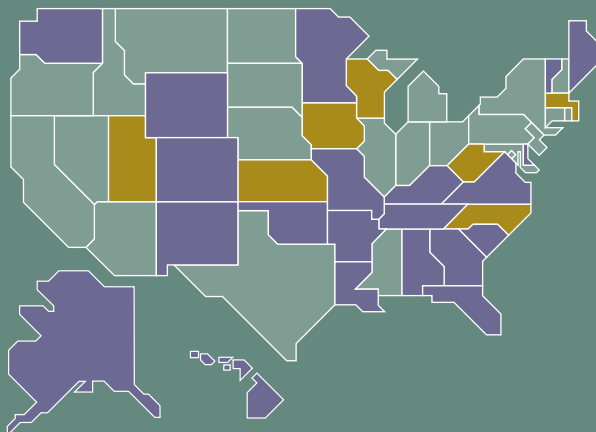
As nurses rise through the public health ranks, they are bringing the knowledge and experience they have acquired in the field back to the policy table with tangible results. Across the country, they are crafting and implementing innovative strategies to advance the health of the public. In some states and counties, nurse leaders are creating new paradigms that are transforming the ways in which governments carry out the business of public health.

Through a series of profiles, this brief illustrates the dramatic ways in which nurse leaders in policymaking positions are transforming public health at the county, state, and federal levels. The brief also looks at policy initiatives aimed at strengthening nursing leadership and facilitating nurse license portability. For a discussion of public health workforce issues and model programs, see *Charting Nursing's Future* 7 (also dated September 2008).

Figure 1 Executive Positions in Public Health Nursing (PHN) by State

- Health department has a nurse executive whose chief focus is PHN
- Health department has a nurse executive who dedicates significant time to PHN in addition to other responsibilities

This map reflects only those states with functioning nurse executives as of September 2007. A number of other states—Mississippi, California, and Texas, for example—have subsequently made significant strides toward establishing nurse executive positions.



Source: Map data courtesy of the Association of State and Territorial Directors of Nursing. Data collected with funds from Department of Health and Human Services, Centers for Disease Control and Prevention, Cooperative Agreement award number U50/CCU31903.

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The Value of Nursing

Lorri Tanner, RN, county nurse manager, Walton County Health Department, educates Georgia lawmakers on the public health nursing workforce shortage that afflicts her state. A record number of Georgia's public health nurses have met with their legislators and testified before the General Assembly in the past two years, spurred by the efforts of Carole C. Jakeway, RN, MPH, chief nurse of the Georgia Division of Public Health, and Cathalene Teahan, RN, MSN, chief advocate and policy consultant, to formulate policies that can remedy Georgia's recruitment and retention crisis. (For more on Georgia's nursing policy achievements, see *Charting Nursing's Future* 7, p. 7)



Photo: GTA Media Productions

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Nursing's Growing Influence in Policy Circles

Historically, nurses have been called upon to carry out most public health initiatives, from campaigns to prevent STDs among teens to mobilizations to care for chronically ill seniors in the aftermath of a flood. Yet despite their central role in these endeavors, nurses were typically absent from key policy discussions.

In recent years, nurse leaders in public health have asserted a growing influence in policy circles. More than half of state public health departments have a senior nurse executive (see figure 1, p. 1). While some of these individuals hold positions of limited scope and authority, those in chief nurse or public health nursing director positions typically take part in their state's health policy debates.

In addition, nurse leaders hold the top health positions in New Hampshire and Tennessee (see p. 6). And as of 2005, 34 percent of local health departments had a nurse at the helm. Nurses are also shaping public health policy through professional and nonprofit associations, in state legislatures, and in the U.S. Congress (see p. 8).

As the public health mandate expands in the face of 21st-century challenges, the visibility of nurse policymakers will likely increase. Their expertise in prevention and health promotion and their experience in delivering care have become valued assets, positioning them to play major roles in developing effective policies for assuring the public's health.

