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Public Policy and the Legislative Process

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Key Concepts

1. Legislation at the state and national levels can greatly influence the ongoing careers of professional nurses. The consequences of nurses' nonparticipation in the legislation process are that someone else influences legislative decisions on health care in which nurses should have played a major role or that nursing issues are overlooked altogether.
2. In an annual honesty and ethics survey, the Gallup social research organization has found nurses outrank all other professions year after year.
3. The Medicare End-Stage Renal Disease program is responsible for oversight of access, quality, and cost issues related to health care of patients with CKD stage 5 needing kidney replacement therapy.
4. The three branches of the federal government – executive, legislative, and judicial – were designed in the U.S. Constitution to ensure a central government in which no individual or group gains too much control.
5. A bill faces difficult odds in winding its way through the House and Senate. Typically, in a 2-year session of Congress, about 10,000 bills are introduced and less than 500 of them become law.
6. It is difficult and time consuming to translate an idea for legislation into law due to our complicated system. This was the intention of our Founding Fathers, who envisioned a minimal role for the federal government.
7. The increasing complexity of public health issues has forced lawmakers to rely heavily on the expertise and opinions provided by nurses and other healthcare professionals.
8. Influencing the legislative process involves educating legislators and staff on healthcare issues. These are not foreign concepts to nurses who spend their days educating patients and colleagues, marketing ideas to physicians, and selling good health practices to patients.

In health care, as in most sectors, the only constant is change. These are years of rapid change in health care. Nurses face many challenges and have many opportunities to participate in and influence the formation of health policy. As citizens, nurses can become very effective in their lobbying efforts, whether on the federal, state, or local level. When nephrology nurses are visible and armed with information about the issues, key players, and the processes, they can be powerful advocates for change.

In the United States, the End-Stage Renal Disease (ESRD) program is a story of access, cost, and quality, the three-policy issue areas related to health care. While separate and distinct, these areas are inextricably linked. Access was created with the passage of legislation and today refers more to beneficiaries' access to quality care than to treatment itself. Cost quickly became an issue due to the growing number of beneficiaries and continues to be dealt with in legislation that addresses coverage and regulations that determine payment policy for covered items and services. Quality has moved far beyond the basic structure and process-oriented conditions of participation or coverage in the Medicare program and is now defined and measured in terms of clinical outcomes.

For nurses working in nephrology, the ESRD program exists because a bill was introduced responding to a recognized need in communities that was brought to the attention of legislators and was supported by the medical and scientific community of the time.

As the largest group of healthcare professionals caring for individuals with chronic kidney disease (CKD), the responsibility of nurses to continue the tradition and advocate for the future health of the ESRD program should be clear. The nonlicensed staff, certified clinical hemodialysis technicians, play an integral part of delivering care to dialysis patients and advocate on the patients' behalf to the healthcare professionals.

The purpose of this chapter is to introduce nephrology nurses to some of the current policy issues related to the ESRD program, the legislative process, and the importance of its role in the development of public policy.

Contemporary Issues in Chronic Kidney Disease

Access to Care Issues

The Medicare Beneficiary Improvement and Protection Act (BIPA) of 2000 required the General Accounting Office (now known as the Government Accountability Office) to study the access of Medicare beneficiaries to dialysis services (U.S.

Government Publishing Office, 2000). The study was to determine if there was a sufficient supply of facilities, whether Medicare payment levels were appropriate to ensure continued access to such services, and to improve access and quality of care that could result in the increased use of long nightly and short daily hemodialysis modalities. The report, *Medicare Dialysis Facilities: Beneficiary Access Stable and Problems in Payment System Being Addressed*, found that patient access to care appeared to be adequate, although there was less access to home dialysis (General Accounting Office, 2004). They also noted that the reimbursement system was in need of change.

Reimbursement changes were explored when the Centers for Medicare and Medicaid Services (CMS), the agency in the U.S. Department of Health and Human Services (HHS) responsible for managing the two federal programs, used demonstration projects in 2006 to redesign the prospective payment system. This system bundled the costs of services, including separately billable drugs, into one payment amount.

CMS noted that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary of HHS to report to Congress on the necessary elements for a broader case-mix adjusted prospective payment system and to conduct a 3-year demonstration project beginning January 1, 2006, that uses such a payment system. Throughout the decade of 2003–2013, changes to the prospective payment system were proposed. The American Nephrology Nurses Association (ANNA) has been involved with others in the nephrology field to advise about the feasibility and effect of such changes.

Population changes may affect access to care. In the United States population of people over age 20, the incidence of CKD decreased from 1998 through 2004 and has been stable at 12% to 14% of the population through 2012 (USRDS, 2015).

CKD can, but does not always, lead to the need for kidney replacement therapy. By the end of 2013, only 0.2% of the population over 20, or just over 661,500 cases of CKD 5D, had been reported (USRDS, 2015). A number of current federal public health initiatives related to obesity and diabetes are targeting the long-term effects of those conditions on kidney function and, if successful, may lead to some reduction in this incidence.

Access to nephrology professionals, nephrologists, and registered nurses is a related concern. The specialty of nephrology is in transition, with fewer new physicians entering nephrology for a variety of reasons. The supply of nephrologists is not evenly spread across the country and does not reflect the distribution of patients with kidney diseases. In addition, nephrologist participation in interprofessional care, including use of nurse practitioners and physician assistants, lags behind that of other specialties in internal medicine (Salsberg et al., 2015).

Over several years, there have been concerns about the nursing workforce as it ages. However, in recent years, there has been an increase in younger nurses. To illustrate, in 1988, half of the nursing workforce was under 38 years of age; by 2004 that figure rose to 46 years and was not changed by 2008. This slowing of the trend in aging resulted from an increase in employed RNs less than 30 years of age, the first increase seen in this age group since federal workforce studies started in 1977 (HRSA, 2008). There is a continuing concern about the number of experienced nurses approaching retirement age. These workforce issues raise concerns about patient access to quality care by experienced nephrology clinicians.

On the state level, where nursing practice is regulated, nurses have faced legislative issues addressing nurse–patient staffing ratios, mandatory overtime, the scope of practice for licensed practical nurses and advanced practice nurses, and delegation authority to unlicensed assistive personnel. Specific to the dialysis setting, a number of states have taken action to regulate dialysis technicians or address their practice specifically within the scope of RN and LPN delegation authority (O'Keefe, 2014). It is expected that such state-level activity will continue into the future and that nurses will need to educate state nurses' associations, state boards of nursing, legislators, and other groups about their specific clinical practice areas and how these attempts to protect citizens can be meaningfully applied.

The population affected by CKD 5D merits scrutiny as this can affect policy developments. From 1980 through 2000, the incidence of CKD 5D had been rising in the United States. Reviewing current data, the adjusted incidence rate of 352 per million/year in 2013 was the lowest since 1997. This rate has been roughly stable from 2000 to 2013, and the mean age for diagnosis ranges from 60 to 65 years. Among those aged 45 to 74, the number of cases of CKD 5D continues to rise, while the number of cases for people 75 and over has been generally stable (USRDS, 2015).

Nurses should be aware of population changes and continue to advocate for policies that meet the needs of vulnerable subsets of patients with CKD. A useful reference document titled *Annual Data Report*, issued by the United States Renal Data System (USRDS), includes detailed information about this population (USRDS, 2015).