State Policies that Support Public Health Nursing

The Argument for State-Level Nursing Leadership

"It's typical for health departments to formulate response and disease prevention plans, bringing nurses in at the last minute or without consulting them at all," says Joy F. Reed, EdD, RN, head of Public Health Nursing and Professional Development in North Carolina. She remembers a frantic call from a nursing colleague in another state who was asked to produce a smallpox immunization plan the night before it was due to be filed with the federal government. Fortunately, Reed had a model plan at the ready. Reed also recalls a school-based immunization program in her state that cost some local health departments three times the money they received because it failed to account for key logistical issues related to implementation. "If health directors had talked to nurses first and incorporated their perspectives, they would have been aware of the complications and budgeted accordingly."

Reed has been involved in public health planning efforts in North Carolina since her position was reestablished in 1995 after having been eliminated due to state budget woes. According to the Association of State and Territorial Directors of Nursing (ASTDN), 21 states had an

executive nurse in 2007 whose chief responsibility was public health nursing. Another seven states had a senior-level person for whom nursing was part of a larger portfolio (see figure 1, p. 1). These positions ranged from chief nurse or director positions with significant staff and budgetary authority to senior nurses in state health departments who primarily functioned as liaisons to public health nurses in largely autonomous local departments.

ASTDN sees the establishment of a public health nursing executive in all states as key to revitalizing public health nursing. With financial support provided through the Association of State and Territorial Health Officer's cooperative agreement with the Centers for Disease Control and Prevention (CDC), ASTDN is working to develop a job description template that states can adapt to create an executive position that suits each individual public health system, be it centralized, decentralized, or mixed.¹

Proponents say the position's chief value lies in putting senior nurse leaders at the table with senior government officials when policy and plans are formulated and financial resources are allocated. The position also gives nurses at the grassroots a voice at the state level, assists health departments

in meeting workforce challenges, and improves quality of care by establishing standards for clinical procedures and protocols.

Some public health officials have questioned how a public health nurse executive would function given potential structural impediments in particular states. New York, for instance, has a highly decentralized system that gives local governments direct control of local health departments. Nevertheless, the director of New York's Sullivan County Health Department, Carol S. Ryan, RN, MPH, supports creating a state-level nurse executive who could set practice standards and act as an advocate on recruitment and retention issues. "We have excellent ad-hoc nurse leadership at the state level and some strong support from non-nurses in the public health ranks," says Ryan, "but they have no power or budgetary authority of their own specifically for public health nursing practice. A state nursing director is needed to inform future practice and to better the public's health."

In California, which has a mixed system with some state services provided at the local level, a bare-bones proposal to create a public health nurse executive encountered resistance due to cost and other concerns

when it was first introduced in 2007. It is currently proceeding through the state legislature as a revenue-neutral measure and may be signed into law later this year. The bill has the support of the state's local and county physician health officers and nursing directors. Although its passage would not create a nursing department with its own budget, advocates expect the position to improve communication among nurses in different departments and programs; assist them in sharing best practices; and give them a voice in policy discussions, especially regarding emergency preparedness.

Competing Approaches to Facilitating License Portability

As Hurricane Katrina demonstrated all too dramatically, the ability of health professionals to work across state lines is essential to an effective disaster response. All states have ratified the Emergency Management Assistance Compact (EMAC), which provides license recognition for health personnel on loan from one state to another. However, these compacts vary from state to state. As a result, no uniform system exists to ensure liability protection for private sector health practitioners willing to volunteer across state lines.

The current practice of nurse licensure based on state boundaries worked well for most of the last century, but the need for a flexible response capability and the rise of care delivery via telehealth have called this practice into question. When a

nurse from one state gives advice to a patient in another, which state has jurisdiction? Which provides liability protection to the nurse and protection from malpractice to the patient? The absence of laws that address these questions has left both nurses and the public vulnerable.

These concerns prompted the National Council of State Boards of Nursing (NCSBN) to vote unanimously in 1997 to advocate a new model of licensure based on mutual recognition. The council then developed model language that states have used to establish a Nurse Licensure Compact (NLC), which allows nurses licensed in one compact state to practice in another. Compact states ensure that their nursing workforce is licensed and in good standing by regularly submitting nurse license and license discipline information to Nursys®, a computer database created by NCSBN and accessible to all state boards of nursing.

As of July 2008, 23 state legislatures have voted to adopt the NLC, but many are reluctant to do so. Some worry about embracing an untested model, while others cite concerns surrounding discipline, delegation of authority, or loss of licensing revenues from practitioners who live outside their jurisdictions. "Whatever the obstacles to forming a licensure compact, we ought to be able to overcome them," says Carole C. Jakeway, RN, MPH, chief nurse of the Georgia Division of Public Health. "Especially during a pandemic when a shortage of

nurses may be especially severe, there won't be time to negotiate agreements. We'll have to be all about saving lives."

The American Nurses Association (ANA) supports an alternative way of addressing the need for a flexible response capability. ANA advocates that states adopt the Uniform Emergency Volunteer Health Practitioners Act prepared by the Uniform Law Commission. This model law provides license reciprocity for private sector volunteers, clarifies how their scope of practice will be determined, and provides nurses and other volunteers with a range of legal protections that address specific concerns related to emergency deployments. The act has been introduced in 19 state legislatures since 2006, and as of July 2008, 6 states had adopted it.

In the wake of September 11 and the 2002 anthrax attacks, the U.S. Congress also recognized the importance of facilitating license and credential verification of volunteer health professionals during emergencies. Congress authorized the development of the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and provided funding in 2004 and 2005 to assist states and territories in creating standardized volunteer registration systems. As of 2008, 40 states and territories have operational systems, and the most recent Pandemic and All Hazards Preparedness Act mandated that the Department of Health and Human Services link these systems at the federal level by December 2007 to better coordinate future deployments. This linkage has yet to occur, but even with a fully linked system, the registry does not address how health workers may be used or what legal protections would apply to their deployment.



"There is a simpler fix: a national nursing license, but whenever there are scope-of-practice issues, there are conflicts among the professions. We need a national dialogue among stakeholders, the American Medical Association and American Nurses Association for starters. There is urgency around this in terms of emergencies, but it's also important for individuals in terms of economic mobility and for rural border communities that face shortages."

Bobbie Berkowitz, PhD, RN, CNA, FAAN, Alumni Endowed Professor of Nursing, University of Washington

Strategic Plan Focuses on Underlying Causes of Disease

In the late 1990s, a group of Wisconsin innovators took on the task of transforming the state's public health system under the leadership of **Margaret Schmelzer, RN, MS**, Wisconsin's director of public health nursing and health policy. Known to public health leaders throughout the state for her superb networking skills and her track record in public health law, Schmelzer was well suited to take on this monumental task.



To begin, she invited representatives of all 72 counties, the state's Native American tribes, racial and ethnic minorities, academia, non-profit groups, and the health care and insurance industries to join state government officials in shaping the 10-year plan. Nurses made up the dominant professional group, bringing with them a holistic view of health that accounts for psychological, social, spiritual, and environmental factors in addition to biological ones in determining what makes a healthy community.

The resulting document, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public (HW 2010)*,² is a bold departure from its predecessors. Building on the Institute of Medicine's seminal 1988 report *The Future of Public Health*,³ the plan defines public health as a social enterprise and proposes a strategic, scientifically based, and collaborative approach to creating a healthy public. It includes an implementation plan and outcome measures. And most significantly, it focuses on health risks rather than on disease. In so doing, it replaces the traditional laundry list of health priorities (Wisconsin's previous plan

had 327), with a framework designed to radically transform the public health system.

The framework is exceptionally concise, with only 11 health priorities that target the state's most prevalent underlying causes of disease and mortality, or risk factors (see box below). The plan also includes five infrastructure priorities that delineate what is needed to achieve the health goals.

Some individuals and groups have expressed concern that their areas of specialty are no longer explicitly recognized in the state plan. Schmelzer is sensitive to the needs of these critics and invites their input and collaboration. Nevertheless, she remains firm in her belief that focusing on risk factors rather than diseases and conditions is the right strategic approach. "We can no longer afford to waste time addressing the manifestations of illness. We need to get to the underlying causes of illness, injury, premature death, and disability."

To track its progress in meeting *HW 2010*'s goals, Wisconsin has retooled its reporting system to correlate specific measures with the state plan's health objectives. The data is updated semiannually and can be accessed over the Web at *Track 2010*⁴ by independent researchers. These include the University of Wisconsin's Population Health Institute, which uses the data to rank the health status of Wisconsin's counties and produce one-page "snapshots" of county health outcomes and health determinants, which have proven extremely useful to localities.