Cost Issues

As documented by the *2013 USRDS Annual Data Report*, the National Institute of Diabetes and Digestive and Kidney Diseases and the CMS Annual Facility Survey, the rate of existing CKD 5D cases has increased each year since 1980 through 2001, though the rate has stayed somewhat flat from 2001 through 2009. Based on the most current data, over 871,000 patients were being treated for CKD 5D as of the end of 2009, nearly 381,500 of them on dialysis (USRDS, 2013). Between 1980 and 2009, the prevalent rate for CKD 5D increased nearly 600 percent, from 290 to 1,738 cases per million population.

The changes in the number of patients remains the driving force behind the overall changes in ESRD program expenditures. Variation in Medicare expenditures per patient year can arise from a number of causes, such as the actual care provided to patients with CKD 5D, changes in the types of patients who are being treated (older, more people with diabetes, hypertension, etc.), changes in costs to Medicare for specific services, and changes in Medicare billing practices.

Total spending in the United States for ESRD in 2011 from all sources was over $29 billion, a 3.17% increase over

2010; Medicare ESRD spending totaled over $28 billion. Listed below is Medicare spending per person per year 2011.

- ESRD total – $75,670
- hemodialysis (HD) – $87,945
- peritoneal dialysis (PD) – $71,630
- transplant – $32,922 (excludes cost of organ procurement)

On a per-patient-per-year basis, the cost increased 0.76% between 2010 and 2011. This stabilization in payments per patient is related primarily to the bundle payment system and the QIP (USRDS, 2013).

The ESRD program covers less than 1% of all Medicare beneficiaries, but in 2002 it consumed nearly 7% of the Medicare budget. Clearly, a disproportionate share of Medicare expenditures is spent on Medicare ESRD beneficiaries. ESRD beneficiaries cost an average of at least five times more than beneficiaries in other categories:

- $6,211 is spent per aged beneficiary (greater than 65 years of age)
- $4,751 per disabled beneficiary (non-ESRD)
- $34,709 per ESRD beneficiary

Average Medicare spending per beneficiary is $6,301 (Medicare Payment Advisory Commission [MedPAC], 2005).

Diabetes is a significant disease contributing to CKD in the United States and the world. In 2012, 9.3% of the population, or 29.1 million Americans, had diabetes. For those Americans age 65 and older, almost 26% of the population had diabetes (Centers for Disease Control and Prevention [CDC], 2014). While not all individuals with diabetes develop CKD, these numbers have considerable impact on the need for kidney replacement therapy.

Disproportionate Medicare spending and the potential growth of population in need of services will keep the ESRD program under the close scrutiny of legislators and CMS personnel. Alternative payment mechanisms, such as an expanded bundle of services included in the composite rate payment for dialysis, continue to be explored. Nurses will have to be diligent in evaluating the impact and effectiveness such alternatives are likely to have on their workplaces and on patient care delivery and outcomes and in sharing that evaluation with policymakers.

Quality Issues

Policy actions to ensure healthcare quality have been far less frequent or significant than actions to increase access to care or to decrease healthcare costs, making it the least visible aspect of the cost–access–quality policy triangle (Cherry & Jacob, 2017). This began to change in 1996 when President Clinton established the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This 32-member body was charged with making recommendations to the president on how to preserve and improve quality in the healthcare system.

Building on that work, in 1999 the Institute of Medicine (IOM) Committee on Quality of Health Care in America released a highly publicized report, *To Err is Human – Building a Safer Health System.* It suggested that as many as 95,000 people die annually in U.S. hospitals due to healthcare errors. In spring 2001, the same IOM committee released its final report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* which made recommendations for achieving fundamental quality improvements in health care. Many of the recommendations addressed issues relevant to nursing, such as licensure and scope of practice. Other recommendations related to changing reimbursement patterns were applicable to the nephrology setting.

Specifically, the 2001 report noted that current payment methods did not lend themselves to an environment of improved quality of care because there is little incentive to address overuse and misuse of services. To address these inherent flaws, the report advocated that providers able to demonstrate improved patient outcomes be properly rewarded for doing so.

In its March 2004 Report to Congress, the MedPAC recommended that Congress establish a quality incentive payment policy for physicians and facilities providing outpatient dialysis services (MedPAC, 2004). The Commission rightly pointed out that the outpatient dialysis sector is a ready environment for tying quality measures to payment in that:

- Outcome measures are available that are evidence based, developed by third parties, and agreed upon by the majority of providers.
- CMS can collect provider-specific information without excessive burden on providers.
- Measures can be adjusted for case mix so providers are not discouraged from taking riskier or more complex patients.
- Many providers can still improve upon some of the measures.

However, MedPAC supported funding the quality payment by setting aside a small proportion (2%) of physicians' and facilities' payments as a means to motivate investment in better care.

Following the report, Sen. Max Baucus (D-MT), ranking Democrat on the powerful Senate Finance Committee that has jurisdiction over Medicare, introduced legislation (S.2562, https://www.congress.gov) which, among other things, would have implemented the MedPAC and IOM recommendation. ANNA did not support the legislation because it was felt that the current dialysis composite rate was not sufficient for most providers to be reduced by the proposed 2% without putting access and quality care at risk.

The heightened interest in health policies that promote quality and protect consumers is likely to continue, and nurses have expertise to bring to this critical aspect of the policy debate.

Coming Together Around Access, Cost, and Quality

Overview: Brief History of Medicare ESRD Reimbursement

Over the past three decades, we have seen many changes within the Medicare End-Stage Renal Disease (ESRD) program, which has provided access to lifesaving therapy to over 20 million people with CKD and has given hope to individuals who would otherwise face certain death. One in 10 American adults, more than 20 million, has some level of CKD (CDC, 2014).

The enactment of the ESRD program provided a guarantee of federal payment for dialysis and transplantation, and coupled with private insurance coverage that followed, an

industry was spawned that has expanded access to KRT for all those in need. Fixed dialysis reimbursement throughout the history of the program has led to efficiencies in care delivery, technologic improvements, industry consolidation, and vertical integration in a number of provider companies and has affected the mix of registered nurses in staffing patterns. Medicare coverage for immunosuppressive drugs after transplantation for 3 years was the program's first foray into coverage of outpatient medications.

When Medicare was first established in 1965, it did not provide coverage for individuals needing KRT. At that time, kidney failure was a fatal disease, as treatment was not available outside of a limited number of clinical study centers. Once it was clear that dialysis could be performed as a chronic therapy, lack of insurance coverage became a barrier to treatment. This led to the passage of the Medicare ESRD program. The following provides a brief history of some of the major changes in reimbursement for the Medicare ESRD program since its enactment in 1972.

Social Security Amendments of 1972 (P.L. 92-603) In October 1972, Congress passed the Social Security Amendments of 1972. Under this Act, Congress changed the Medicare law to extend coverage to individuals who were under 65 years of age, had CKD 5D, and had (or were the spouse or dependent of someone who) worked long enough to qualify for Social Security. Such coverage became effective July 1, 1973. Medicare's payment policy for outpatient dialysis from 1973 to 1983 limited reimbursement by a payment ceiling of $138 per treatment. Like other Medicare Part B benefits, Medicare pays 80 percent of the allowable rate.