The federal government is looking to the Wisconsin plan for guidance in formulating the next national health plan, *Healthy People 2020*. Schmelzer was invited to serve on a 14-member technical expert panel that made recommendations on how to reduce the number of plan objectives, currently at 467, and create a new framework.

Despite the respect garnered by *HW 2010*, progress in meeting its health goals has been erratic. The state has met or exceeded its targets in the areas of smoking cessation and breast-feeding, both of which receive dedicated and sustained funding from the federal government. Yet Wisconsin has the worst African American infant mortality rate among 40 reporting states; its adult obesity rate has doubled since 1990; and the state leads the nation in a range of drinking problems. Schmelzer and other observers single out lack of funding for public health as the primary cause.

Wisconsin ranks 50th in the nation in terms of state investment in public health with state spending at \$9.16 per capita in 2007, well below the national median of \$33.26. A 2007 report by Wisconsin's Public Health Council asserts that "failure to fully implement the state health plan is one of the reasons these problems show little to no improvement." The report calls on the state to double its financial support of public health.

Wisconsin's Health Priorities

- Access to primary and preventive health services
- Adequate and appropriate nutrition
- Alcohol and other substances use and addiction
- Environmental and occupational health hazards
- Existing, emerging, and reemerging communicable diseases
- High-risk sexual behavior
- Intentional and unintentional injuries and violence
- Mental health and mental disorders
- Overweight, obesity, and lack of physical activity
- Social and economic factors that influence health
- Tobacco use and exposure

Source: Wisconsin Department of Health and Family Services, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* (PPH 0276), April 2002.

²<http://dhfs.wisconsin.gov/statehealthplan/>

³<http://www.iom.edu/CMS/3809/15244.aspx>

⁴<http://dhfs.wisconsin.gov/statehealthplan/track2010/index.asp>

Cultivating New Public Health Paradigms: Michigan

Addressing the Nursing Shortage as a Public Health Concern

While other states struggle to provide funding for nursing education, Michigan is investing tens of millions of dollars in a multiyear effort to build its nursing workforce. Governor Jennifer Granholm sees the state's projected shortage of 18,000 nurses by 2015 as a direct threat to the public's health, and as a welcome opportunity in a state that is struggling to create jobs. She has tasked her staff with addressing both these problems and has created a new position, the chief nurse executive (CNE), to ensure that nursing remains a visible part of the equation.

Michigan's CNE is uniquely positioned to focus exclusively on policy and legislation that supports nursing. Unlike nursing leaders in other states who typically work under senior administrators in their departments of health, the CNE has direct access to the governor, her health policy advisor, and others in business and the media who can support the administration's nursing agenda.

“Michigan is striving to lead the nation in investment, innovation, and tangible outcomes from our initiatives to address the nursing shortage and the workforce needs of our state. Jeanette Klemczak's work as chief nurse executive has been an integral part of this success.”

Jennifer M. Granholm,
governor of Michigan



“The strength of this position comes from being at enough tables to put together resources that might not ordinarily be available or even known to nursing,” says the state's first and current CNE **Jeanette Wrona Klemczak, RN, BSN, MSN**. “I consider the nursing shortage a public health issue, and the Labor and Economic Growth Department sees it as an economic issue. Together we've been able to leverage considerable resources to address some of those needs.”

Klemczak and her economic growth colleagues are encouraging well-educated but unemployed workers such as engineers and lab technicians to consider nursing as a second career. They persuaded the governor to allocate \$30 million for pilot accelerated second-degree nursing programs that are attracting a demographically diverse student group, including former autoworkers. The money has gone to a partnership formed by the nursing schools, hospitals, and the Regional Skills Alliance, Michigan's equivalent of a workforce investment board. The partners were able to open 3,000 clinical placements for nursing students throughout the state in just two years.

More recently, Klemczak's office has proposed creating the Michigan Nursing Corps, whose purpose is to



produce 500 new nursing faculty. More than half of the faculty members at most Michigan nursing schools are eligible for retirement, and only 8 percent of Michigan's nurses have the master's degree needed for a career in academia.

The legislature allocated \$1.5 million in 2008 to pilot the corps. Another \$5 million was appropriated in 2009 despite the fiscal challenges facing the state. “This speaks volumes about our governor's and our legislators' understanding and commitment to addressing our communities' nursing needs,” says Klemczak. She estimates that the corps will need \$45 million over three years to replenish the state's nursing faculty ranks and graduate the additional nurses needed to address the shortage. Last year alone, Michigan's nursing schools turned away 4,400 qualified applicants.

Michigan's CNE position also represents an innovation in funding for system-level nursing leadership. Klemczak's salary comes out of the state's Nurse Professional Fund, which is paid for by a \$2 earmark on the biannual nurse licensing fee. Because the CNE is paid directly from this fund, the position is protected from cuts that periodically impact all state budgets. The fund also supports nursing scholarships, continuing education, and research and development.

“We call Jeanette our chief nurse advocate because that is what she does for us—advocate. Once nurses understand that the increased nurse licensing fee makes her work and other programs that benefit nurses possible, they readily support it.”

Tom Bissonnette, MS, RN, executive director for nursing practice and operations at the Michigan Nurses Association



Cultivating New Public Health Paradigms: Tennessee

State Health Commissioner Brings Business and Nursing Perspectives to the Policy Arena

“Everywhere I go, I start with ‘My name is Susan Cooper, and I am a registered nurse.’” As one of only two state health officers in the United States who are nurses, it’s not surprising that **Susan R. Cooper, MSN, RN**, feels the need to remind audiences of her professional background in clinical care and emergency nursing. In January 2007, she became the first nurse to serve as commissioner of the Tennessee Department of Health.



Cooper was an associate dean at Vanderbilt University in 2005 when Governor Phil Bredesen asked her to create a safety net for uninsured state residents who were about to lose their coverage by TennCare, the state’s Medicaid replacement program. In this initial foray into state-level policymaking, Cooper says she drew on the communication, teamwork, and priority setting skills she had acquired as the manager of a hospital emergency department. She also applied business tactics borrowed from her experience establishing the Center for Advanced Practice Nursing and Allied Health at Vanderbilt, and serving as codirector of the Health Systems Management program at the university’s School of Nursing. Finally, she relied on the nursing process of assessment, planning, implementation, and evaluation to help Tennessee develop a viable solution to caring for its uninsured.

Cooper was able to sort through the demands of competing constituencies to prioritize

those goals that were achievable and develop strategies for providing access to care. Her initiatives included setting up bridge programs for special populations, such as transplant recipients and those on dialysis, and developing an infrastructure to provide primary care to the uninsured. Now state residents can receive care in local health departments, as well as at community and faith-based clinics, and at federally qualified health centers that receive additional funding to support the influx of new patients. As a result, the state was able to facilitate 500,000 primary care encounters for uninsured residents over the course of the first year.

In 2007, the Centers for Disease Control and Prevention reported that Tennessee ranked number one in the nation for adults with diabetes who check their blood sugar daily. Data analyses found a significant positive association between regular blood sugar monitoring and the number of doctor visits made annually.

Assuring access to medical care is a core function of public health. Nevertheless, experts argue that providing that care directly to individuals is an undue burden on public health entities, one that hinders their ability to address population health needs (see *Charting Nursing’s Future* 7, p. 2). Tennessee’s health departments did not provide primary care to the uninsured prior to the TennCare disenrollment. All states face the challenge of assuring access to care

for the uninsured. Some jurisdictions are finding alternate solutions to balancing this need with the need to provide population-focused services (see p. 7).

Since accepting the commissioner’s post, Cooper has seen Tennessee’s national health ranking move from 47th to 46th. “This may not sound like a lot,” Cooper acknowledges, “but it reflects some significant steps forward.” A wide-ranging smoking cessation effort that Cooper championed reduced smoking rates from 26.7% to 22.6% in less than two years. Her leadership of GetFitTN, a statewide effort to address diabetes risk factors, including obesity, has led to a proliferation of local programs designed to get the people of Tennessee moving more and eating healthier foods.

GetFitTN reflects Cooper’s philosophy that “if you want to change things, you need to get down to the community level.” The initiative buttresses the power of localities to develop their own fitness and nutrition programs at the grassroots level while the state provides technical expertise and publicity. Cooper personally visits program sites to celebrate local accomplishments.