ESRD Program Amendments of 1978 (P.L. 95-292) The ESRD Program Amendments of 1978 included several new provisions for the ESRD Program to encourage home dialysis and eliminate some of the existing financial disincentives to transplantation. These changes provided for immediate Medicare entitlement (without a 3-month waiting period) for people who chose self-dialysis or transplantation as their initial treatment modality. The law also provided for the implementation of a prospective reimbursement method for dialysis payment and extended Medicare transplant benefits from 12 to 36 months posttransplant.

Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) The ESRD provisions of the Omnibus Budget Reconciliation Act of 1981 again called for the establishment of a prospective payment system for outpatient dialysis to include a single rate to cover all supplies and services associated with a routine dialysis treatment. Other provisions modified rules to make Medicare the secondary payer to employer group health insurance for the first 12 months of Medicare entitlement. Pursuant to this law, the prospective "composite rate" payment system was implemented. It established a per-treatment payment rate, adjusted for geographic wage differences. This averaged $123 per treatment, down from the prior $138 rate, with a slightly different rate for hospital-based programs. For the first time, home and in-center dialysis treatments were paid at a single base composite rate, which was intended to be an incentive to promote home dialysis.

Medicare Modernization Act (MMA) of 2003 (P.L. 108-173) The MMA contained the most far-reaching changes to the ESRD program since its creation. There were no changes to reimbursement in 2004, but in 2005 the composite rate was increased by 1.5%. The MMA changed the way the Medicare program reimbursed facilities for the cost of separately billable dialysis-related drugs and biologics, basing payment on the Average Sales Price (ASP) plus 6%. To prevent a major reduction in reimbursement related to this change in drug payment, in 2005 Medicare began augmenting the composite rate payments with a drug spread "add-on" – the historical difference between Medicare payment and provider acquisition cost, which was to be adjusted annually beginning in 2006. MMA case-mix adjusted the composite rate for beneficiary age, body surface area, and low body mass index. The MMA also called for a report by the Secretary of Health and Human Services on a fully bundled dialysis prospective payment system (PPS) to incorporate all the formerly separately billable items and services into the dialysis payment.

Medicare Improvements for Patients and Providers Act (MIPPA) 2008 (P.L. 110-275) MIPPA required Medicare to establish a full PPS for ESRD services to include the composite rate components, plus injectable drugs and biologics and their oral equivalents, laboratory tests previously paid for separately, and renal-related oral medications. MIPPA also eliminated the differential payment between independent and hospital-based dialysis programs. The law called for an annual update to the PPS payment rate; this update was 1% for both 2009 and 2010.

Beginning in 2012, the PPS base rate was to be increased annually by an ESRD market basket percentage increase factor, minus 1%. The PPS "bundle" was implemented in 2011, reducing payment by 2% at the outset, in anticipation of efficiency gains by providers under the PPS system. The base rate was $229.63 before wage adjustment. Some adjusters were included at the patient level and the facility level as well as a home training add-on payment. MIPPA also required ESRD providers to meet certain quality metrics, to be defined annually.

This Quality Incentive Program (QIP) went into effect in 2012 and was the first pay-for-performance program in the history of Medicare. The purpose of the QIP was to incentivize providers to continue to provide high quality care and protect patients from potential cuts to quality of care that might occur with the changes in the reimbursement system. Facilities that fail to meet the minimum scores on the defined metrics may lose as much as 2% of their total Medicare reimbursement for a payment year. The initial QIP included three clinical measures related to dialysis adequacy and anemia management. Clinical and reporting measures are published annually through notice and comment rulemaking for the following year.

The American Taxpayer Relief Act of 2012 (ATRA) (P.L. 112-240) Under ATRA, Medicare is required to recalculate the dialysis bundled payment rate for 2014 to account for changes in use of drugs and biologics as a result of the PPS. This law delayed inclusion of oral drugs into the ESRD PPS and required providers to report monitoring of bone and

mineral metabolism to CMS. The Protecting Access to Medicare Act of 2014 (PAMA) amended ATRA to delay payment for ESRD-related oral-only drugs until January 1, 2024.

Kidney Care Partners In 2003, the members of the kidney care community formed an alliance, Kidney Care Partners (KCP), a coalition of patient advocates, healthcare professionals, providers, and suppliers. They were all united in a mission, individually and collectively, to ensure that patients with CKD receive optimal care and are able to live meaningful lives, that dialysis care is readily accessible to all those in need, and that research and development leads to enhanced therapies and innovative products (www.kidneycarepartners.com).

KCP was the first broad-based kidney community stakeholder group in the history of the ESRD Program. ANNA was one of the first organizations to join KCP and has played an active role in the coalition's efforts since that time. The major initiative for 2003 was to have an annual update to the composite rate included in the Medicare prescription drug legislation that seemed destined to move through the Congress that year.

Unsuccessful in that attempt, in 2004 the KCP member organizations prepared a more extensive agenda, this time adding other issues of access, cost, and quality in their legislative agenda. After months of defining and negotiating the elements, KCP was successful in getting the ESRD Modernization Act of 2004 introduced in both the House of Representatives and the Senate (H.R. 4927 and S. 2614, respectively) to address their identified concerns (https://www.congress.gov).

These bills did not advance in 2004, as there was no Medicare legislation that year, given the passage of the landmark Medicare prescription drug legislation the year before. They "died" with the close of the 108th Congress at the end of 2004.

Undaunted and committed to its goals, KCP was successful in getting legislation, the Kidney Care Quality and Improvement Act (H.R. 1298 and S. 635), reintroduced in 2005 (https://www.congress.gov). This legislation, like its predecessor, called on Congress to:

- establish an annual update framework for the ESRD composite rate
- create public and patient education initiatives to increase awareness about CKD
- provide Medicare coverage for CKD education services for Medicare-eligible patients
- improve the home dialysis benefit
- align the incentives for reimbursement for vascular access surgery with the stated clinical goal to promote creation of native fistulae
- establish a demonstration project to test outcomes-based ESRD reimbursement systems
- evaluate the effect of the 2003 physician reimbursement changes for nephrologists

A recent innovation in patient care involves the ESRD Seamless Care Organization (ESCO) project. In the model for ESRD, dialysis clinics, nephrologists, and other providers join together to create an ESCO to coordinate care for matched beneficiaries. ESCOs are held accountable for clinical quality and financial outcomes measured by Medicare spending, which includes funding for dialysis services and their aligned ESRD beneficiaries. Through this model, dialysis providers are encouraged to think beyond their usual roles in care delivery, and it supports them as they provide patient-centered care addressing beneficiary health needs, both in and outside of the dialysis clinic.

In coming together around access, cost, and quality, it is important for nurses to focus on health policy initiatives that may impact their daily work with patients with CKD: their workplace, their individual practice, and the quality of life for their patients. ANNA strives to be informed on initiatives about nephrology care and keep its members up to date. ANNA contracts with a lobbying organization in Washington, DC, to assist in this effort.

The Importance of Action

In 1791, the first amendment to our U.S. Constitution was adopted, which guarantees freedom of speech, the right to assemble, and the right to petition the government. In the 19th century, famed historian Alexis de Tocqueville noted the importance of actions by private citizens in fostering the health of a democratic society (Mansfield & Winthrop, 2000). Active participation in government today is no less important than it was in previous centuries.