“You can’t do this job in an office,” she says. “You have to get out there and touch people to let them know that they’re important. That’s part of what being a nurse is all about. It’s the connection you have with people that makes change possible.”

The Value of Nursing

The acquisition of maternal and child health services has become significantly easier for eligible residents since Paul Kuehnert, MS, RN, (at left) became executive director at Illinois’s Kane County Health Department (KCHD) in June 2007. He worked with the area’s federally qualified health centers (FQHCs) to institute a “No Wrong Door” policy that allows clients to receive the same integrated set of services at KCHD or an area FQHC. Formalized agreements have transformed an environment in which these providers previously competed for WIC dollars, into a cooperative environment that puts clients’ needs first.



Cultivating New Public Health Paradigms: Florida

Quality Improvement Journey Spurs a Decade of Change

In 1997, Florida's legislature created the Florida Department of Health and gave it jurisdiction over county health departments. Uncertainty about the financial and other repercussions of these changes started the Miami-Dade County Health Department (MDCHD) on a quality improvement journey that has been widely admired.

MDCHD had at its disposal Florida's Sterling Management Model, which is based on the nationally recognized Malcolm Baldrige Criteria for Performance Excellence. With the Sterling Model as a guide, MDCHD embarked on a program of leadership development, organizational self-assessment, strategic planning, communication, and employee training.

A pioneering MDCHD administrator, Annie Neasman, RN, MS, set this ambitious process in motion before assuming new responsibilities at the state level. Her successor,

Lillian Rivera, RN, MSN, is credited with providing the leadership that brought the process to fruition. After she took the helm, MDCHD became the first Florida agency to be twice honored with the state's prestigious Sterling Award. Rivera credits the Baldrige Criteria with "enabling us to not only sustain our direction, but to continually measure and improve how service is delivered to our customers."

As part of its quality improvement journey, MDCHD underwent a fundamental change in service mix. The 1991 passage of a half-cent county sales tax to support Miami's Jackson Memorial Hospital created pressure on the hospital to take on new responsibilities and an opportunity for MDCHD to divest itself of its primary care clinics. Over the course of three years, MDCHD transferred its prenatal and pediatric primary care services to

"I started the journey to create a definable roadmap with benchmarks so we could demonstrate our value. Then Lillian took the process beyond my wildest dreams. Today's MDCHD is a phenomenal tribute to the power of having a vision and people with the ingenuity to carry it out."



Annie Neasman, RN, MS, former administrator, Miami-Dade County Health Department

the hospital system. This allowed MDCHD to use the financial resources previously spent on primary care to more fully support population-focused initiatives in areas such as disease prevention, environmental health, and emergency preparedness.

Miami-Dade is the eighth largest county in the United States and home to 2.5 million residents. The area also receives 11 million visitors a year and draws large numbers of new immigrants and refugees. To keep pace with this growing demand, MDCHD recruits health professionals to work on a volunteer basis and contracts with nonprofit and faith-based clinics

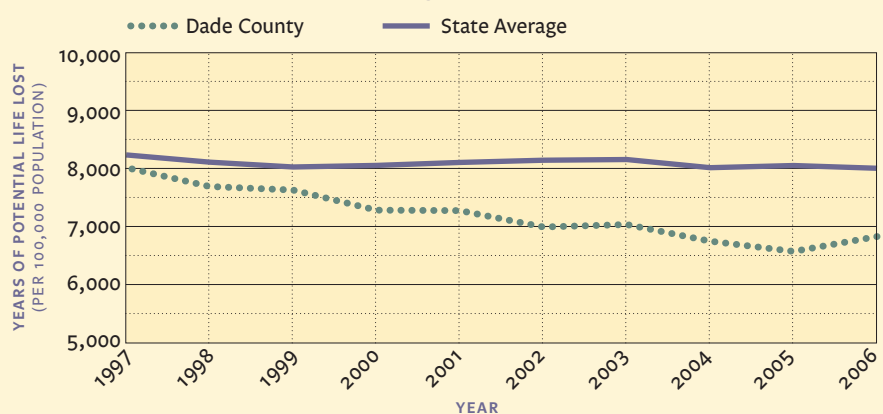
to provide primary care and other health services to eligible county residents. In 1992, Florida established the Volunteer Health Services Program, which gives liability protection to volunteer providers. According to Rivera, the program took off in Miami-Dade when the performance improvement process revealed its strategic value in meeting the county's health goals. The value of volunteer services and contributions rose almost sixfold in the last decade. Today it is estimated at \$29 million annually, a substantial supplement to the department's \$67 million cash budget.