There are many ways to participate in government, and the single most important activity in our democracy is exercising the right to vote. An informed voter is familiar with the candidates or issues and the potential impact of the candidate's election or passage of a referendum. Other ways to be part of government involve participating in campaigns, helping organizations that support or oppose legislative issues, contacting legislators about issues, and providing testimony at legislative hearings.

Legislation at the state and national levels can influence the ongoing careers of professional nurses. Every state's nurse practice act controls nursing education and practice. These laws can be amended, eliminated, or drastically rewritten in the state legislatures. Special interest groups can have an impact on nursing practice, even if the groups do not include nurses. In addition, proposed or passed legislation involving health care, social issues, or general education can impact the population with which nurses work. Nationally, previous or current legislation such as Medicare, Social Security, health insurance reform, healthcare research or education funding, and labor relations can all affect nursing practice.

Keeping in mind that nursing is a predominantly female profession and that women only obtained the right to vote in 1924, it becomes easy to understand that nursing is barely out of its infancy in terms of developing its full potential in this area. Nurses still have a tendency to underestimate their strength in influencing legislation. However, over the years there has also been increasing recognition that nurses must become involved in legislative issues. The consequences of nonparticipation are that someone else influences legislative decisions on health care in which nurses should have played a major role or that nursing issues are overlooked altogether. For example, nurses were not involved in the drafting of Medicare legislation which, when enacted in 1965, did not include any reimbursement mechanisms for nurses.

There are over 3.4 million nurses in the United States, and as a group, they can have considerable impact on laws governing the country and those affecting health care. In its annual honesty and ethics survey, the Gallup social research organization has found nurses outrank all other professions. This has been true for over a decade (Riffkin, 2014).

Nurses can use this credibility; they are viewed as honest and knowledgeable advocates for health issues. Nurses have been elected to office in several states and the U.S. Congress. Nursing students have been active in legislative affairs, providing testimony on federal funding for nursing education and passage of state child abuse laws. Several professional nursing organizations keep their members apprised of current issues and concerns.

In recent years, nephrology nurses have played a major role in educating local, state, and federal legislators about dialysis and transplantation by inviting them to visit their workplaces as part of ANNA's ESRD Education Initiative. With the support of their employers and working with other professional colleagues, nurses have been the central figures in increasing the awareness and understanding of policymakers and their staff about CKD and the ESRD program. This increased activity in the political arena is important, and it is essential that it continue. Building on the public's trust in the profession, nurses have the potential to be even more influential in policy and legislative issues. Understanding the legislative and policy development processes is foundational to building nursing strength in this area. The next several sections are included to improve this understanding.

Structure of the Federal Government

The U.S. Constitution designates three branches for the federal government: legislative, executive, and judicial. Three branches are designed to ensure a central government in which no individual or group gains too much control. The legislative branch includes Congress, which makes laws. The executive branch includes the president, vice president, and the Cabinet, which carry out laws. The judicial branch includes the Supreme Court and other federal courts, which evaluate the laws.

The federal government has a system of checks and balances to act in the best interests of U.S. citizens. Each branch can influence or change acts of the other branches. For example, the president can veto laws passed by Congress, Congress can override a presidential veto, and Congress can pass new laws to supersede an unpopular Supreme Court decision. In other examples, Supreme Court justices can overturn laws deemed unconstitutional, and the Senate can reject presidential appointments to the Cabinet.

Executive Branch

This branch encompasses the office of the president, vice president, Cabinet, executive departments, independent agencies, and other boards, commissions, and committees. The president and vice president can be elected or re-elected every 4 years. The president can be elected no more than twice, while the vice-president can serve an unlimited number of 4-year terms.

Key activities of this branch include the president serving as head of state, leader of federal government, and commander-in-chief of the U.S. Armed Forces. The vice president supports the president and serves as president if the president is not able to serve. Cabinet members advise the president and include heads of executive departments. Cabinet members are nominated by the president and approved by the Senate. Within the executive branch, responsibility for health policy lies with the Department of Health and Human Services (HHS). Within HHS, Medicare and Medicaid programs are managed through the Centers for Medicaid and Medicare Services (CMS).

Legislative Branch

The primary responsibility of this branch is to develop laws and confirm or reject presidential appointments. The Legislative branch, or Congress, is bicameral, meaning it has two chambers: Senate and House of Representatives. Congress has the authority to declare war and the Senate advises the Executive branch on treaties. Members of Congress are elected, and they have a responsibility to respond to the needs of the people as they develop bills that become federal laws. There are 100 senators, two per state. A Senate term of office is 6 years with no limit for re-election. There are 435 representatives, distributed among states according to population. Additional nonvoting delegates represent the District of Columbia and U.S. territories. A representative serves a 2-year term with no limit for re-election.

Judicial Branch

The judicial branch interprets the meanings of laws, applies laws to individual cases, and decides if laws violate the U.S. Constitution. This branch comprises the Supreme Court and other federal courts. There are nine justice positions on the Supreme Court, and justices are nominated by the president, approved by a Senate majority of at least 51 votes. There is no term limit for Supreme Court justices. They serve until their death, retirement, or removal in exceptional circumstances.

Other federal courts. The Constitution grants Congress the authority to establish other federal courts.

How a Bill Becomes Law

Nurses have long been involved in the drafting of policy and the procedures to carry them out within their employer organizations. National health policy is crafted in much the same way. At the federal level, however, such policies are written in the form of laws passed by Congress. The procedures for carrying out these laws are expressed in federal regulations and published in the Federal Register.

A bill faces difficult odds in winding its way through the House and Senate. Typically, in a 2-year session of Congress, some 10,000 bills are introduced. Less than 500 of them become law. The only measures assured of passage are those that provide annual funds that keep the government operating, and sometimes they aren't passed on schedule. Otherwise, it takes strong White House support or the support of a substantial number of lawmakers for a bill to survive.

A bill can be introduced in either house of Congress, or

it can be introduced in both houses simultaneously. Anyone can initiate a bill. It is a citizen's demand for action, and it can originate from an individual who takes his ideas to a legislator, or it can originate within and be put forth by a special interest group, such as the KCP example stated earlier in this chapter. Obviously, the larger and more politically active the group is, the better chance they have of being heard. If there are several such groups representing even more citizens (that is, voters) with an interest in the issue, they may come together as a coalition in support of or in opposition to a legislative proposal and have even more clout.

In addition to individuals and special interest groups, some common originators of bills are a governmental administrator, agency, or department; a delegation of citizens in a legislator's district; a legislative committee; or a legislator. Many more citizens involve themselves in responding to legislation that has already been introduced than are involved in the initial introduction of a bill.

Committee Structure

Much of the work of Congress occurs in the House and Senate committees, each with jurisdiction over certain areas of law. Committees are further divided into subcommittees. Virtually all bills are sent to these panels after introduction, and many die there as a result of inaction.

The two major committees in the Senate that have jurisdiction over health care and oversee the activities of the HHS are (1) the Finance Committee and its Subcommittee on Health, with jurisdiction over Medicare and Medicaid, and (2) the Health, Education, Labor, and Pension Committee, which authorizes programs under the Public Health Service Act, including federal funding of nursing education and research, National Institutes of Health programs, and the Centers for Disease Control and Prevention.

In the House of Representatives, there are also two major committees that are primarily responsible for health issues. The Energy and Commerce Committee, Subcommittee on Health, which among other things, authorizes the programs under the Public Health Service Act, has jurisdiction over Medicaid, and shares jurisdiction for Medicare Parts B, C, and D with the Ways and Means Committee, Subcommittee on Health. The latter has exclusive jurisdiction over Part A (hospital insurance).

In both houses, the appropriations committees, subcommittees on Labor, Health and Human Services, and Education, are responsible for yearly appropriations for health items in the federal budget, except the entitlement programs (like Medicare or Medicaid). Other committees in both houses, such as the budget committees, affect healthcare issues in their work.

Subcommittee Work

Once a committee takes up a bill, it usually holds public hearings. At this time, the members of the committee hear testimony from the bill's sponsors, administration officials, expert witnesses, and interest groups. Written testimony can be submitted for the record by a group or individual that is not asked to participate at the hearing.

The next step in the process is for the bill to go to "markup," which is a committee session during which the legislators go over the proposal line by line and vote on amendments, or changes. The committee then considers the bill. The outcome is to do one of the following:

- Approve the bill (report it out to the full committee) with or without amendments, some of which can change the nature of the bill completely
- "Kill" or stop action on the bill
- Draft a new bill to accomplish the same goal but in a different manner

The subcommittee to which a bill is referred is the first place where its fate can be influenced. If the bill is never put on the committee agenda or is not approved, it will generally not proceed further. The chairman, always a member of the majority party in that chamber, has the power to keep the bill off the agenda or to introduce it early or at a favorable time.

To get the desired action, which may be any of the above, interested persons or groups begin their legislative action at this point. All members of the subcommittee, especially the chairman, are important targets for the individuals or organizations interested in the outcome of the legislation. Individual members of these organizations whose legislators sit on the subcommittee may be asked to contact their legislator because of the influential position he or she has over the fate of the legislation at this point. Letters, phone calls, fax messages, emails, and personal contacts are used to reach the chairman and other committee members.

Committee Work

The same process outlined for subcommittees takes place at the full committee level, the next step in the legislative process for a bill that is reported out of the subcommittee. Opportunity for citizen/organization action occurs in the same way, focusing this time on the chairman and members of the full committee.

A bill that survives committee action can then be scheduled for action "on the floor," meaning the total membership of the body. Under certain circumstances, amendments may be proposed at this stage and are approved or rejected by the majority of those assembled.

House and Senate Action

In the House, most bills approved by committee proceed to the Rules Committee to determine how the bill will be handled on the House floor, how much time will be allotted for debate, and whether amendments will be permitted. The majority leader, who is chosen by the majority party, decides whether or when to call up a bill for action. Members are given a limited amount of time to speak for or against the measure. Most issues are dealt with in a few hours.

In the Senate, bills approved by committees go directly to the calendar and are taken up whenever the majority leader of that body decides to call them. There are fewer limits on debate in the Senate than in the House, and rules allow members to speak twice for as long as they want on any issue before the Senate.

In light of this, to speed action on a bill, the majority leader may seek "unanimous consent" to vote at a certain time. If a member objects to this, a motion to limit debate (and therefore prevent a bill's opponents from "filibustering") may be offered. The procedure, called cloture, requires 60 affirmative votes. This is often difficult to obtain on

closely divided issues. The majority leader rarely proceeds on an issue that they want to succeed until he is assured of at least 60 votes.

The Voting Process

Roll-call votes in the House are cast electronically, each member using a plastic card and inserting it in terminals located throughout the chamber. The Senate still votes by voice; each senator replies "aye" or "nay" as the roll is called. After a bill passes one chamber, it is sent to the other for a complete repetition of the process it went through in the first chamber.

Conference Committee

The bill is sent to a conference committee for one of two reasons: (1) if the bill passed by the House and the one passed by the Senate on the same subject are not the same, or (2) if the bill has been amended by the second chamber after passing the first, and the first chamber does not agree with the amendments.

This committee consists of an equal number of members of each chamber, the "conferees," and usually includes members from the committees who originally handled the bills. Once the members of the conference committee are named by the leadership, opportunity for citizen action begins again.

The conference committee attempts to work out a compromise that will be accepted by both houses. Sometimes, however, the conferees are not able to arrive at a compromise and the bill dies, but usually an agreement is reached. The conference report issued by the committee when it achieves a compromise is sent to both chambers for vote. The compromise bill must be approved by each chamber before it is sent to the White House for action by the president.

Presidential Action

After passing both chambers, a passed bill goes to the Oval Office. If the president approves it or fails to take action within 10 days, the bill becomes law. If Congress is not in session, and the president does not sign the bill within 10 days, it does not become law. This is known as a "pocket veto." The president may veto the bill outright and return it to the chamber of origin. A two-thirds affirmative vote in both chambers is necessary to override the veto. Voting on a veto is often along party lines.

It is easy to understand why it is so difficult and time-consuming to translate an idea for legislation into law with such a complicated system of checks and balances provided by the due process of law in the U.S. democratic government. Additionally, extreme political pressure from within the government and the external influence of individuals and special interests play a big part. This was the intention of our Founding Fathers, who envisioned a minimal role for the federal government and a more primary role for the states, as they created a true representative government.

Federal Budget Process

In early February each year, the president is required to submit the budget request to the Congress. This document represents a year of work by agency officials who channel their budget requests up to the cabinet level and through the Office of Management and Budget. It is their responsibility to reconcile the requests with the president's programs. Within 6 weeks after receiving the president's proposed budget, all standing House and Senate committees submit their views and estimates of expenditures for the coming year for programs under their jurisdiction to their respective budget committees. The House and Senate budget committees set economic priorities and make spending recommendations to the appropriations and tax committees.

Each spring Congress is required to pass a budget resolution that limits the level of funds that appropriations committees can approve. The resolution establishes a number of things, including targets for and ceilings on total federal spending and budget authority, targets for appropriations and other forms of spending in the budget, and a floor on total revenues. Once approved by Congress, the resolution serves as a guide to the appropriations and other spending committees on the amount of funding available for programs within their jurisdiction.

The annual congressional budget cycle is composed of three main processes: authorization, appropriations, and budget resolution. An authorization bill is a prerequisite for an appropriations bill. Passed through the process described above, authorizing legislation specifies the substance of federal programs and the agency that will implement them; it also establishes program policies and the program's budget limit. A program may be authorized annually or less frequently. Renewal or modification of such programs is known as reauthorization. Responsibility for authorizing most healthcare programs rests with the committees of jurisdiction, which were previously mentioned.

Once an authorization bill is enacted, meaning a program is authorized under the law, Congress must pass yearly appropriations bills to determine the actual amount of funds that will be available for the authorized program. The appropriations process also determines how much funding each department or agency receives for a specific fiscal year. If zero funds are appropriated, the program is essentially dead for that fiscal year.

Within the House and Senate Appropriations Committees there are 13 subcommittees. One of which, the subcommittee on Labor, Health, and Human Services and Education, appropriates funds for most health programs. Because the Constitution requires all revenue measures to originate in the House of Representatives, it initiates all appropriations and taxation bills. Therefore, the House Appropriations Committee plays a major role in crafting spending bills. Interest groups and agencies appeal to the Senate Appropriations Committee when they disagree with the funding decisions made in the House.