Strong partnerships also contribute substantially to MDCHD's ability to pursue its mission. Rivera spearheaded the development of the Consortium for a Healthier Miami-Dade, a 50-member organization that has joined forces with the health department to promote healthy lifestyles and combat chronic disease. Additional partnerships with the Miami-Dade County Hospital Preparedness Consortium and The Children's Trust focus on disaster response and on placing nurses and paraprofessionals in county schools.

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Figure 2
Years of Potential Life Lost Prior to Age 75 in Florida



Source: Miami-Dade County Health Department Office of Epidemiology.

The Centers for Disease Control and Prevention use Years of Potential Life Lost (YPLL) to track deaths occurring prior to age 75, which is the average life span. Because these deaths are considered premature, they provide a useful measure of a community's health status. Miami-Dade says it is on track to match its best national peers in this measure.

Advocating for the Public's Health on Capitol Hill

From the start of her career working in a hospital emergency room and in inner city clinics in Philadelphia, **Ellen-Marie Whelan, RN, PhD**, witnessed close-up the unintended consequences of government health policies. This led her to question the reasoning behind Medicaid reimbursement rules and to pursue further study. After completing a PhD degree in health policy and a postdoctoral research project at Johns Hopkins University, Whelan had acquired the tools she would need to address these problems in the policy arena.

In 2003, she was awarded a Robert Wood Johnson Foundation Health Policy Fellowship and assigned to the office of Senator Tom Daschle (D-SD). After a year on Capitol Hill, Whelan made a long-term commitment to



Ellen-Marie Whelan with U.S. Senator Tom Daschle

on Health, Education, Labor, and Pensions. In that capacity, she contributed to the passage of a bill reauthorizing funds for breast and cervical cancer screening and helped shape legislation reauthorizing the Food and Drug Administration.

“As a nurse and a researcher, I was able to incorporate key recommendations from the Institute of Medicine such as making information about recently approved drugs available to

polymaking. She joined the staff of Senator Barbara A. Mikulski (D-MD), as staff director for the Subcommittee on Retirement and Aging, a part of the Senate Committee

the public via the Web in a timely fashion.”

In the coming years, Whelan hopes to influence policy on health care reform. “Having cared for patients and researched these issues, I bring a different perspective to the dialogue about how we deliver care.”

RWJF fellowships are just one way that nurses can get involved on Capitol Hill. Many congressional offices welcome health professionals, including nurses, to spend a year assisting their representatives as health legislative aides. Some offices also welcome nursing students for brief internships, and professional organizations typically provide opportunities for their members to influence health policy at the federal level. Three former nurses are serving in Congress today, Lois Capps (D-CA), Eddie Bernice Johnson (D-TX), and Carolyn McCarthy (D-NY).

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By 2007, 94 percent of customers said they would recommend MDCHD services to others; employee satisfaction had risen from a low of 32 percent at the time of the department's first self-assessment to 77 percent; and MDCHD's transformation had inspired like-minded efforts throughout the state.

In 2005, the Florida Department of Health replaced its quality assurance process with a performance improvement model that allows county health departments to systematically assess their performance and plan for and manage their own improvement efforts. In contrast to quality assurance programs that emphasize moni-

toring and corrective action, this performance improvement initiative casts the state health office as a supportive partner providing technical assistance and resources. Through its Office of Performance Improvement, Florida has created assessment tools that allow counties to chart their progress on a common set of metrics. Reports

compare county statistics with state averages and reveal trends over time.

The Robert Wood Johnson Foundation has awarded Florida

a grant so it can share its quality improvement models with peers from other states. Adopting performance improvement practices is expected to facilitate the future accreditation of local health departments, a move that many believe will lead to substantial improvement in the provision of public health services nationally.

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