As the federal fiscal year begins on October 1, it is expected that all appropriations bills for the new fiscal year will be enacted by that date. When this is not the case, to avoid a shutdown of the federal government, a Continuing Resolution may be passed by Congress that permits federal agencies to continue to operate at their current funding level until their regular appropriations bills are enacted.

Federal Regulatory Process

Once a bill is signed by the president, the House of Representatives standardizes its text and publishes it in the United

Steps in the Regulatory Process

1. U.S. Congress passes a bicameral bill and U.S. president signs bill into law.
2. Law is assigned to a specific federal agency for regulation development.
3. Agency researches issues and proposes regulations, Notice of Proposed Rulemaking (NPRM). The supporting documents are available for review at http://www.regulations.gov/#!home.
4. The NPRM is listed in the Federal Register for public consideration and comment. The comment period can last for several months.
5. The federal agency issues draft regulations for further public review and comment.
6. The federal agency issues a final rule on the law, which carries the full force of the law, but does not exceed the scope of that law.
7. The final rule is published in the Federal Register and added to the Code of Federal Regulations (CFR). Daily updates to the CFR can be found in the electronic CFR at www.ecfr.gov.

Figure 48-1

States Code. This is the listing of all general and permanent laws of the country. The law is usually written in general terms, often not including details for how individuals, businesses, and state or local governments might follow the law. To put the law into action, regulations or rules are written by assigned federal agencies. Rules and regulations are highly important because they are supported by the force of law and provide specific details about carrying out the new law. The steps of the regulatory process are outlined in Figure 48-1.

The period of public comment, while regulations are in development, is an excellent time to influence the rules and ultimately the law. Organizations and individuals can make recommendations or gain membership on advisory committees to contribute to this regulatory process. ANNA cooperates regularly with CMS on development of regulations. ANNA members are often called on to educate key personnel about the details of nephrology nursing issues.

Setting the Stage for Legislative Action

With a basic understanding of federal government structure, the interactions of the executive, judicial, and legislative branches, and the process of a bill becoming a law, nephrology nurses have a foundation for influencing legislation. It is helpful to know the current congressional leaders including speaker of the House, president pro tempore of the Senate and majority/minority leaders of both House and Senate. These individuals are elected by their colleagues, they guide bills through the legislative process, and they act as chief advocates for the legislative agendas of their parties.

Most preliminary action on bills happens in committees; there are more than 40 in the House and Senate, with four joint committees and numerous subcommittees. Committee appointments are made by the congressional leaders, and committee chairmanships can be highly prized positions. Committee chairs have enormous influence over which bills and resolutions are passed through for consideration by the full House or Senate. Nephrology nurses involved in political advocacy should know on which committees the congressional delegates serve, and if they hold leadership positions on committees or subcommittees.

Most legislators are elected with the support of their party and have an obligation to support the party's position on issues. Legislators may have made promises to constituents and other supporting organizations for action on issues. These factors influence how legislators work on movement or stagnation of bills in the legislative process. Many legislators have a goal for re-election to the same or higher office, and their actions may be directed toward advancing to their goals.

In each congressional session, thousands of bills are introduced and legislators need information on those within their committee purview, as well as those of importance to their party, constituents, and supporting organizations. Legislative aides work in each congressional office to assist in analyzing the bills and summarizing background information. These legislative staff people can be influential in helping the legislator decide how to vote; it is important to contact them about issues pertinent to nephrology nursing.

Legislative staff come from a variety of backgrounds, ranging from recent college graduates to lawyers, accountants, and experienced policy analysts. Often the staff are those who have time to meet with individual voters, lobbyists, and groups, and often they are well acquainted with health issues. Ongoing relationships with staff can be highly effective in educating legislators about our issues. When they are in the home state, often they are the people who can visit dialysis centers or who arrange the legislator's schedule for an onsite visit. Nurses find that legislative staff usually welcome information about current nursing practice, the nursing focus of patient advocacy, and nursing workforce issues as impacted by pending legislation.

Congress is usually slow to act on many fronts, even on noncontroversial issues. Bills may have to be introduced for several sessions before they make progress. Patience can be a virtue when working with the legislature at both state and federal levels. Cultivating the relationship with congressional staff over time can result in a legislator who understands nursing issues when bills of importance to nursing are under consideration.

The Process of Advocacy

The increasing complexity of public issues has forced lawmakers to rely heavily on the expertise and opinions of professional and trade associations, as well as business, labor, and industry groups. Such expertise is provided by lobbyists, who are paid representatives of businesses and interest groups, many of which wield considerable power in legislative bodies, depending on the size and contribution power of their constituencies,

It is important to remember that individual citizens can also "lobby" for or against legislation. Although there is cer-

tain confusion about the process of lobbying, it is quite simply an attempt to legitimately influence legislators to promote or suppress proposed legislation.

Influencing the lawmaking process involves educating the legislators and staff members who decide what issues to consider in a given congressional year and who vote on those issues as they move through the legislative process. This process of influencing, or lobbying, is nothing more than educating, marketing, and selling. These are not foreign concepts to nurses who spend their days educating patients and colleagues, marketing ideas to physicians to get appropriate orders written, and selling good health habits or practices to patients. There is no special skill set required of nurses who decide they want or need to involve themselves in the legislative process.

There are numerous ways in which lobbyists attempt to influence legislators. Much is done on the basis of direct contact in personal meetings and semisocial gatherings. Lobbyists provide information to the legislators and their staff and introduce resource people to them. They are also valuable in that they keep their interest group informed about any pertinent legislation and aid the group in effective action.

Nurses and Political Action

From the foregoing, it can be seen that nurses and nursing students are major stakeholders in legislation. Whether acting as individuals or as part of groups, such as the American Nurses Association (ANA) and ANNA, they can make an impact on the political scene.

Learning to effectively communicate with legislators is essential to achieving positive results. While legislators want, and often need, to hear from their constituents, their time is limited. Carefully planned and organized contacts are usually the most effective means of communication.

Throughout history, nurses acting alone or in groups have influenced health policy and legislation. Nurses can be effective advocates for patients, families, and healthcare providers. Several strategies are necessary for effective political action. It is helpful for individual nurses to join a group that establishes a legislative agenda and works with similar groups to advance that agenda.

ANNA's Legislative Agenda

The ANNA Board of Directors determines the organization's legislative agenda, with input from all members. The Board issues letters outlining the association's official position regarding a specific piece of legislation. This letter may be sent to committees in the federal government that are working on the legislation.

To enhance political effect, ANNA belongs to the Nursing Community. Over 60 professional nursing organizations are politically active in the Nursing Community, a coalition that bands together to build consensus and advocate on a wide range of nursing and healthcare issues. Such issues cross practice, education, and research, and the Community represents nearly 1 million nurses, nursing students, and nursing faculty.

The KCP (Kidney Care Partners) is another active advocacy group, founded in 2003, and is a coalition of patient advocates, dialysis professionals, care providers, and manufacturers dedicated to working together to improve quality of care for individuals with CKD. Members include major dialysis providers, ANNA, the American Society of Pediatric Nephrology, the American Kidney Fund, and several pharmacologic organizations.

On an individual basis, elected officials at the local, state, and federal levels want and often need to hear from their constituents, but their time is limited. For this reason, it is important to develop an ongoing relationship with officials, use a variety of ways to communicate with them, and be well informed about issues. It may be helpful to remind them that nurses are voters and they are informed about health-related issues. The personal impact stories of individual citizens and constituents (voters) can be influential for decisions about rules, regulations, and laws. At the congressional committee level, contact by individual citizens can be critical. For this reason, ANNA members may be notified about issues of great interest to the association. ANNA's official position, its letter to the congressional committee, and sample letters to legislators are posted with communication links on the ANNA website.

Becoming Knowledgeable

Association Involvement

A number of ways exist for nurses to become more knowledgeable in matters of legislation. ANA and its constituent state groups take a very active role in legislation, as does the National Student Nurses' Association (NSNA). A number of specialty nursing organizations devote significant resources to get involved in the legislative issues that affect their membership and its specific patient population. The major legislative activities of the nursing associations are discussed in the local chapters of these organizations. In addition, members are kept informed about legislation through the written materials of organizations. Major nursing journals routinely report key national legislative efforts and even those on the state level that have particular significance.

Informed by the News

Another way for nurses to become more informed is by reading the news. Feature articles, news stories, and editorials may not cover narrow pieces of legislation of special interest to nurses, such as reauthorization of the Nurse Education Act or funding for the National Institute for Nursing Research, but broader bills will be reported on, such as changes in the Medicare and Medicaid programs and welfare reform.

Some newspapers and news websites list the major bills in the state legislature and in Congress, the action taken on those bills, and their current status. The votes of legislators on particular bills are also occasionally reported. This information enables readers to follow the path of a bill and see how their legislators vote in general. The League of Women Voters and other political action groups can also be a source of such information.

Familiarity with Legislators

One of the first pieces of information with which nurses need to familiarize themselves is the names of their own legislators. The easiest way is to use the Internet. For the House

of Representatives, go to www.house.gov, and for the Senate, visit www.senate.gov. Otherwise, the information can be found at the local post office, city or county clerk's office, or libraries. A local or state League of Women Voters branch is also a good source, as are the district and state nurses' association. The state nurses' associations are usually headquartered in the state capital. Registration and voting are, of course, important, since voters are more influential than their nonvoter counterparts.

Preparing for Contact

Prior to contacting legislators, it is important to do some preparation on the issue at hand and on the legislators themselves. With regard to the latter, be aware of the legislators' party affiliations and whether they have an interest in or any prior knowledge about the issue in question.

Legislators' local offices can be contacted, which are usually listed in the telephone directory online and in print. When calling, simply tell the staff what the issue is and ask if the legislator has taken a position on it or not. To call legislative offices in Washington, dial 202-224-3121 for the Senate information operator and 202-225-3121 for the House operator. Callers will be connected directly to their legislator's office, and operators will provide the direct phone number for future reference. This is still the most effective way to contact a legislator when time is of the essence, such as when an important issue is about to be voted upon.

Communicating by Letter

While this section focuses on writing a letter to a congressional representative, it applies as well to writing state assembly representatives, city council members, the governor, the mayor, or even the president of the United States. The essentials of developing a letter to influence a policy maker are the same regardless of the intended recipient.

For members of Congress, letters can be mailed, emailed, or faxed to the legislator's office. There can be delays with traditional mailing of paper letters, as they undergo scrutiny for possible poisonous materials enclosures, such as anthrax. Faxing is especially helpful if time is critical, and fax numbers are available from the legislators' offices.

The inside address and salutation should look like this:

The Honorable Full Name
United States Senate
Washington, DC 20510
Dear Senator _____:
or
The Honorable Full Name
U.S. House of Representatives
Washington, DC 20515
Dear Representative _____:
or
Dear Congressman/Congresswoman _____:

As the writer, identify yourself immediately in the opening paragraph as:

- A constituent by indicating residence
- A healthcare professional, including any relevant information that may be helpful, such as place of employment and the nature of work done, the patient population affected, etc.
- A member of a large group or coalition, such as ANNA or a state nurses' association, which suggests strength in numbers

It may be important at times, however, to differentiate between issues that are of personal interest and those of any associations you belong to. Sufficient background should be provided to establish the writer as knowledgeable and credible in the specific area or issue of interest. At the end of the paragraph, state the issue and the purpose for writing.

General Guidelines

In terms of discussing the issues, there are several rules of thumb:

Rule 1. Be specific. Use the actual bill number if known. Share the position on the issue and why the writer has come to that position. Ask for the legislator's position on this issue. If possible, include information on the local impact of a specific proposal. Tell the member what should be done. For example, should the member cosponsor the bill, add support to it, arrange hearings on the matter, or cast a particular vote? Look for the member to make a commitment and ask for a response.

Rule 2. Be succinct. Legislators and their staff have very little time, and long letters and documents will not be read. Limit letters to one page and focus on one issue per letter. Pare down support material to a concise fact sheet, double-spaced, with bullets and good statistics and information that can easily be seen "at a glance." Such material will be kept and referred to as necessary.

Rule 3. Be positive. If mentioning a problem, suggest a solution, or if a particular bill is the wrong approach, explain a better approach.

Rule 4. Be persistent. One contact probably will not be enough. Call the office a week or so after sending a letter to ask if it was received and to discuss it further with the appropriate staff member. (The staff members are assigned different types of issues. Typically, speak to the legislative assistant [LA] for health.) Ask for an appointment to discuss it with the legislator when they are in town. Keep the heat on!

Rule 5. Be courteous. It is not wise to threaten any kind of action if the legislator is not helpful. If a vote is contrary to the position, let the member know politely of the difference and remind them that nurses are members of the voting public.

Rule 6. Maintain contact. This need not be time-consuming and is important in relationship building. Send a note of thanks for a specific vote or for some activity that was held locally. Such behavior makes asking for something later a lot easier.

Rule 7. Report back. Let nursing organizations know about communication with legislators. If the legislator replies indicating support, the association leadership can use that letter in Washington to ensure that support. Sometimes

members say they cannot support a measure because they haven't heard from their constituents. Knowing that letters were sent and having copies of them can be very helpful.

Rule 8. Remember common manners. Always thank the legislator for time spent in a meeting or on the phone, or for a vote on an issue.

In closing the letter, establish oneself as a source of information and offer assistance as a resource for more information. Prepare to be called if the issue becomes a hot topic. Invite the member or the staff to the workplace if that would help illustrate the point.

It cannot be stressed enough how much letters count! Sometimes specific letters are read by the members on the floor of the House or Senate. Some letters are shared with colleagues if they illustrate a point particularly well. Members are told every day how much correspondence came in to both the district and Washington offices on a particular topic. Nurses' voices will be heard. Don't forget to spread the word to others in the workplace or personal network. Urge them to communicate as well.

The Personal Visit

Personal visits with legislators and staff members are a very effective means of grassroots advocacy. It is generally wise to be on time and stick to the agreed-upon time frame, be friendly and polite, greet the legislator with a firm handshake, and keep the visit short. As with letter writing, it is important to identify as a nurse and to offer to be a resource in the area of health care of one's expertise. Also, identify early in the meeting the purpose of the visit. Present the facts in an orderly manner, be succinct, and avoid jargon or too many statistics.

It is thoughtful to comment on any of the legislator's bills or votes of which nurses approve. It is appropriate to ask if the legislator has taken a position on the issue at hand. Most of the guidelines for letter writing are also applicable to personal visits, including making a specific request of the legislator. They may hear the legislator's position on the issue. If asked a question you cannot answer, do not lie; simply promise to get the information and provide it to them at a later date. This is one way to establish yourself as a reliable source of information that could improve access to the legislator in the future.

At the end of the meeting, establish agreement on when to follow up and with whom, and then do so. Leave a one- or two-page fact sheet that summarizes the issue and your position. Include the name and phone number of a contact person if there should be a need for further information. Leave behind a business card as well. Remember the value of saying thank-you, and follow up after the meeting with a letter thanking the legislator or staff member. Take this opportunity to reiterate your position, and include any information requested during the meeting.

Telephone Calls

Telephone calls are best for obtaining information. Lobbying calls should be kept very short. When making the call, ask for the legislative assistant who handles health issues, since this person can give the best indication of the member's position on the issue. To find out the legislator's Washington office telephone number, call the Capitol switchboard at 202-225-3121 (House) or 202-224-3121 (Senate) and ask to be connected.

History of ANNA's Involvement in the Legislative Arena

ANNA began its involvement in the legislative and regulatory arenas under the leadership and direction of Nancy Sharp during her tenure on the Board of Directors and as the association's president in 1981–1982. The association established a Government Relations Committee to formally begin its journey into these arenas. In the decade of the 1980s, the association's first Legislative policy statement appeared. That early document supported concepts such as access, quality, cost, support for increasing organ donation, the need for national standards related to dialysis supplies and water treatment, and Medicare coverage of immunosuppressive drugs. These concepts continue to be areas of concern in the 21st century.

1980s and 1990s

During the 1980s and 1990s, ANNA had an active Government Affairs Committee, which was involved in passage of the National Organ Transplant Act, establishment of the Division of Organ Transplantation in the Health Resources and Services Administration of the Public Health Service, development of the Organ Procurement and Transplantation Network, and the Scientific Registry of Transplant Recipients. From the start of its political policy activities, ANNA has supported foundational concepts such as access to care, quality of care, cost effectiveness, data collection for building an evidence base, and issues of patient responsibility. Such concepts continue to be part of ANNA's legislative agenda.

In 1985, the Nurse in Washington Internship was established. ANNA supported this professional development opportunity with planning assistance, faculty presentations, and by funding members to attend the event. This support continues to the current time and several ANNA members have benefitted from the experience.

By the late 1980s, ANNA expanded the legislative activity to include a State Legislative Representative program to facilitate grassroots lobbying beyond the national level. ANNA published a *Legislative Handbook* which was distributed to the state legislative representatives. By the early 1990s, ANNA had a legislative representative in almost every chapter across the country.

In 1992, a legislative workshop was conducted in Washington, DC, for 50 ANNA chapter legislative representatives. This workshop continues to the present time, conducted every 2 years. Throughout the decade of the 1990s, legislative work and education for members was sustained with chapter officer materials, orientation documents for the legislative representatives, and further development of the legislative representative role.

2000 through 2010

In this decade, legislative representatives evolved into Regional Legislative Advisors and participated in Regional Executive Committees. What was once ESRD Education Day

expanded into ESRD Education Week. The ESRD Briefing Book for State and Federal Policymakers was compiled for use when hosting policymakers at dialysis facilities. The Legislative Workshops continued every 2 years and in 2004, nearly 300 nurses visited their congressional delegation on Capitol Hill to advocate for nephrology nursing issues.

During these years, ANNA members began taking senators, representatives, their staff, and other government officials on tours of dialysis and transplant units so they could better understand the current nephrology policy issues. The committee was renamed in 2004 as the Health Policy Committee. At this time, ANNA's legislative and policy activities were regrouped as the Health Policy Committee. In 2008, ANNA was actively involved in the Medicare Conditions of Coverage final rule and continues to advocate for quality and accessibility of care.

An objective of this committee has been to encourage more nurses to learn about and to incorporate legislative advocacy and public policy information into their professional activities. The committee and legislative consultants keep the membership informed through publications in *ANNA Update* and *Nephrology Nursing Journal.* This includes the organization's annual legislative agenda and Legislative Policy Statements. The legislative agenda is set by the Board of Directors with input from the Health Policy Committee, and is based on the association's Long-Range Strategic Plan.

ANNA has been active with several nephrology interest groups, including ESRD networks and the KCP, as they grapple with issues of healthcare reform, quality/safety initiatives, and changes in funding for dialysis, research, and nursing education. ANNA's Board of Directors, Health Policy Committee, and legislative consultant continually monitor and respond to issues affecting nursing, Medicare, and the ESRD program, providing information to federal policymakers, regulatory agencies, and those who influence policy decisions on various government boards and commissions. This is done based on ANNA's Legislative Agenda, which is updated and approved by the Board of Directors each year. The legislative agenda is to a large extent based on the association's Long-Range Strategic Plan.

Throughout this decade, ANNA sent numerous letters of support for a variety of nephrology issues including, but not limited to, prospective pay for ESRD care, nursing workforce development, physician payment policies, insurance coverage of immunosuppressant medications, and quality standards for CKD care. During this same time, at the state level, ANNA worked to protect patient safety and the quality of CKD care, helping to establish standards of practice and training for dialysis technicians. If this sounds like a repeat of activities in past years, it is just that, because these issues arise repeatedly from year to year. Funding for services, education, and research is a recurring issue in health care.

Summary

ANNA has been and continues to be a strong advocate for nephrology nursing issues in the legislative arena at state and federal levels. Over time, our members have developed considerable understanding of the legislative process and legislative advocacy. The biannual ANNA Legislative Workshop and the Nurse in Washington Internship both serve to actively strengthen legislative advocacy skills for nurses. Nursing activist Peggy Chinn has encouraged nurses by stating that the most worthy goal that nurses can select is that of arousing their passion for a kind of political activism that will make a difference in their own lives and in the life of society. Let that continue to be a goal for nurses in the 21st century as well.

Abbreviations and Acronyms

ANA	American Nurses Association
ANNA	American Nephrology Nurses Association
ASP	average sales price
ATRA	American Taxpayer Relief Act
BIPA	Medicare Beneficiary Improvement and Protection Act
CDC	Centers for Disease Control and Prevention
CKD	chronic kidney disease
CMS	Centers for Medicare and Medicaid Services
HHS	U.S. Department of Health and Human Services
ESCO	ESRD Seamless Care Organization
ESRD	end-stage renal disease
HRSA	U.S. Department of Health and Human Services Health Resources and Services Administration
KCP	Kidney Care Partners
KRT	kidney replacement therapy
MedPAC	Medicare Payment Advisory Commission
MIPPA	Medicare Improvements for Patients and Providers Act
MMA	Medicare Modernization Act
NSNA	National Student Nurses' Association
PAMA	Protecting Access to Medicare Act of 2014
PPS	prospective payment system
QIP	Quality Incentive Program
USRDS	United States Renal Data System

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